## Agenda

### Item 1.0: Welcome, introductions and apologies
- Declaration of conflicts of interest (1.1)
- Minutes of the meeting held on 30 March 2017 (1.2)
- Matters/Actions arising (1.3)

### Item 2.0: Chair and chief officer reports
- Chair’s report (2.1)
- Chief officer’s report (2.2)

### Item 3.0: Governing body assurance
- Governing body risk assurance framework report (3.1)
- BHRUT performance risks (3.2)

### Item 4.0: Service transformation and development
- System delivery framework (4.1)
- Consultation on the draft Health and Wellbeing Strategy for Redbridge 2017-2021 (4.2)

### Item 5.0: Quality and performance
- Patient experience report (5.1)
- Finance and activity report (5.2)
- Contract report (5.3)
- Quality report (5.4)

### Item 6.0: Development/governance
- Finance committees - proposals (6.1)
- The East London Health and Care Partnership agreement (6.2)
- Finance & delivery committee chair’s report (6.3)
- Audit & governance committee chair’s report (6.4)
- Work of the Financial Recovery Programme Board and financial recovery programme progress summary (6.5)
- Minutes of sub-committees and relevant fora:
  - Primary care committee
  - Quality & safety committee
  - Patient engagement forum
  - Joint executive committee

### Item 7.0: AOB
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<thead>
<tr>
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<th>Time</th>
<th>Lead director</th>
<th>Attached, verbal or to follow</th>
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## Glossary of terms and abbreviations

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<thead>
<tr>
<th>Term</th>
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<td>AO</td>
<td>Accountable Officer</td>
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<td>ADL</td>
<td>Activities of Daily Living</td>
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<td>APC</td>
<td>Area Prescribing Committee</td>
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<td>Accredited Safe Haven</td>
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<td>Better Care Fund</td>
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<td>BHR</td>
<td>Barking and Dagenham, Havering and Redbridge</td>
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<td>Barking, Havering and Redbridge University Trust</td>
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### Register of interests 2017/18

**Declaration of governing body members**

**Last updated: May 2017**

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<th>Amendment and date</th>
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<td>Dr Anil Mehta</td>
<td>Chair</td>
<td>Fullwell Cross Medical Centre</td>
<td>GP Partner</td>
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<td>The cleaning company</td>
<td>Owner - Sister in law</td>
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<td>Dr Sarah Heyes</td>
<td>Clinical director</td>
<td>The Shrubberies Medical Centre</td>
<td>GP Partner/Principal</td>
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<td>Dr Muhammad Tahir</td>
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<td>Forest Edge practice, Hainault Health Centre</td>
<td>GP Partner</td>
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<td>Nature of interest</td>
<td>Amendment and date</td>
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<td>Dagenham &amp; Redbridge Football Club</td>
<td>Medical adviser &amp; club doctor</td>
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<td>Redbridge local medical committee</td>
<td>Member</td>
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<td>Dr Mehul Mathukia</td>
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<td>GP Principal</td>
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<td>GP Partner from 1/5/16. Brother is a GP Principal</td>
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<td>Valia Consultancy – Healthcare &amp; research consultancy</td>
<td>Director/Owner/Shareholder</td>
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<td>Dr Shabana Ali</td>
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<td>works is receptionist/admin.</td>
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<td>GP with special interest in cardiology</td>
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<td>Director. Husband is also a director</td>
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<td>Employed at surgery that is a shareholder. Employed as locum in the Hub.</td>
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<td>Brother is a director – freelance GP-services to</td>
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<td>Dr Shujah Hameed</td>
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<td>Ah-Fee Chan</td>
<td>Secondary care consultant</td>
<td>North Middlesex University Hospital NHS Trust</td>
<td>Consultant in Anaesthetics and Intensive Care Medicine</td>
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<td>Nadia Medical Services Ltd (March 2015)</td>
<td>Director of the company providing consultant services at a range of private facilities in London where practice privileges are given</td>
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<td>Charles Beaumont</td>
<td>Associate Independent Lay Voting Member for Audit Committee and</td>
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<td>Conor Burke</td>
<td>Accountable officer</td>
<td>None</td>
<td></td>
<td>Your business works (not trading) - removed Jan 2017 Redbridge college – removed Jan 2017</td>
</tr>
<tr>
<td>Louise Mitchell</td>
<td>Chief operating officer</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Tom Travers</td>
<td>Chief financial officer</td>
<td>Royal Free Foundation Trust</td>
<td>Wife works in finance department</td>
<td></td>
</tr>
<tr>
<td>Jacqui Himbury</td>
<td>Nurse director</td>
<td>None</td>
<td></td>
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<tr>
<td>Khalil Ali</td>
<td>Lay member</td>
<td>Dr Joseph’s GP practice, Collier Row, Romford St Francis Hospice, Havering Cancer Research</td>
<td>Family GP Spouse is donor Spouse is a donor</td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>Role</td>
<td>Organisation</td>
<td>Nature of interest</td>
<td>Amendment and date</td>
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<td></td>
<td></td>
<td>Brentwood Citizen's Advice Bureau</td>
<td>Lay Member</td>
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<td></td>
<td></td>
<td>Barking and Dagenham CCG</td>
<td>Lay Member</td>
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<td></td>
<td></td>
<td>Havering CCG</td>
<td>Lay Member</td>
<td>Benwin Leighton Paisner (BLP) <strong>removed</strong> May 2017.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>PricewaterhouseCoopers</td>
<td>Kiren Pandya (son) Management consultant (2013)</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Accenture</td>
<td>Anand Pandya (son) Solicitor</td>
<td><strong>Added</strong> May 2017</td>
</tr>
<tr>
<td></td>
<td></td>
<td>University of Essex</td>
<td>Independent Audit Committee member (2013-19)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Southend on Sea Borough Council</td>
<td>Independent Audit Committee Member (2016-18)</td>
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</table>
Draft Redbridge Clinical Commissioning Group Governing Body minutes

held on 30 March 2017 Becketts House

Present:
Dr Anil Mehta (AM)   Clinical Director and Chair
Dr Shabana Ali (SA)   Clinical Director
Dr Syed Raza (SR)   Clinical Director
Dr Sarah Heyes (SH)   Clinical Director
Dr Anita Bhatia (AB)   Clinical Director
Dr Jyoti Sood (JS)   Clinical Director
Dr Mehul Mathukia (MM)  Clinical Director
Dr Muhammad Tahir (MT)  Clinical Director
Kash Pandya (KP)   Lay member - governance
Khalil Ali (KA)    Lay Member-PPI
Conor Burke (CB)   Accountable Officer
Tom Travers (TT)   Chief Finance officer
Jacqui Himbury (JH)   Nurse Director

In Attendance:
Marie Price (MP)   Director of Corporate Services
Vicky Hobart (VH)   LBR Director of Public Health
Anne-Marie Keliris (AMK)  Company Secretary
Lee Eborall    NELCSU

Apologies:
Louise Mitchell (LM)   Chief Operating Officer
Caroline Maclean   Operational director, adult social service, LBR
Dr Ah Fee Chan (AFC)   Secondary Care Consultant
Cathy Turland (CT)   CEO Healthwatch
Dr Shujah Hameed (SHA)   Clinical Director

<table>
<thead>
<tr>
<th>Item</th>
<th>Welcome and apologies</th>
</tr>
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<tbody>
<tr>
<td>1.0</td>
<td>The Chair welcomed members to the meeting and apologies for absence were noted.</td>
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<table>
<thead>
<tr>
<th>Item</th>
<th>Declarations of conflicts of interest</th>
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<tbody>
<tr>
<td>1.2</td>
<td>The Chair reminded governing body members of their obligation to declare any interest they may have on any issues arising at the meeting which might conflict with the business of Redbridge clinical commissioning group.</td>
</tr>
</tbody>
</table>
  
  Declarations declared by members of the governing body are listed in the CCG’s Register of Interests. The Register is available either via the secretary to the governing body or the CCG website at the following link:

Dr Sood reported that Newbury Park practice is now a member of Healthbridge and would complete an updated declaration of interest form.

1.3 Minutes of the last meeting
The minutes of the meeting held on 26 January were agreed as a correct record.

1.4 Matters/Actions arising
The committee noted the actions taken since the last meeting.

2.0 Chair & Accountable Officer’s Reports

2.1 Chair’s report
The Chair presented his report covering the following areas:
- RTT
- Financial situation
- BHRUT special measures
- Networks and localities
- Meetings

The governing body noted the report.

2.2 Chief Officer’s report
CB presented his report covering the following areas:
- BHRUT
- Financial recovery
- Clinical engagement
- CCG development
- BHR Accountable Care System and Sustainability and Transformation Plan (STP)
- CCG assurance
- Health and wellbeing board update
- Meetings

KA commented that he was pleased to note that BHRUT were no longer in special measures. He also highlighted the need to continue investment in primary healthcare and mental health.

VH commended the CCG for their input into BHRUT coming out of special measures.

The governing body noted the report.

1.50pm Dr Raza arrived

3.0 Governing body assurance

3.1 Governing body assurance framework
MP presented a report which outlined the key risks to the clinical commissioning group in achieving its corporate objectives as identified in the governing body risk assurance framework. There are five risks on the GBAF:

1. Barking, Havering and Redbridge University Hospitals Trust (BHRUT) emergency care performance
2. BHRUT referral to treatment times (RTT) performance
3. BHRUT cancer 62 days
4. Barts Health (BH) performance against key targets, A&E, RTT and cancer
5. BH quality concerns
6. Risks to the delivery of the CCG’s budget
7. Planned acute contract activity versus actual activity

The Chair commented that risks continue to be the same for a significant time and hoped that by setting up of the clinical cabinet improvements will be more evident. CB responded that the clinical cabinet will support the whole system and not just constitutional targets.

SAli asked how any innovations the clinical cabinet suggest will be funded. CB responded that any benefits delivered from innovations will need to be demonstrated. He added that budgets have been committed and challenging discussions around outcomes is required on how we deliver services differently in the future.

The governing body noted the current risks escalated to the GBAF and levels of assurance in the controls and mitigating actions being taken.

### 3.2 BHRUT performance risks

CB presented a report which provided a further update on the key actions the CCG is taking to seek performance improvements at the Trust. It is doing this by both holding the Trust to account through its contract and other mechanisms, as well as providing overall support through wider system initiatives overseen through the A&E Delivery Board and the joint RTT Programme Board.

- **A&E** – It was noted that A&E is relatively stable and comparable to other trusts in London. Due to the significant scrutiny on urgent and emergency care nationally there is significant focus on BHRUT from the Secretary of State and we will continue to focus on delivery in supporting the system to recover.

- **RTT** – It was noted that recovery is ahead of plan and the latest validated position on the 52 week wait is expected in early May. Return to the constitutional standard is expected by the summer.

- **Cancer** – It was noted that the Trust was on track to recover the position by the end of March. There had been challenges in urology but this was also back on trajectory.
CB welcomed the news that the Trust is now out of special measures and proposed that the governing body considers standing down this regular report at the next meeting.

KA commended LM for her work on the RTT programme and on behalf of patients, staff at BHRUT should also be commended. KP echoed this. He noted that A&E attendances at King George’s are higher than Queen’s hospital and questioned the reason for this. CB reported that the difference between the two sites was marginal.

The Chair commented that A&E pressure will continue to increase due to a continued shortage of GPs in Redbridge.

The Governing Body noted the action being taken to date to mitigate the performance risks at BHRUT.

2.15pm Dr Tahir arrived

<table>
<thead>
<tr>
<th>4.0 Corporate strategy and planning</th>
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<tbody>
<tr>
<td>4.1 System delivery framework and plan (SDFP)</td>
</tr>
<tr>
<td>CB presented a report which updated on progress made to date against implementation of the System Delivery Framework and to seek governing body agreement to delegating sign-off, of the final submission, to the Chair and Accountable Officer.</td>
</tr>
<tr>
<td>KA commented that it would be helpful to see the level of communications and engagement planned as the proposals will be very confusing for the public. CB noted that communications and engagement plan will be key to this and the plan will address both the current challenge as well as the medium to long term future.</td>
</tr>
<tr>
<td>KP referred to provider cost improvement plans (CIP) and questioned how these will fit into the SDFP. CB responded that STP board will receive provider CIP plans which are also part of the scope of this work. KP suggested that any communications should include this wider figure. CB agreed that this would be included once the figure has been confirmed.</td>
</tr>
<tr>
<td>KP suggested adding milestone reviews to FRPB terms of reference to ensure governance is working. He also suggested that the investment committee may not be required in future. CB agreed that this will need to be reviewed.</td>
</tr>
<tr>
<td>CB reported on the independent review of system delivery arrangements which should start to describe the underlying financial position. He also reported that Mike Farrar will facilitate discussion between the CCG and BHRUT governing body/boards.</td>
</tr>
<tr>
<td>The governing body:</td>
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<tr>
<td>• Noted the System Delivery Framework governance structure</td>
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</tbody>
</table>
• Delegated authority to the Chair and Accountable Officer to sign off the final submission of the System Delivery Framework to regulators on 31 March 2017.
• Noted the alignment to the STP and devolution processes
• Approved the terms of reference for the FRPB

4.2 Finance Budget 2017/2018
TT presented a paper which reported that an updated operating plan was submitted to NHS England on 27 February 2017. The operating plan sets out the planned activity and performance levels for the coming year. Alongside this a finance template was submitted which forms the budgets for the CCG. The budget outlined in the paper is the resource plan to deliver the 17/18 operating plan.

As per the previous operating plan submitted in December, the CCG did not meet the in-year break even requirement and submitted a 17/18 plan the delivers a deficit of £2.5m. This position includes a challenging QIPP target of £15.2m. The QIPP target includes £2.6m of full year impact of 16/17 schemes and £12.6m of new 17/18 schemes.

The system wide work to deliver QIPP is ongoing. The QIPP submitted in the plan reflects the system delivery plan at 22 February 2017. The CCG agreed the presentation of QIPP in the operating plan with NHSE.

The forecast used in the plan has been updated to Month 10 and the detailed expenditure in the plan has been updated to include all contracts agreed to date. In line with previous submissions the plan includes assumptions with regard to inflation, demographic and non-demographic growth, investment and full year / non recurrent impact of 2016/17 issues.

A high level of unmitigated risk has been identified within the plan, it includes QIPP delivery, acute growth, prescribing pricing and CHC growth. In total the net risk has been estimated at £7.5m. Materialisation of this risk if unmitigated, could result in the CCG delivering an in year deficit of £10m. The challenging 2017/18 financial position impacts on the 2018/19 plan. The current 2018/19 plan requires £7m QIPP to deliver an in-year surplus of £0.7m.

KA referred to changes in activity levels from 16/17 to 17/18 and questioned whether a reduction of 8% for first out-patient attendances should be communicated to the member practices. TT agreed that it would be useful to share this information along with demand management and redesign of pathways.

KA questioned whether a statement of intent for investment in primary care should be included. TT responded that any investment will need to go through rigorous financial scrutiny.

The Chair questioned what the two year growth is for Redbridge. TT confirmed it was 2.99%.
The Governing Body agreed the updated 2017/18 and 2018/19 financial plans and noted the financial risks associated with the delivery of the plans.

### 4.3 Healthy London Partnership beyond 17/18

TT presented a report which provided an update on the continued progress of the Healthy London Partnership (HLP) programme and of HLP planning for 2017/18.

Discussion ensued and it was agreed that the benefits the CCG would receive from its investment were unclear. VH commented that it was disappointing to see how the report describes the programmes and more detailed work is going on which is not included in the report and felt it would be a loss if the work did not continue.

The governing body supported the investment in principle subject to further details on value for money and would be submitted to the financial recovery programme board for a formal decision.

### 5.0 Quality and performance

#### 5.1 Patient experience report

KA presented a report which provided a summary of the various feedback that has come through to the CCG from patients and stakeholders highlighting the following areas:

- The current plans and activities regarding the Patient Engagement Forum (PEF)
- Work on strengthening relationships with the voluntary and community sector
- Wheelchair and equipment services review
- PPG questionnaire
- Forthcoming engagement on financial situation

The governing body noted the report.

#### 5.1 Finance & activity report

TT presented the month 11 the CCG reported a year to date deficit of £7,901k with a forecast year end deficit of £10,306k. This is before the application of any risk share funding or the release of the 1% risk reserve. The main drivers to the variance to plan are RTT backlog clearance, acute contracts (including QIPP performance) and continuing healthcare. The reported position includes delivery of a RAG rated Finance Recovery Plan which is forecast to deliver £7,641k of cost efficiencies for Redbridge CCG.

**BHRUT** - The forecast variance reported at Month 11 is an underspend of £286k. The contract is being managed under full PbR rules.

**Barts Health** – The year to date variance shown against the Barts Health contract is £1,505k with a forecast overspend of £1,712k. The forecast position is based on the year end agreement with Barts Health.
Associates and other acute providers - There is high level of overspend across the associates and other acute providers– the current forecast overspend is £3,711k. The position has worsened in month by £496k.

Services Delivered in a Primary Care Setting – The total predicted year end value is an underspend of £558k. The main drivers behind this are:

- Prescribing
- Walk in centre
- Primary care co-commissioning
- Continuing care
- Community services
- Mental health and learning disabilities

The governing body agreed the financial position and noted the action taken to achieve it.

5.2 Contracting report
TT presented a report which updated on the contract performance for Month 9 2015/16 for Acute, Community and Mental Health services highlighting the following:

BHRUT - are failing to meet several of the national standards required in the Operating Framework. Commissioners continue to manage performance actively through subject specific fora for Cancer, Referral to Treatment (RTT) and Accident and Emergency (A&E). There are action plans in place to recover the standards for A&E, RTT, and Cancer with supporting improvement trajectories. A total of eleven contract performance notices (CPN) are open across providers for non-compliance with required national and contract standards (see Appendix 1). The overall quarter 2 reconciliation position for BHRUT is ongoing, with an indicative completion date set for the end of February 2017.

Barts Health - operational and performance issues are being managed by the lead commissioner (Newham CCG) in line with the contractual governance framework. Barts Health is failing to meet several of the national standards required in the Operating Framework. There are a number of action plans currently in place for RTT, cancer, serious incident (SI) management and data quality that are being actively managed by the lead commissioner. The Barts Health is held to account on actions required with associated penalties enforced in accordance within the contract.

NELFT - are performing to quarter 3 contracted standards in their community services and mental health service contracts with the exception of marginal underperformance in the improving access to psychological therapies (IAPT) access target. The CQC published their inspection report and rated NELFT; ‘Requires Improvement’. A quality summit has been held. Commissioners’ response is being led by the Nurse Director.

PELC - The sustainability and accountability of PELC is underpinned by the signing of a 2 year contract by commissioners and during the first year
of the contract PELC’s financial position has stabilised. PELC’s performance for the NHS 111 service in recent weeks has fluctuated due to a surge in call demand and very high call volumes. Green ambulance re-triage for lower acuity calls have been around 65% of all calls re-triaged. Support for the implementation of the ‘Well Led Review’ recommendations has continued through consultants engaged by commissioners. The emergence of serious concerns regarding governance and departure of key senior members of staff, led commissioners to issue a formal contractual action via a CPN for breach of service development improvement plan (SDIP) requirements and retained the ‘Support Team’ services beyond its original remit to continue to support PELC.

LAS - continues to be very challenged in their delivery of the 8 minute response standard, with the year to date for the Redbridge CCG at 57.3% against a standard of 75%.

KA referred to LAS continued failure to achieve performance and was concerned that more funding is being requested. TT acknowledged these concerns and reported that this is being disputed and that concerns have been raised across London and nationally.

The governing body agreed the reported M9 position for the two main acute and two main non-acute contracts.

2.55pm MM left the meeting

5.3 Quality report
JH presented a report which provided assurance that the CCG continues to measure and monitor the quality of the services we commission from all providers including:

- NELFT CQC inspection
- BHRUT CQC inspection
- Barts Health CQC inspection
- Care Home Strategy 2017-2020
- Quality impact assessment process
- System wide recruitment of medical and nursing staff
- Provider quality performance improvements and challenges addressed through the CQRM

The Chair requested an update on GP alerts. JH reported on the recent backlog due to a web link issue and will be undertaking a review on how GP alerts is operating from 1 April.

Clinical directors expressed concern that there is no follow up or feedback from alerts and it was suggested that clinical leads should be alerted and a review of how GP alerts are responded to.

KA referred to the care home strategy and questioned how this is monitored and the process for breaches. JH reported that the care home strategy had been approved by the last quality and safety committee.
which will now develop an implementation plan. She added that when concerns are raised a quality assurance visit takes place.

The governing body noted the report and the following was agreed:
- Clinical leads will be informed when GP alerts are raised
- An update will be provided within the quality report at the next meeting

### 6.0 Development/governance

#### 6.1 Finance & delivery committee chair’s report
The Chair presented a report which provided key highlights of the finance and delivery committee held on 21 February 2017.

The governing body noted the report.

#### 6.2 Audit & governance committee report
KP presented a report which provided key highlights of the audit and governance committee held on 14 February 2017.

The governing body noted the report.

#### 6.3 Minutes of sub committees:
The governing body noted the minutes of:
- Primary care commissioning committee held on 7 December 2016.
- Investment committee held on 14 February 2017.
- Patient engagement forum held on 10 January 2017.
- Joint executive committee held on 8 December 2016.

### 7.0 AOB

- It was agreed that a briefing on the draft health and wellbeing strategy will be provided the next meeting.
- SAli reported that a practice in the Wanstead and Woodford locality was not engaging in locality arrangements. CB would ask the primary care team to make contact with the practice.
- MT expressed concern due to the amount of activity from the acute sector to primary care and the resources not following and the impact this is having on practices. CB noted these concerns and reported that the acute sector is also experiencing pressures and suggested the primary care strategy could address these pressures. SH reported on an exciting development in GP IT which will support practices on workflow optimisation.

### 8.0 Questions from the public
There were no questions from the public.

### 9.0 Date of the next meeting
26 May 2017
### Actions arising from the Redbridge CCG Governing Body held on 30 March 2017

<table>
<thead>
<tr>
<th>Action reference</th>
<th>Action required</th>
<th>Lead</th>
<th>Progress</th>
</tr>
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<tbody>
<tr>
<td>6.4 Quality report</td>
<td>Clinical leads will be informed when GP alerts are raised. An update on GP alerts will be provided within the quality report at the next meeting</td>
<td>JH</td>
<td>Item 5.4 on agenda.</td>
</tr>
<tr>
<td>7.0 Any other business.</td>
<td>It was agreed that a briefing on the draft health and wellbeing strategy will be provided the next meeting. SAli reported that a practice in the Wanstead and Woodford locality was not engaging in locality arrangements. CB would ask the primary care team to make contact with the practice.</td>
<td>VH</td>
<td>On agenda</td>
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<td></td>
<td></td>
<td>SS</td>
<td>There has been a conversation with the Practice Manager about engagement with the Network but due to known capacity issues at the practice they are not able to commit to the Network meetings at this time. The CCG will formally write to the practice head office to make them aware that the CCG has been advised that the practice is unable to participate in the CCG commissioning agenda and shape their local provider network, and that we'd welcome dialogue as to how they might address this situation.</td>
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**Note:** The information provided is a summary of the actions and decisions made during the meeting. For detailed discussions and decisions, please refer to the full meeting minutes and agenda.
To: Meeting of the NHS Redbridge Clinical Commissioning Group Governing Body

From: Dr Anil Mehta, Chair

Date: 26 May 2017

Subject: Chair’s report

Executive summary
The report provides an overview of key activities undertaken by myself and the CCG since the last governing body meeting.

Recommendations
The governing body is asked to note the report.

1.0 Purpose of the report
1.1 To provide an update on my activities since the last meeting and on key CCG news.

2.0 Financial situation
2.1 Since the last meeting Havering CCG’s Directions for RTT have now been formally lifted, but Directions have been issued to Barking and Dagenham, Havering and Redbridge (BHR) CCGs in respect of our financial situation. Governing body members will be aware of the extensive efforts underway to close the financial gap in our borough and wider BHR system. The system delivery report and finance report on the agenda provide further detail on our progress to date and the challenges we still face. Our consultation on spending NHS money wisely is progressing well, with a good level of engagement from residents and stakeholder groups in the borough.

3.0 System developments
3.1 Tackling the financial challenges in Redbridge and our wider system will require a step-change in the way that we work as commissioners and providers. Strategic work at the BHR and NEL level is responding to the challenges faced, and key to this is the development of networks and localities. We have made positive progress in developing our clinical engagement strategy for the system, which has been discussed at our BHR informal weekly meetings and at the System Performance and Delivery Board, co-chaired by Dr Saini of Havering CCG. The Clinical Cabinet met for the first time this month.

3.2 I attended a meeting with Anne Rainsberry, Regional Director of NHS England (London) and the north east London (NEL) CCG chairs on 11 May. We discussed potential changes and realignment of resources to support a focus on accountable care system development and working at scale across the NEL sustainability and transformation plan (STP) footprint where it makes sense to.
3.3 We have a three CCG governing body away day session on 18 May where we will be focussing on the challenges for 2017/18 and our strategic response to these, including the developments discussed with NHSE on 11 May.

4.0 Meetings

4.1 In addition to the many committee meetings I attend, below is a summary of other meetings I’ve been to since the last governing body meeting.

4.2 Meeting with the Mayor of London: My Havering Chair colleague Dr Aggarwal and I attended a positive meeting of London CCG chairs and the Mayor of London, Sadiq Khan. It was a productive meeting, with the Mayor outlining his ambitions with regard to mental health and plans for tackling air pollution. He also expressed his desire to work closely with CCG chairs in future.

4.3 Weekly BHR CCG GB member meeting (IJEC): our weekly meetings have focussed on progress with the system delivery and finance recovery plans, clinical engagement strategy and leadership, and updates on the key programmes.

4.4 Informal CDs’ meetings: I continue to have our local meetings with our clinical leadership team. As reported last time, our focus is primarily on financial recovery, pathway redesign and network/locality progress.

4.5 Health and wellbeing board: the May meeting focussed on the health and wellbeing strategy consultation and the social prescribing programme, which members will be aware is something that this governing body has supported.

5.0 Resources/investment

5.1 There are no additional resource implications/revenue or capital costs arising from this report.

6.0 Equalities

6.1 There are no direct equality implications arising from this report.

7.0 Risk

7.1 The CCG is managing a number of serious risks which are outlined in further detail in the assurance section of this agenda.

8.0 Managing conflicts of interest

8.1 There are no conflicts of interest arising from this report.

17 May 2017
To: Meeting of the NHS Redbridge Clinical Commissioning Group Governing Body

From: Conor Burke, Chief Officer

Date: 26 May 2017

Subject: Chief Officer’s Report

Executive summary
This report provides an overview of key activities undertaken by the Chief Officer and the CCG since the last meeting.

Recommendations
The governing body is asked to:
- Note the progress report

1.0 BHR System Delivery Plan
1.1 The CCGs continue to make progress in identifying opportunities through the System Delivery Plan (SDP). Of the requirement to deliver an in-year (17/18) cost reduction of £55m, the BHR CCGs have identified a total opportunity of £44m, of which £31.5m has been assured. We have implemented revised processes for monitoring delivery and performance of “live” schemes, scheme level reviews are taking place on a weekly basis, with weekly escalation of issues to the Financial Recovery Programme Board.

1.2 The CCGs continue to work closely with system partners, BHRUT and NELFT to develop additional pathway opportunities, to mitigate the current unidentified amount. BHRUT and the BHR CCGs have agreed a joint process of assuring schemes. In addition governance arrangements have been developed at a system level (using existing Integrated Care Partnership Board structures) to ensure wider system ownership of the plan.

2.0 CCG Development
2.1 While it is positive that the Directions in relation to RTT have been lifted, we have since the last meeting been issued with Directions regarding the CCG’s deteriorating financial position. As members will be aware, we have been focussing our efforts with partners as summarised above to deliver a sustainable financial position for the BHR CCGs and our wider health and care system.

2.2 We are due to receive the final outputs of the related review of our arrangements, but have already developed a draft action plan. This recognises the requirements to further integrate governance, to build on our executive and clinical leadership arrangements, the wider ‘one team’ pan-BHR programme approach and closer system working. We have an away day of the three governing bodies on 18 May to explore this further and agree our priority objectives and organisation development plan for the current year. The revised objectives will be reported back to the next governing body meeting.

3.0 Health and Wellbeing Board update
3.1 At the Redbridge Health and Wellbeing Board on 15 May discussions focused on the Care City Innovation Test Bed Programme and a progress report on the Redbridge Social Prescribing Programme.
4.0 Meeting attendance
4.1 On 29 March I presented at a Transforming Workplace Health. I spoke about some of the activities and initiatives the CCG has implemented over the last year and some of the challenges that we face with regards to workplace health.

4.2 On 3 May I attended the London Chief Officers meeting, which Simon Stevens, Chief Executive of NHS England joined, and which focused on 17/18 delivery priorities.

5.0 Equalities
5.1 There are no equalities implications arising from this report.

6.0 Risk
6.1 There are no risks arising from this report.

7.0 Managing of conflicts of interest
7.1 There are no conflicts of interest issues relevant to this report.

8.0 Resources/investment
8.1 There are no additional resource implications/revenue or capitals costs arising from this report and no impact on sustainability.
Executive summary
The governing body assurance framework (GBAF) has been reviewed to reflect the current significant risks to the organisation. There are five risks on the GBAF, with one risk that has been de-escalated and one of the three grouped Barts Health (BH) performance risks also de-escalated. Risk ratings are based on the April 2017 risk register.

The five risks on the GBAF are:
1. Barking, Havering and Redbridge University Hospitals Trust (BHRUT) emergency care performance
2. BHRUT cancer 62 days
3. BH performance against key targets, A&E and RTT
4. BH quality concerns
5. Risks to the delivery of the CCG’s budget

With the good progress BHRUT has made against the referral to treatment times (RTT) performance standard this risk has been de-escalated from the GBAF as the Trust is on track to meet the end of September 2017 trajectory. The BH cancer performance risk has also been de-escalated because the Trust has sustained delivery of the 62 day target since September 2016. These two risks will remain on the collaborative risk register.

Recommendations
The governing body (GB) is asked to:
- Note and comment on the current risks escalated to the GBAF and the levels of assurance in the controls and mitigating actions being taken
- Raise and discuss other potential risks that may require escalation to the next GBAF or where the risk has reduced de-escalation.

1.0 Purpose of the Report
1.1 The purpose of the GBAF is to outline the key strategic risks to the Clinical Commissioning Group (CCG) in achieving its corporate objectives and the controls in place to provide assurance that the risks are being managed.

2.0 Background/Introduction
2.1 The CCG’s governing body has a responsibility to maintain sound risk management and ensure that internal control systems are appropriate and effective, and where necessary to take appropriate remedial action. The CCG’s risk register consists of risks that are local to the
borough and risks that the CCG has in common with its collaborative partners, Barking and Dagenham and Havering CCGs.

3.0 Current risks on the GBAF
3.1 There are five risks on the GBAF. Please refer to appendix 1 for the full details. These fall under four of our six corporate objectives and are as follows:

Corporate objective 1
Ensuring that planned care is appropriate, timely and of high quality – with a particular focus on tackling the RTT delays.

Risk 1.3: BHRUT cancer performance standard: The Trust has consistently not achieved the 62 day cancer waiting time target with potential clinical risk to the patient pathway impacting on early detection and survival rates.

Mitigation:
- Revised, robust and realistic trajectory from the Trust to resume delivery of the performance standard by 31 March 2017 and at specialty level (urology) by May 2017
- Fortnightly CCG led 62 day Cancer Performance Recovery Board with BHRUT
- Fortnightly operational stock take meeting with the CCG, BHRUT and NEL Commissioning Support Unit
- Collaborative capacity and demand plan agreed and completed
- Weekly monitoring of planned against actual activity

The Trust has achieved the agreed cancer trajectory at an aggregate level to resume delivery of the performance standard by the end of March 2017 and as a result of this good progress the risk has been reduced from red rating of 16 (severe) to a high amber rating of 12. However the Trust target at specialty level is planned for delivery by 31 May 2017 and urology remains the specialty at risk. The data to confirm achievement of the May target will be available in July at which time this risk will be reviewed and may be de-escalated from the GBAF.

Collaborative objective 3:
Implementation of the system wide urgent care strategy and redesign of the urgent care pathway

Risk 3.1: BHRUT’s on-going failure to deliver A&E performance standards will impact, 1) quality improvement in emergency care, 2) put patients at risk, 3) cause reputational damage and 4) delay the implementation of acute reconfiguration programmes.

Trust performance has improved significantly over the past year, prior to the onset of winter pressures. In the context of the current nationally reported pressures the Trust is no longer identified as one of the very high risk Trusts in London. It should be noted however that performance is still fragile.

Mitigation:
- The Accident and Emergency Delivery Board is leading the work to support operational delivery
- UEC programme established with five delivery work streams delivering the improvements required across the system. Plan reviewed by Emergency Care Improvement Programme (ECIP) with priority to patient flow / discharge
- Friends and family test (FFT) scores recovery plan and performance monitored through CQRM and SPR
- Detailed delivery plan agreed for all work streams and aligned where necessary with the System Recovery Plan
- Acute reconfiguration now being led through NEL STP.
Collaborative objective 5
High quality, compassionate and safe care for all commissioned services – delivering better outcomes.

Risk 5.4a and c. Barts Health (BH) performance – this risk groups together two performance areas that BH are failing to achieve, RTT and urgent and emergency care. There are also data quality concerns that present a further challenge for commissioners. The risks could threaten the long-term viability of the Trust and could put patients at risk and cause reputational damage.

Risk 5.4a – 18 weeks RTT - significant issues exist affecting the delivery of this target - key issues with the number of patients on the incomplete waiting list and those waiting over 52 weeks.

Mitigation:
- RTT recovery is reflected in the improvement plan work being undertaken by BH after being placed in special measures in March 2015 with oversight by our lead commissioners via the RTT and monthly performance meetings with the Trust.
- Trust to produce an initial return to national reporting trajectory and roadmap for review at the RTT Recovery Programme Board by 9 June 2017.
- To return to reporting on RTT in October 2017
- The Trust is undertaking real time validation of the PTL
- Performance is reviewed at the contract review group monthly (CRG) (lead commissioner)
- Monthly BH (BHR CCGs) escalation and review meeting with updates on performance

Risk 5.4c: Urgent and emergency care - failure to deliver quality improvements at BH (specifically at Whipps Cross hospital)

Mitigation:
- Monthly Urgent Care Working Group for the Whipps Cross system attended by Waltham Forest CCG, NELFT, Local Authorities, LAS and other partners which feeds into the monthly A&E Delivery Board.
- Monthly A&E Delivery Board attended by all 3 WEL CCGs and partners across NE London.
- Progress against the improvement plan reviewed jointly by all commissioners. The Trust’s A&E trajectory is to achieve compliance with the 95% standard by March 2018 (and to achieve 90% by September 2017).
- Serious incident issues being addressed via the Clinical Quality Review Meeting (CQRM) (attended by the nurse director on behalf of BHR CCGs).

Risk 5.6: If BH do not achieve their quality indicators, (Never Events, Serious Incidents - recurring themes and the 4 harms, 1) Healthcare acquired Infections (HCAI), 2) Venous Thrombus Embolisms (VTE), Pressure Ulcers and Falls, patients may receive poor quality of care and suffer harm. More recently further concerns have developed around the management of serious incidents and complaints as well as compliance with Regulation 20 – the Duty of Candour.

Mitigation:
- Monitor the impact of the CQC improvement plan
- Formerly escalate concerns to the lead commissioner via a number of sources, i.e., Quality Leads meeting
- Share concerns with the NECL Quality Surveillance Group
- Update the Quality and Safety Committee at each meeting – Committee to recommend further actions as necessary
- Quality risks reviewed at CCG and BH escalation meeting and risk escalated via letter to the lead commissioner
Apply contract performance notices
Noncompliance formally raised at the lead commissioner quality Key Performance Indicators meeting and for escalation as breach of contract.

**Collaborative objective 6:**
Continued focus on our development as an organisation and health system so that we can meet the challenges ahead and deliver better outcomes, quality and financial efficiency.

**Risk 6.2: (revised):** Significant risks to the delivery of the CCGs' financial plan - legal directions on financial delivery of our QIPP requirements in year and management of any acute over activity relating to underlying performance: a) Legal Financial directions, b) If we do not deliver against the CCGs' QIPP plans the CCGs will be in breach of its financial control total and c) risk of over performance in acute, continuing care or prescribing activity.

**Mitigation:**
- Implementation of the CCG’s action plan from the finance and governance review
- BHR CCGs developed System Delivery Framework and Plan, as a mechanism to drive system recovery
- Weekly Financial Recovery Programme Board (FRPB) chaired by the Chief Financial Officer
- Financial Recovery Planning, Delivery and Monitoring group (FRPDM) established with the responsibility for oversight of the QIPP development process and monitoring delivery against plan, reporting to the Financial FRPB
- Financial risk mitigation via our integrated financial strategy across north east London sustainability and transformation plan (STP) with continued development through the STP process
- Aim to overachieve the QIPP requirement to provide stretch generating schemes and therefore savings over and above the £55m target

4.0 De-escalated and amended risks

4.1 Risk 5.4b – BH 62 days cancer target has been de-escalated from the GBAF because the Trust has sustained achievement of this standard since September 2017. Given delivery of the cancer target the risk rating has reduced from a red (severe) rating of 20 to an amber (high) rating of 12. This risk will remain on the BHR CCGs’ collaborative risk register and where it will continue to be monitored.

4.2 Risk 6.1 - BHRUT 18 Weeks RTT standard. The BHRUT risk regarding the failure to deliver the 18 week standard has been de-escalated from the GBAF in April 2017 because of the good progress being made against the agreed trajectory and the Trust being on track to achieve the September 2017 target. The risk rating has reduced from a red (severe) rating of 15 to an amber (high) rating of 8. The risk will remain on the BHR CCGs’ collaborative risk register where it will continue to be monitored.

4.3 Risks 6.2 – The risk regarding acute activity (PbR) has been reviewed and incorporated into the risk regarding the delivery of the CCG’s financial plan.

5.0 Resources/investment

5.1 There are no additional resource implications/revenue or capital costs arising from this report. The cost of operating effective risk management arrangements is met from within existing resources.

6.0 Equalities

There are no equalities considerations arising from this report
7.0 Risk
7.1 This report also links to the following GB papers being presented at this meeting and provide greater detail on key risks mentioned above and the organisations mitigations.

- GBAF risk ref. 1.2, 1.3 and 3.1 relates to the BHRUT performance report
- GBAF risk ref. 6.1 relates to the contract report and the system delivery framework report

8.0 Managing conflicts of interest
8.1 There are no conflicts of interest considerations arising from this report.

Attachments:
Appendix 1 - Governing body assurance framework and summary

Author: Pam Dobson, deputy director, corporate services, BHR CCGs
Date: 5 May 2017
Appendix 1 – NHS Redbridge CCG

Corporate objective 1: Ensuring that planned care is appropriate, timely and of high quality – with a particular focus on tracking the referral to treatment (RTT) delays.

Risk Description:

BHRUT cancer performance standard: The Trust has consistently not achieved the 62 day cancer waiting time target – with potential clinical risk to the patient pathway impacting on early detection and survival rates.

<table>
<thead>
<tr>
<th>Initial Risk Rating 5/2015</th>
<th>Controls</th>
<th>Assurances I = internal E = external</th>
<th>Current risk rating</th>
<th>Evidence for assurance</th>
<th>Gaps</th>
<th>Proposed actions</th>
<th>Target Risk – 30/06/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Fortnightly operational stocktake meeting between the CCG, BHRUT and NEL CSU</td>
<td>3. Weekly cancer performance pack reviewed with weekly update to EMT regarding potential risks. (E)</td>
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</table>

Likelihood (3) x Impact (4) = Severe 12

Evidence for assurance

Control Assurance

Proposed actions

Target Risk – 30/06/17

Likelihood (2) x Impact (4) = High 8

Additional remedial actions agreed for urology specialty to return to the 62 day standard by 31 May 2017

NB: BHRUT are on track to achieve the 62 day cancer standard at Trust level by 31 March 2017 (excluding urology). Given this progress it is proposed that the risk rating that currently stands at 20 is reduced to 15 and that this will be updated on the March 2017 risk register.
**Collaborative objective 3:** Implementation of the system wide urgent care strategy and redesign of the urgent care pathway

**Risk Description:**
BHRUT's on-going failure to deliver A/E performance standards will impact, 1) Quality improvement in emergency care, 2) Put patients at risk, 3) Cause reputational damage and 4) Delay the implementation of acute reconfiguration programmes.

**Lead director:** Alan Steward  
**Risk ref:** 3.1

<table>
<thead>
<tr>
<th>Initial Risk Rating 6/2013</th>
<th>Controls</th>
<th>Assurances I = internal E = external</th>
<th>Current risk rating</th>
<th>Evidence for assurance</th>
<th>Gaps</th>
<th>Proposed actions</th>
<th>Target Risk – 30/06/17</th>
</tr>
</thead>
</table>
| Likelihood (4) x Impact (4) = Severe 16 | 1. Accident and Emergency Delivery Board (formerly the SRG).  
2. Urgent and Emergency Care (UEC) Programme Steering group  
4. Winter only - daily surge calls with the Trust and reassurance with NHSE | 1. Minutes of the monthly Accident and Emergency Delivery Board. (E)  
2. Minutes of the monthly UEC Programme Steering Group. (E)  
3. Minutes of monthly contractual meetings – SPR / CQRM. (I)  
4. Notes of daily surge call. (E) | The BHRUT Performance Risks report and Contract report provide greater detail on the management of this risk. | None | There are no gaps and the commentary below provides update.  
1. A&E Delivery Board leading the transformation programme to deliver Operating Plan commitments. BHRUT – with the support of partners – was delivering the agreed STP trajectory but winter surge has impacted on this.  
2. The A&E Delivery Board invited ECIP – the national UEC experts – to review our plans and progress. Key feedback was the focus on the patient flow / discharge and this is now reflected in our plans.  
3. Continued monitoring and management through local performance management framework  
4. Continued liaison with NHSE and the NHSI to provide assurance on delivery, particularly through winter surge arrangements.  
5. Now moving into assurance and support arrangements for 17/18.  
6. Daily winter calls stepped down to bi-weekly. | Likelihood (4) x Impact (3) = High 12 |
**Collaborative objective 5:** High quality and compassionate and safe care for all commissioned services – delivering better outcomes

**Risk Description:** (Two performance areas are grouped together here that BH are failing to achieve)

**Barts Health (BH) performance.** BH continues to fail operational standards, a) referral to treatment times (RTT) and c) A&E, (specifically Whipps Cross). There are also data quality concerns that present a further challenge for commissioners. This could: A) Threaten the long-term validity of the Trust, B) Put patients at risk and cause reputational damage.

<table>
<thead>
<tr>
<th>Initial Risk Rating 7/2014</th>
<th>Controls</th>
<th>Assurances</th>
<th>Current risk rating</th>
<th>Evidence for assurance</th>
<th>Gaps</th>
<th>Proposed actions</th>
<th>Target Risk 31/10/17</th>
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<tr>
<td>1. Monthly Collaborative Commissioning Committee (CCC) meetings led by the lead commissioner, Newham CCG (Chief Officer) (CCGs only)</td>
<td>1. Minutes of the CCC meeting. (E)</td>
<td></td>
<td></td>
<td>1. Trust to produce an initial return to national reporting trajectory and roadmap for review at the RTT Recovery Programme Board by 9 June 2017</td>
<td>1. Programme Board to sign off trajectory and road map</td>
<td>BHR CCGs in attendance at Barts Health improvement plan meetings for Whipps Cross as associated commissioner.</td>
<td></td>
</tr>
<tr>
<td>2. Monthly A&amp;E Delivery Board meeting, led by BH Chief Executive, attended by Newham CCG on behalf of commissioners.</td>
<td>2. Minutes of the A&amp;E Delivery Board. (E)</td>
<td></td>
<td></td>
<td>2. STP trajectories agreed for A&amp;E (including local site level trajectories).</td>
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<tr>
<td>3. Bi-monthly Technical Sub Group (TSG) and monthly Contract Review Group (CRG) meetings, led by Newham CCG, attended by BH.</td>
<td>3. Minutes of the TSG and CRG. (E)</td>
<td></td>
<td></td>
<td>2. STP trajectories signed off by BH, lead CCG and NHSI and NHSE for delivery by 31 March 2017.</td>
<td></td>
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<tr>
<td>4. Monthly RTT assurance meeting, led by Newham CCG, attended by BH, monitoring RTT performance and recovery - site specific remedial action plans (RAP) in place and monitored.</td>
<td>4. Minutes of the RTT assurance meeting. (E)</td>
<td></td>
<td></td>
<td>2. STP trajectories signed off by BH, lead CCG and NHSI and NHSE for delivery by 31 March 2017.</td>
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</table>

NB: Risk 5.4b – 62 days cancer performance standard has been de-escalated in April 2017 because the Trust has sustained delivery of this standard since September 2017. This risk will remain on the BHR CCGs’ collaborative risk register where it will continue to be monitored. The risk rating of these combined risks has been reduced but remains a severe rating from 20 reduced to 16.
**Risk Description (revised):** If Barts Health do not achieve their quality indicators, (Never Events, serious incidents - recurring themes and the 4 harms, 1) Healthcare acquired Infections (HCAI), 2) Venous Thrombosis embolisms, pressure ulcers and falls), patients may receive poor quality of care and suffer harm. More recently further concerns have developed around the management of serious incidents and complaints as well as compliance with Regulation 20 – the Duty of Candour.

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<td></td>
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<td>I = internal E = external</td>
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<tr>
<td>1.</td>
<td></td>
<td>1. Remedial action plans and recovery trajectory. (E)</td>
<td></td>
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<td></td>
<td>1. Remedial action plans for SI and Duty of Candour</td>
<td>BHR CCGs in attendance at Barts Health improvement plan and CQROA meetings for Whipps Cross as associated commissioner.</td>
</tr>
<tr>
<td>2. BH Contract Review Group, attend by the lead commissioner on behalf of BHR CCGs</td>
<td>2. Minutes of monthly CRG (E)</td>
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<tr>
<td>3. Monthly system escalation and assurance route from BHR CCGs (Redbridge as lead) to the Lead Commissioners AO – Newham.</td>
<td>3. Letters of escalation to lead commissioners (March 2017) (E)</td>
<td></td>
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<tr>
<td>4. Barts Health (Whipps Cross) monthly Clinical Quality Review and Oversight Assurance (CQROA) meeting with NHSI and NHSE.</td>
<td>4. Minutes of the CQROA meeting (E)</td>
<td></td>
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<tr>
<td>5. Performance enforcement notices issued by the Care Quality Commission (CQC) following an inspection in July 2016.</td>
<td>5. WX to self-assess to determine if any notices can be closed</td>
<td></td>
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<tr>
<td>6. Quality reports to every Quality and Safety (Q&amp;S) Committee detailing issues, actions taken and impact.</td>
<td>6. Minutes of the Q&amp;S Committee</td>
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<td>7. Monthly SI panels including all NEL CCGs</td>
<td>7. Minutes of the SI panel meetings. (E)</td>
<td></td>
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**Lead director:** Jacqui Himbury  
**Risk ref:** 5.6
**Collaborative objective 6:** Continued focus on our development as an organisation and health system so that we can meet the challenges ahead and deliver better outcomes, quality and financial efficiency.

Risk Description: (Revised)
Significant risks to the delivery of the CCGs' financial plan - legal directions on financial delivery of our QIPP requirements in year and management of any acute over activity relating to underlying performance: a) Legal Financial directions, b) If we do not deliver against the CCGs' QIPP plans the CCGs will be in breach of its financial control total and c) risk of over performance in acute, continuing care or prescribing activity.

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</thead>
<tbody>
<tr>
<td>1</td>
<td>Weekly Financial Recovery Planning, Delivery and Monitoring group (FRPDM) oversight of the QIPP development process and monitoring delivery against plan.</td>
<td>1 Minutes of FRPDM meetings and risk log and mitigations for all schemes (I)</td>
<td>2</td>
<td>The contract report and the system delivery framework report provides greater detail on the management of this risk.</td>
<td>1. Further schemes to be identified to cover the savings gap.</td>
<td>1. Working with providers and STP partners to identify additional schemes continues</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Weekly Financial Recovery Programme Board (FRPB) Senior Executive meetings (revised TOR).</td>
<td>2 Minutes of the FRPB Senior Executive meetings (I)</td>
<td>3</td>
<td></td>
<td>2. Fully functioning programme management office (PMO).</td>
<td></td>
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</tr>
<tr>
<td>3</td>
<td>Formal escalation route to Finance and Delivery Committee</td>
<td>3 Minutes of the bi monthly Finance and Delivery (F&amp;D) committee (I)</td>
<td>4</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>4</td>
<td>Clinical engagement and leadership strengthening via the Joint Executive Committee (JEC) monthly, FRPB and F&amp;D committee.</td>
<td>4 Minutes of the JEC (I)</td>
<td>5</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>5</td>
<td>Independent review of finances jointly commissioned with NHSE</td>
<td>5 Report of the independent review (E)</td>
<td>6</td>
<td></td>
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<tr>
<td>6</td>
<td>Monthly NHSE London Assurance meeting</td>
<td>6 Minutes of the NHSE London assurance meeting (E)</td>
<td>7</td>
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<tr>
<td>7</td>
<td>Minutes of bi monthly Governing Body meeting (I)</td>
<td>7</td>
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</tbody>
</table>

Lead director: Tom Travers
Risk ref: 6.1

**Likelihood (4) x Impact (5) = Severe 20**

1. Further schemes to be identified to cover the savings gap.
2. Fully functioning programme management office (PMO).

1. Working with providers and STP partners to identify additional schemes continues.
2. PMO project controls and monitoring processes have been strengthened. Alignment of required resource is in progress and will be in place by September 2017.

<table>
<thead>
<tr>
<th>Lead / GBAF ref.</th>
<th>Risk description (summarised)</th>
<th>Previous risk ratings</th>
<th>Current rating</th>
<th>End of year forecast</th>
<th>Target risk level</th>
</tr>
</thead>
<tbody>
<tr>
<td>L Mitchell 1.3</td>
<td>Failure to deliver national performance standards on cancer at BHRUT for 62 days.</td>
<td>16 20 16 16 16 16 20 20 20 20 20 12</td>
<td>8</td>
<td>12</td>
<td>8</td>
</tr>
<tr>
<td>A Steward 3.1</td>
<td>Failure to deliver quality improvement in urgent and emergency care at BHRUT.</td>
<td>16 16 16 16 16 16 16 16 16 16</td>
<td>16</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>L Mitchell 5.4, a &amp; c</td>
<td>Failure of Barts Health (BH) to meet a number of operational standards, RTT &amp; A/E, data quality and others.</td>
<td>20 16 20 20 20 20 20 20 20 20 20 16</td>
<td>8</td>
<td>12</td>
<td>8</td>
</tr>
<tr>
<td>J Himbury 5.6</td>
<td>If Barts Health do not achieve their quality indicators, (Never Events, serious incidents - recurring themes and the 4 harms, patients may receive poor quality of care and suffer harm.</td>
<td>20 20 20 20 20 20 20 20 20 20 20 20 12</td>
<td>12</td>
<td>12</td>
<td>16</td>
</tr>
<tr>
<td>T Travers 6.1</td>
<td>(Revised) Risk of failure to deliver the CCG’s budget plans.</td>
<td>20 20 20 16 16 16 20 20 20 20 20 20</td>
<td>8</td>
<td>20</td>
<td>10</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk Summary</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total risks last report</td>
<td>7</td>
</tr>
<tr>
<td>New risk(s) escalated</td>
<td>0</td>
</tr>
<tr>
<td>Risks de-escalated this report</td>
<td>2</td>
</tr>
<tr>
<td>Total GBAF risk this report</td>
<td>5</td>
</tr>
<tr>
<td>Lead / GBAF ref.</td>
<td>Risk Description</td>
</tr>
<tr>
<td>-----------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>L Mitchell 1.2</td>
<td>Failure to meet the 18 weeks referral to treatment times targets at BHRUT</td>
</tr>
<tr>
<td>L Mitchell 1.3</td>
<td>Failure to deliver national performance standards on cancer at BHRUT</td>
</tr>
<tr>
<td>A Steward 3.1</td>
<td>Failure to deliver quality improvement in urgent and emergency care at BHRUT</td>
</tr>
<tr>
<td>L Mitchell 5.4, a, b &amp; c</td>
<td>Failure of Barts Health (BH) to meet a number of operational standards, RTT, cancer, A/E, data quality and others</td>
</tr>
<tr>
<td>J Himbury 5.6</td>
<td>Quality standards not being met at BH - for C.Diff, and MRSA and FFT</td>
</tr>
</tbody>
</table>
NHS Redbridge risks de-escalated from the GBAF

<table>
<thead>
<tr>
<th>Risk description, ref and lead</th>
<th>Initial risk rating</th>
<th>Target risk level and date</th>
<th>Risk rating when de-escalated</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>De-escalated April 2017</strong>: Failure to meet the 18 weeks referral to treatment times targets at BHRUT.</td>
<td>5 x 5 = 25</td>
<td>1 x 3 = 3</td>
<td>2 x 4 = 8</td>
</tr>
<tr>
<td></td>
<td>June 2014</td>
<td>March 2017</td>
<td>April 2017</td>
</tr>
<tr>
<td><strong>De-escalated April 2017</strong>: BH continues to fail a number of operational standard – risk 5.4b, cancer 62 days target. (This was part of the grouped BH performance risks 5.4 a, b and c).</td>
<td>5 x 5 = 25</td>
<td>3 x 4 = 12</td>
<td>3 x 4 = 12</td>
</tr>
<tr>
<td></td>
<td>July 2014</td>
<td>March 2017</td>
<td>March 2017</td>
</tr>
<tr>
<td><strong>De-escalated in April 2017</strong>: If the acute contract activity is greater than planned (under payment by results (PbR) this could result in higher costs. (This risk has been combined with risk 6.1).</td>
<td>4 x 4 = 16</td>
<td>4 x 5 = 20</td>
<td>4 x 5 = 20</td>
</tr>
<tr>
<td></td>
<td>June 2016</td>
<td>March 2017</td>
<td>April 2017</td>
</tr>
<tr>
<td><strong>De-escalated January 2017</strong>: Failure to deliver improved access to IAPT services. (Ref. 4.1) Lead S Morrow.</td>
<td>1 x 1 = 3</td>
<td>3 x 3 = 9</td>
<td>3 x 3 = 9</td>
</tr>
<tr>
<td></td>
<td>Sept 2014</td>
<td>31 Dec 2016</td>
<td>31 Dec 2016</td>
</tr>
</tbody>
</table>
## Risk grading matrix

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Insignificant cost increase/time disruption. Rarely noticeable reduction in scope or quality</td>
<td>Insufficient cost increase/time disruption. Insignificant harm.</td>
<td>Incident was preventable or incident occurred and there was no harm.</td>
<td>Loss of one working day</td>
<td>Short term low staffing leading to reduction in quality (less than 1 day)</td>
<td>Small loss &lt;£1000</td>
<td>Minor recommendations</td>
<td>Rumors</td>
<td>1</td>
<td>Rare</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Minor</td>
<td>Loss of 0.1% of budget</td>
<td>Justified complaint involving inappropriate care</td>
<td>Loss of one working day</td>
<td>Ongoing low staffing levels reducing service quality</td>
<td>Loss of 0.1% of budget</td>
<td>Recommendations given. Non-compliance with standards</td>
<td>Local media</td>
<td>2</td>
<td>Unlikely</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Moderate</td>
<td>Moderate reduction in scope or quality</td>
<td>Individual(s) required first aid. Staff needed 3 days off work or normal duties</td>
<td>Below excess levels. Justified complaint involving inappropriate care</td>
<td>Loss of more than one working day</td>
<td>Late delivery of key objectives/service due to lack of staff. Ongoing unsafe staff levels. Small error owing to insufficient training</td>
<td>Loss of more than 0.5% of budget</td>
<td>Reduced rating. Non-compliance with standards</td>
<td>Local media frontpage story</td>
<td>3</td>
<td>Possible</td>
</tr>
<tr>
<td>4</td>
<td>Major</td>
<td>10-25% cost or time increase. Failure to meet secondary objectives</td>
<td>Individual(s) died as a result of incident. Multiple claims or single major claim. Permanent loss of premises or facility.</td>
<td>Claim above excess level. Multiple justified complaints</td>
<td>Loss of one working week</td>
<td>Uncertain delivery of services due to lack of staff. Large error owing to insufficient training</td>
<td>Loss of more than 1% of budget</td>
<td>Enforcement action. Low rating. Non-compliance with core standards</td>
<td>Local media short term</td>
<td>4</td>
<td>Likely</td>
</tr>
<tr>
<td>5</td>
<td>Severe</td>
<td>&gt;25% cost or time increase. Failure to meet primary objective</td>
<td>Individual(s) died as a result of the incident. Multiple claims or single major claim. Permanent loss of premises or facility.</td>
<td>No delivery of service. Critical error owing to insufficient training</td>
<td>Loss of more than 1% of budget</td>
<td>Loss of more than 1% of budget</td>
<td>Prosecution. Zero rating. Severe critical report</td>
<td>National media more than 3 days. MP/Ministry of Defence concern</td>
<td>5</td>
<td>Certain</td>
<td></td>
</tr>
</tbody>
</table>

### Risk category

- **Extreme**
- **High**
- **Medium**
- **Low**
**How to interpret the CCG governing body assurance framework (GBAF):**

**Risk ref**
This is a risk identifier attributed to the risk by the CCG risk lead

**Lead director**
This is the executive lead with responsibility for:
- managing the risks to the corporate objectives and
- liaising with the risk lead to ensure the GBAF is up to date

**Reporting to the CCG governing body or other committee on progress**

**Risk ratings:**
The risk rating is derived from conversation between the lead director (or nominated deputy) and the risk lead. The risk score is calculated using the risk grading matrix. There are three types of risk rating used in the CCG GBAF.
- **Initial risk rating:** this grades the risk as if there were no remedial measures in place. This is called the ‘inherent risk’.
- **Current risk rating:** this grades the risk taking into account the remedial measures. The remedial measures should aim to 1, reduce the likelihood of the risk materialising, 2, reduce the impact of the risk if it does happen and 3, reduce both.
- **Target risk rating:** this is the level of risk that the CCG is prepared to accept and the level of risk that must be aimed for.

<table>
<thead>
<tr>
<th>Risk Ref</th>
<th>Lead Director</th>
<th>Risk Description</th>
<th>Initial Risk Rating (June 13)</th>
<th>Controls</th>
<th>Assurances</th>
<th>Current Risk Rating</th>
<th>Gaps</th>
<th>Assurance</th>
<th>Proposed Actions</th>
<th>Target Risk – 1/4/14</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.3</td>
<td>M5</td>
<td>Commissioning organisations are not able to run patient level validations for the first quarter to validate non contract activity which will present a financial risk</td>
<td>15</td>
<td><strong>Our current control is we have issued instructions to the CSU not to pay un-validated invoices. Where we have a contract we will pay in line with the contract and monitor activity.</strong>&lt;br&gt;<strong>Where there is no contract we will develop an alternative validation process. Until the process is developed we will not pay the invoices.</strong></td>
<td><strong>A regular weekly report is being developed with the CSU to report on the progress.</strong>&lt;br&gt;<strong>The audit committee will be updated on performance to only pay validated invoices.</strong></td>
<td>15</td>
<td><strong>A detailed process for non contract invoicing requires urgent development.</strong>&lt;br&gt;<strong>A regular report will be produced for the audit and governance committee.</strong>&lt;br&gt;<strong>Develop new validation process</strong></td>
<td>3</td>
<td><strong>Proposed actions</strong> Where gaps have been identified, list the actions required to put them into place. Ensure they have a named lead and target date</td>
<td></td>
</tr>
</tbody>
</table>
To: Meeting of the NHS Redbridge Clinical Commissioning Group Governing Body

From: Conor Burke, Accountable Officer

Date: 26 May 2017

Subject: BHRUT Performance Risks

Executive summary
The CCGs have been managing a number of performance issues at Barking, Havering and Redbridge University Trust (BHRUT) around A&E, Referral to Treatment (RTT) and Cancer access standards. These issues have all been regularly reported and included in the CCG’s Risk Register and Governing Body Assurance Framework.

This report provides a further update on the key actions that the CCG has taken to seek performance improvements at the Trust. It has done this by both holding the Trust to account through its contract and other mechanisms, as well as providing support through wider system initiatives overseen by the A&E Delivery Board and the joint RTT Programme Board and Cancer Performance Recovery Board.

The CCGs have worked closely with NHS Improvement and NHS England (NHSE), as well as local partners as the “system leader” to ensure that performance is recovered and then sustained.

Given the considerable performance improvements at the Trust and the lifting for ‘special measures’ as reported to the last governing body meetings, it is proposed that this be the last ‘exception’ report and that performance at the Trust is reported to this governing body through the regular quality and contract reports.

Recommendations
The Governing Body is asked to:

- Note the action being taken to date to mitigate the performance risks at BHRUT
- Note the significant delivery of the RTT recovery trajectory year to date.
- Suggest any further actions that the CCG should consider to address the performance and quality risks for local people.
- Agree that reporting on the Trust’s performance form part of the standing contracting and quality reports.

1.0 Purpose of the Report
1.1 The CCG’s Governing Body Assurance Framework and the risk register have identified a number of areas where the CCG is concerned about performance issues at BHRUT. This report provides an update on the actions that the CCG is taking to seek performance improvements at the Trust on A&E, RTT and Cancer.
2.0 A&E

2.1 The CCGs and BHRUT as part of the contract and planning round 2016/17, agreed an improvement trajectory for A&E performance. This trajectory is linked to the Sustainability and Transformation Fund (STF), a national fund available to provider organisations to support improvement to stabilise operational performance.

A&E performance at BHRUT in Quarter One and Quarter Two (to end of September) achieved the improvement trajectory agreed between the CCG and the Trust as part of the 2016/17 planning round achieving 81.8% in Quarter One (cumulative) and 89.1% in Quarter Two. October validated performance was 88.2% which did not achieve the improvement trajectory, November performance improved to 88.9%, but December saw performance deteriorate to 84.3% which meant that total performance was below the expected 90% in Quarter Three. Validated performance for January was 78.22%, a further deterioration on December but performance improved in February (87.35%) and also March (un-validated 88.35%). Un-validated Q4 performance is below the improvement trajectory of 91.5%.

2.2 As the Trust did not meet the STF trajectory in Q3, an appeal was submitted to NHSE / NHSI to secure STF funding. Recognising the additional demand experienced by the Trust – a position common across all Trusts – the CCG supported the Trust’s appeal.

2.3 A continuing high level of ambulance conveyances were reported in February and March, with a particular growth in conveyances at King George Hospital (KGH). A review of Intelligent Conveyancing has been agreed following surges in conveyances seen at particular sites over the winter period to assure operation and support to Trusts under pressure. These increases have been seen across the NEL sector and have been escalated to NHS England to investigate.

2.4 February 2017 attendances (21,206) were 12.7% lower than the previous month (24,289) but continue to grow year on year – 3.7% growth for April 2015 – February 2016 compared to the same period for this financial year. (Note: figures quoted are Trust wide and includes patients from all commissioners).

2.5 Performance for 60 minute breaches has improved significantly in February compared to the 26 breaches reported in January. No breaches were reported.

2.6 The Trust performance has improved significantly since Christmas and for the last week in March the Trust achieved above the 86.3% trajectory, for the month, on 5 of the 7 days.

2.7 The Barking, Havering and Redbridge system developed an Urgent and Emergency Care (UEC) programme for 2016/17 which addresses the five key areas identified by the national A&E Improvement Plan. The Trust continues to work with partners to improve performance by:

- continuation of the streaming and redirection of patients
- developing the workforce for the non-admitted pathway at Queen’s Hospital through the recruitment of Acute Care Providers (ACPs)
- improving flow within the hospital by embedding the SAFER flow care bundle (Senior review, All patients will have expected discharge dates, Flow, Early discharge and Review) to increase the number of patients who are discharged earlier in the day and to reduce unnecessary waiting times for patients
- Streamlining complex discharges by focusing on a ‘home first’ approach to discharge and reviewing rehabilitation pathways and criteria.
3.0 Referral to Treatment (RTT)

3.1 Following improvements in data quality the Trust returned to national reporting for RTT performance for October data (published December 2016).

3.2 The Joint RTT Programme Board has been established across the BHR health economy to improve access to planned care for patients. The Programmes’ priority is to reduce the number of patients waiting over 52 weeks, and to secure recovery of the national standard of 92% of incomplete pathways being within 18 weeks by end of September 2017.

3.3 As illustrated below the Trust has significantly reduced its Patient Treatment list (PTL) over the last 12 months with a total reduction of 18,846 patients. The number of patients waiting over 52 weeks has reduced to ‘3’ for the March submission to UNIFY

<table>
<thead>
<tr>
<th></th>
<th>3 Apr 16</th>
<th>23 Apr 17</th>
<th>Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTL Size</td>
<td>57,374</td>
<td>38,528</td>
<td>-18,846</td>
</tr>
</tbody>
</table>

3.4 Please see Appendix 1 at the end of this report containing a graph and table showing the progress in 18 Week RTT Incomplete standard delivery.

3.5 The RTT Recovery Plan sets out the actions to be taken by the system to regain compliance with the constitutional standard and a trajectory for compliance by end of September 2017.

3.6 A significant reduction in the number of patients waiting longer than 18 weeks for treatment has been achieved. This reduction has been achieved through a combination of focussed booking and treatment of patients with long waits, creation of additional capacity, validation of the PTL and securing additional capacity through outsourcing of admitted and non-admitted pathways.

3.7 The challenge of delivering the national standard for RTT has been prioritised by all three BHR Clinical Commissioning Groups (CCG). During 2016/17 they had the responsibility of averting 24,575 GP outpatient referrals in-year by sending patients to a range of alternative independent sector and community providers. At end of March 2017, a total of 28,540 referrals have been diverted - 22,187 were redirected to alternative services and 6,353 diverted to new pathways.

4.0 Cancer Waiting Times

4.1 Cancer performance is one of the eight national priorities for delivery. In February the Trust achieved 7 out of 8 of the national standards failing only the 62 day urgent GP referral to treatment standard.

4.2 In response to the contract escalation, an action plan setting out core actions required to develop and agree service and specialty level action plans and trajectories to achieve full recovery and a detailed plan for short term actions to support improvement was received in July. The final remedial action plan with agreed trajectory by tumour site was received in September with a recovery date for the standard of March 2017.
4.3 Delivery against trajectory has been good but there are risks to the standard being delivered based on local information for February. The Trust continues to be confident of delivering the standard for March 17.

4.4 The core themes addressed by the action plan are PTL management, diagnostics and histopathology – capacity, waiting times and reporting timescales, demand and capacity, administration, and culture and communication.

4.5 A Cancer Performance Recovery Programme Board was established and is chaired by a clinical director to monitor progress and delivery of the recovery action plan and to provide assurance to the BHURT contract review meeting (SPR).

5.0 Resources/investment
5.1 There are no additional resource implications/revenue or capitals costs arising from this report.

6.0 Equalities
6.1 There are no equalities implications arising from this report.

7.0 Risk
7.1 The risks in relation to the Trust’s performance are outlined in the governing body assurance framework.

8.0 Managing conflicts of interest
8.1 There are no conflicts of interest that have been identified associated with this report.

Author: CSU
Date: 02\textsuperscript{nd} May 2017
Appendix 1.
18 Week RTT Incomplete standard progress delivery.
To: Meeting of the NHS Redbridge Clinical Commissioning Group Governing Body

From: Conor Burke, Chief Officer

Date: 26 May 2017

Subject: System Delivery Framework

Executive summary
During 17/18 BHR CCGs are required to deliver £55m of saving, in year, with £35m against the BHRUT contract. In response to the financial challenge facing the BHR system, the CCGs have developed the System Delivery Framework, as a mechanism to drive system recovery.

The System Delivery Framework, incorporates changes to both local and system level governance across BHR, to support the programme. This includes implementation of the System Delivery and Performance Board (part of the sub-structure of the Integrated Care Programme board) which will take the lead role in scrutinising and assuring implementation of system plans.

BHR CCGs and BHRUT issued a joint submission to regulators detailing plans and progress to date against identification and implementation of the £35m BHRUT tranche of the System Delivery Framework in March.

Recommendations
The governing body is asked to:

- Note current delivery against the System Delivery Framework

1.0 Purpose of the Report
1.1 This paper is to advise the governing body of progress made to date against implementation of the Systems Delivery Framework.

2.0 Background/Introduction
2.1 The financial challenges facing the BHR health system, following agreement of 2017-19 NHS contract values, are significant, requiring BHR CCGs to deliver an in-year (17/18) cost reduction of £55m, £35m of which is against the BHRUT contract. NHSE requires the BHR CCGs to achieve ‘in-year breakeven’ in 2017/18.
2.2 In its August 2016 draft proposals for governance of the Integrated Care Programme Board, the formation of a System Delivery and Performance Board was envisaged, acting as a forum to drive improved provider performance and joint ownership of plans.

3.0 System Delivery Framework position as of 28 April
3.1 As requested by both regulators (NHS England and NHS Improvement), BHR CCGs and BHRUT were required to submit a jointly owned document, detailing plans and processes to ensure delivery of the initial £35m tranche of the System Delivery Framework (SDF).

3.2 The CCGs completed this submission as required, on 31 March 2017, and have subsequently met with NHSE to discuss progress. The CCGs will continue to report progress to regulators, thorough routinely scheduled assurance meetings.

3.3 The latest position against the SDF, at 28 April, is as follows:

3.3.1 BHR CCGs have identified a total opportunity of £44.0m
3.3.2 BHRUT and BHR CCGs have agreed a joint process of assuring schemes. In addition governance arrangements have been developed at a system level (using existing ICPB structures) to ensure wider system ownership of the plan.
3.3.3 CCGs are assured of a value of £31.5m (against the entire £55m programme)
3.3.4 BHRUT are assured of a value of £18.0m (against the £35m BHURT specific element of the programme)
3.3.5 BHR CCGs are undertaking a review of 17/18 investment assumptions to understand if these could be used to support the underlying financial position. This review process will be managed through the FRPB
3.3.6 The CCGs continue to work closely with system partners, BHRUT and NELFT to develop additional pathway opportunities, to mitigate the current unidentified
3.3.7 The CSU is supporting the CCGs to realise any benefits from the implementation of schemes designed by STP colleagues, particularly impacting on the Whipps Cross site
3.3.8 CCGs have implemented revised processes for monitoring delivery and performance of “live” schemes, scheme level reviews are taking place on a weekly basis, with weekly escalation of issues to the FRPB

4.0 Resources/investment
4.1 There are no additional resource implications/revenue or capitals costs arising from this report.

5.0 Equalities
5.1 There are no equalities implications arising from this report.

6.0 Risk
6.1 No additional risks are outlined in this report.

7.0 Managing conflicts of interest
7.1 There are no conflicts arising from this report.

Author: James Gregory – PMO Director
Date: 28 April 2017
To: Meeting of the NHS Redbridge Clinical Commissioning Group CCG Governing Body

From: Vicky Hobart, Director of Public Health, Adult Care and Wellbeing, London Borough of Redbridge

Date: 26 May 2017

Subject: Consultation on the draft Health and Wellbeing Strategy for Redbridge 2017-2021

Executive summary

The introduction of the Health and Social Care Act 2012 placed a statutory duty on Health and Wellbeing Boards to produce a joint Health and Wellbeing Strategy for their local area. The draft 2017-21 strategy sets out our new ambitions for improving the health and wellbeing of Redbridge residents over the next four years.

On 21 March 2017 we entered into a 12 week consultation period inviting residents, partners, voluntary and community sector organisations and those who work in Redbridge including Councillors and local MPs to have their say on the proposed vision and ambitions. Feedback from the consultation will help us develop the final strategy, ensuring it meets the needs of the people of Redbridge.

The consultation will run from 21 March to 12 June 2017 and is available on the Redbridge Council website at www.redbridge.gov.uk/consultations

Recommendations

The governing body is asked to:

- Note the draft health and wellbeing strategy and consultation period
- Note the required CCG input and responsibility
- Receive the agreed report following consultation in July 2017
1.0 Purpose of the Report

1.1 The governing body is being asked to acknowledge the consultation on the draft health and wellbeing strategy.

2.0 Background/Introduction

2.1 This, our second Health and Wellbeing Strategy for Redbridge covers the period 2017-21, in line with the national Five Year Forward Views for health and care services, and local medium term financial plans. It sets out our ambitions over the next four years for the health and wellbeing of people in Redbridge. As an overarching strategy for our place, Redbridge, it unites with other relevant strategies across our partner organisations to set out our approach and key ambitions for improving the health and wellbeing of the people and communities in the borough.

3.0 Draft strategy focus

3.1 This draft strategy provides an overview of the ways in which the Redbridge Health and Wellbeing Board will seek to improve health and reduce health inequalities in the Borough, through the range of organisations and partnerships that the Health and Wellbeing Board represents. These are set out in

- A series of statements about the (proposed) strategic direction that will be taken i.e. directional statements.
- A set of six concrete ambitions to be achieved over the next four years, relating to child health, diabetes, cancer, mental health, housing and end of life care.

4.0 Resources/investment

4.1 At this stage there are no identified financial implications for the Council. It is anticipated that that the strategy will be delivered in conjunction with and alongside exiting mechanisms. However, given the financial operational climate of both the Council and CCG, the delivery of this may be impacted upon any by any further future financial and commissioning decisions.

4.2 The key focus of the strategy of prevention, early intervention and whole system integration should aim to focus financial resources on prevention and improved care pathways through integration, and therefore, in time begin to alleviate future costs pressures away from acute settings.

5.0 Equalities

5.1 An equalities impact assessment will take place once we have received the consultation feedback and the final strategy has been approved.

6.0 Risk

6.1 None identified.

7.0 Managing conflicts of interest

7.1 No conflicts of interest identified.

Attachments: Draft Health and Wellbeing Strategy – an electronic copy is available to governing body members here:

http://consultations.redbridge.gov.uk/s/HWBStrategy/

Author: Vicky Hobart
Date: 03/05/17
To: Meeting of the NHS Redbridge Clinical Commissioning Group Governing Body

From: Khalil Ali, Lay Member (PPI)

Date: 26 May 2017

Subject: Patient Experience report

Executive summary

Patient and public engagement is critical to informing the work of the CCG as a commissioner of health services on behalf of Redbridge residents.

There are a wide range of sources from which the CCG can draw valuable and insightful feedback from the public including, but not limited to: its members who as GPs engage with the public on a daily basis, directly from patients themselves via our established patient engagement forum and from a vast range of stakeholders with whom we engage, for example, voluntary sector organisations and local authority colleagues.

This report reflects the on-going engagement activities that have taken place with the public since our last governing body meeting as well as other sources of feedback.

The report includes a summary of:

- The current plans and activities regarding the Patient Engagement Forum (PEF)
- Work on strengthening relationships with the voluntary and community sector
- Wheelchair and equipment services review
- PPG development and questionnaire
- Engagement on the CCG’s proposals to address the financial challenge

Recommendations

The governing body is asked to:

- Note the range of feedback from the PEF (and other stakeholders), and that there is a process in place to ensure that appropriate responses are communicated to them.

1.0 Purpose of the report

1.1 To provide a summary of the range of feedback that has come through to the CCG from patients and stakeholders.

2.0 Redbridge CCG Patient Engagement Forum (PEF)

2.1 At our March PEF meeting the main topic was the current consultation “Spending NHS money wisely”. Louise Mitchell, Transformation Programme Director, gave a brief overview of the current consultation and the challenging situation regarding the financial position of the BHR CCGs.
2.2 PEF members asked questions on a range of issues including: over the counter medication and health tourism concerns. The link to the consultation document was sent to PEF members and they were encouraged to complete the questionnaire. Notes from the meeting will be submitted given they capture the group’s initial response to the proposals.

2.3 Louise Mitchell advised PEF members the proposals will not affect life threatening conditions (e.g. cancer) and she explained the process and principles with regard to procedures of limited clinical effectiveness (POLCE).

2.4 The May meeting focussed on developments with the GP networks and localities in Redbridge. Natalie Keefe from the primary care team provided an update on progress and initiatives such as text messages for appointments and the leadership programme for clinical leads.

The meeting also heard the latest updates from Healthwatch and the Youth Council. Healthwatch advised the PEF on their mental health survey and accessible information standard work with practices. The Youth Council informed the group about the new ‘Citizen App’ as a helpful tool for resolving queries and issues.

3.0 Community and voluntary sector
3.1 Our community visits and participation in community events continue. On 19 April we visited the Carers’ Support group in Wanstead. In general, the group understood and broadly supported the proposals within the ‘spending money wisely’ consultation. Members were encouraged to complete the questionnaire.

4.0 Equipment and wheelchair service review
4.1 The first meeting of the Wheelchair Patient Engagement and Communications Group was held on 22 February in Maritime House, Barking. Service user representatives from all three boroughs attend.

4.2 The second meeting of the Community Equipment Service Users’ Group was held on 28 February, and included representatives from across the BHR CCGs’ patient engagement forum groups. The service users’ survey have been finalised, with valuable input from the patient representatives who helped with the structure of the questionnaire and its contents.

5.0 Patient Participation Groups (PPGs)
5.1 Work in supporting PPGs to develop continues, with assistance and information provided to those practices that need help recruiting members.

5.2 We have circulated a new PPG questionnaire to all practices and PPGs across BHR. The main purpose of this survey is to find out what kind of support PPGs need and how they operate at present. The information will be collated into a report and the recommendations/action plan shared with colleagues.

5.3 Thirteen practices have representatives on the Redbridge CCG PEF.

6.0 PEFs/PERF Chairs’, Vice-Chairs and Lay members’ meeting:
6.1 The last meeting will took place on 27 April in Becketts House. The meeting discussed the strategic issues affecting the BHR CCGs and an update on the new structure and ways of working of the CCGs was provided. The group agreed that the way that the PEF
and PERF works needs to reflect the new arrangements at BHR level and Marie Price, Director of Corporate Services provided some initial options, and agreed to develop these further for consideration by members.

7.0 Public consultation “Spending NHS money wisely”
7.1 The consultation BHR CCGs “Spending NHS money wisely” was launched mid-March. We are visiting various community groups and voluntary sector organisations in order to provide them with relevant information and encourage them to complete online questionnaire. We are holding several drop-in sessions in the community across BHR to talk to the public about the consultation.

8.0 Resources
8.1 There are no resource issues relevant to this report.

9.0 Equalities
9.1 The work on engagement in the borough, through the CCG’s patient engagement forum structure, and through collaboration with patients; the voluntary sector and other key stakeholders, should contribute to reducing inequalities in access to healthcare and support the CCG in meeting its equality objectives.

9.2 On 12 April we attended the Pan London Equality Leads’ meeting. This meeting was co-chaired by Barts Health NHS Trust HR Director, who is also representative on HR Directors Network. The links have been made also with the Chief Nurse for London. There was a suggestion to continue with quarterly E&D Pan-London meetings and to focus on 1-2 topics for work in the subgroups.

10.0 Risks
10.1 There are no identified risks in relation to this report.

11.0 Managing conflicts of interest
11.1 There are no conflicts of interest relevant to this report.

Author: Boba Rangelov, Patient and Public Engagement Advisor, BHR CCGs
Date: May 2017
To: Meeting of the NHS Redbridge Clinical Commissioning Group Governing Body

From: Tom Travers, Chief Financial Officer

Date: 26 May 2017

Subject: Finance and Activity Report Month 12

Executive Summary

Key Headlines
- The draft final accounts position is breakeven.
- In Month 12 the 1% non-recurrent risk reserve from the CCG (£3.69m) and WELC CCGs (£5.72m) was released into the financial position. Without the 1% reserve release the CCG would have recorded a deficit.
- The financial position remains very challenging. An underlying opening deficit has been used in the development of the 17/18 budgets which have been presented to the Governing Body in February and March.
- External Audit are currently reviewing, the 16/17 accounts. The final accounts are due to be approved at Governing Body on 26 May.

Recommendations
The Governing Body is asked to:
- Agree the draft financial position noting the actions taken to achieve it and that the external audit of the annual accounts is still in progress.

1 Purpose of Report
The purpose of this report is to brief the Governing Body on the overall draft financial position as at the end of March 2017 (Month 12) and report on the overall financial position for the financial year 2016/17.

2 Background/Introduction
As at the end of Month 12 the CCG reported a breakeven position against a year to date planned surplus of £370k, representing variance to plan of £370k

3 Report Content
Resource limit
The CCG has a resource limit of £386,347k. There have been six changes to the resource limit at Month 12 being, the 1% non-recurrent risk reserve from the WELC CCGs, Demand Management for LAS, Evaluation Project, HLP, 111 Pharmacy Project and children and young people (CYP) waiting times. The funding breakdown is highlighted below.
<table>
<thead>
<tr>
<th>Description</th>
<th>£'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recurrent Programme Baseline Allocation</td>
<td>335,688</td>
</tr>
<tr>
<td>Primary Care Co-Commissioning</td>
<td>33,553</td>
</tr>
<tr>
<td>Non Recurrent Requirement</td>
<td>(3,692)</td>
</tr>
<tr>
<td>Non Recurrent Return</td>
<td>3,692</td>
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<tr>
<td>Marginal Rate Non Elective Collection</td>
<td>1,948</td>
</tr>
<tr>
<td>Marginal Rate Non Elective Return</td>
<td>(1,948)</td>
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<td>Return of Surplus/(Deficit)</td>
<td>370</td>
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<td>Q1 Eating Disorder Service</td>
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<td>Q1 TB Corrections</td>
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<tr>
<td>HLP 0.15% Due To Islington CCG</td>
<td>(504)</td>
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<tr>
<td>IR Rules IAT</td>
<td>(72)</td>
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<tr>
<td>London Health and Care Devolution Pilot</td>
<td>286</td>
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<td>GP Development Programme</td>
<td>27</td>
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<td>Q2 Latent TB</td>
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<td>CYP Local Transformation MH</td>
<td>62</td>
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<td>NHS111 (IUC) Workforce Programme - Early Adopters Backfill Funding</td>
<td>49</td>
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<tr>
<td>Children and Young transformation</td>
<td>23</td>
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<tr>
<td>Mth08 CEOV adjustment</td>
<td>(399)</td>
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<tr>
<td>GP Resilience</td>
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<td>HLP 111 Links Programme</td>
<td>58</td>
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<td>HLP Programme 111 Links Integration</td>
<td>40</td>
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<td>Healthy London Partnership Underspend</td>
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<td>OCCG Admin Levy</td>
<td>67</td>
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<td>NHS PS move to market rents</td>
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<td>Funding Transfer for IUC Evaluation Pilots</td>
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<td>Levies Due To Islington CCG</td>
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<td>Demand Management for LAS</td>
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<td>NELCSU Evaluation Project</td>
<td>200</td>
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<td>HLP</td>
<td>(358)</td>
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<td>NHSEL 111 PHARMACY PROJECT</td>
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<td>WELC 1% Risk Share</td>
<td>5,721</td>
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<td>CYP Waiting Times Tranche 2</td>
<td>61</td>
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<td>Programme Resources</td>
<td>379,902</td>
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<td>Running Costs Allocation</td>
<td>6,445</td>
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<tr>
<td><strong>Total Resources 2016-17</strong></td>
<td><strong>386,347</strong></td>
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Month 12 Reported Position
The CCG revenue financial position is summarised in the table below

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<tr>
<th>Commissioner Function</th>
<th>Redbridge CCG Financial Position 2016/17</th>
<th>Month 12 - 31st March 2017</th>
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<tr>
<td></td>
<td>Final Draft Year End £000's</td>
<td>Final Draft Year End £000's</td>
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<tr>
<td>Acute Clinical SLA</td>
<td>176,973</td>
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<td>Acute Other</td>
<td>28,867</td>
<td>29,381</td>
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<tr>
<td>Acute sub-total</td>
<td>205,840</td>
<td>211,157</td>
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<td>Services Provided in a Primary Care Setting (including walk in centres)</td>
<td>6,007</td>
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<td>Delegated Primary Care</td>
<td>33,217</td>
<td>32,789</td>
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<td>Prescribing</td>
<td>39,177</td>
<td>38,432</td>
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<tr>
<td>Mental Health &amp; LD</td>
<td>29,718</td>
<td>29,473</td>
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<tr>
<td>Community Healthcare</td>
<td>23,821</td>
<td>23,785</td>
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<td>Continuing Care</td>
<td>19,878</td>
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<tr>
<td>Programme Spend</td>
<td>21,875</td>
<td>14,816</td>
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<tr>
<td>Healthcare Provision sub-total</td>
<td>173,692</td>
<td>168,747</td>
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<tr>
<td>CCG Running Costs</td>
<td>6,445</td>
<td>6,443</td>
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<tr>
<td>Running Costs</td>
<td>6,445</td>
<td>6,443</td>
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<tr>
<td>Total Expenditure</td>
<td>385,977</td>
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<tr>
<td>Resource Limit</td>
<td>386,347</td>
<td>386,347</td>
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<tr>
<td>Surplus/Deficit</td>
<td>370</td>
<td>(0)</td>
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</table>

As at the end of March (Month 12) the CCG reported a breakeven draft final accounts position, against a year to date planned surplus of £370k.

Agreement was reached across North East London (NEL) to risk share each CCGs’ 1% reserve. In Month 12 both BHR and WELC CCGs’ were able to release their 1% reserve to mitigate the financial position of BHR CCGs. For Havering CCG the total release equated to £9.4m, which included a £5.72m contribution from WELC CCGs. Without the risk share the CCG would have recorded a deficit.
As reported throughout the year the main drivers to the variance to plan are RTT backlog clearance, acute contracts (including QIPP performance) and continuing healthcare. These pressures have been partially offset by an underspend in the Programme area, which relates to the use of the 1% risk share and contingency. There are also smaller underspends within Delegated Primary Care, Prescribing, Community and Mental Health and Learning Disabilities.

Earlier in the year, in recognition of the financial risk faced, the CCG placed itself into turnaround. Given the financial position of the CCGs it is important that decisions from turnaround continue to contribute to future years to ensure ongoing financial sustainability. The reported position includes savings of £7,641k which is in line with the RAG rated Finance Recovery Plan.

The challenging financial position continues into 2017/18, with the CCG facing a recurrent underlying opening deficit which is forecast to be £731k. This position includes £2,596k of full year QIPP savings and before the application of business rules, it therefore includes a level of financial risk. Failure to deliver these savings will adversely impact the underlying position.

The consequences of an underlying deficit highlights the urgent need for sustainable financial recovery, which needs to be fully integrated into the CCG’s transformation programmes. BHR CCGs' developed a System Delivery Framework as a mechanism to drive system recovery. To date £44m of savings opportunities have been identified across BHR CCGs, an update on the progress of the framework is presented to this meeting in a separate paper.

The underlying opening deficit has been used in the development of the 17/18 budgets which were presented to the Governing Body in February and March. Budgets have also been reviewed by Joint Executive Committee (JEC) in April. In addition the Finance and Delivery Committee reviewed the high level of unmitigated risk that is within the 17/18 budgets at its April meeting. The ongoing review and QIPP delivery and the level of unmitigated risk will be critical to understanding the financial position.

External audit are currently reviewing, the 16/17 accounts and so the reported position is provisional at this stage. The final accounts are due to be approved at Governing Body on 26 May. The audited accounts are due to be submitted to NHS England on the 31 May 2016.

4 Resources/Investments
n/a

5 Equalities
n/a

6 Risk
n/a

7 Managing conflicts of interest
n/a

Author: Tom Travers, Chief Finance Officer
Date: May 2017
To: Meeting of the Redbridge Clinical Commissioning Group Governing Body

From: Tom Travers, Chief Financial Officer

Date: 26 May 2017

Subject: Contract Report

This report is in relation to the CCG’s main providers: Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT), Barts Health NHS Trust (Barts Health), North East London Foundation Trust (NELFT), Partnership of East London Cooperatives (PELC) and the London Ambulance Service (LAS).

BHRUT: A year-end agreement for 2016/17 has been reached with BHRUT at a value of £347m across all 12 CCGs. The share for the BHR CCGs is £339.3m.

BHRUT are failing to meet some of the national standards required in the Operating Framework. Commissioners continue to manage performance actively through the Cancer, Referral to Treatment (RTT) and Accident and Emergency A&E pathways. There are action plans in place to recover the standards for A&E, RTT, and Cancer with supporting improvement trajectories which are being monitored by Commissioners via relevant Boards. A gradual improvement towards achieving the A&E trajectory of 91.5% is noted in the unvalidated reported data for March (88.35%) compared with the validated data reported for February (87.35%) and the validated reported data for January (78.29%). A total of nine contract performance notices (CPNs) are open at BHRUT for non-compliance with required national and contract standards. The two previously open CPNs for the community and mental health providers have now been closed (see Appendix 1).

Barts Health: A year-end agreement of £103m for the 2016/17 contract has been reached with Barts Health against a plan contract value of £97.3m across BHR CCGs. The year-end agreement is -£1.7m over plan for Redbridge CCG.

Barts Health operational and performance issues are being managed by the co-ordinating commissioner (Newham CCG) in line with the contractual governance framework. Barts Health is not currently meeting the A&E 4 hour standard and action plans are in place to recover performance to the level of the agreed STF trajectory. The Trust is not currently reporting on RTT and an action plan is in place to resume reporting and to clear the number of patients waiting over 18 weeks. The Trust is meeting both the Cancer and Diagnostics standards.

CPNs were issued in March on the performance against local KPIs at Whipps Cross for Serious Incidents, Complaints and Duty of Candour. Action plans and trajectories have been received from the Trust and Waltham Forest CCG will lead on monitoring these at CQRMs. Barts Health is held to account on actions required with associated penalties enforced in accordance within the contract where applicable.

NELFT: NELFT is performing to quarter 3 contracted standards in their community services and mental
health service contracts with the exception of the Improving Access to Psychological Therapies (IAPT) access and recovery targets.

The CQC published their inspection report and rated NELFT as ‘Requires Improvement’. A quality summit has subsequently been held. The commissioners’ response is being led by the Nurse Director.

PELC: The first year of a 2 year contract (2016/18) has helped to stabilise PELC’s financial position and enabled its accountability and sustainability. PELC’s performance for the NHS 111 service in recent weeks has fluctuated due to surge in call demand. Green ambulance re-triage for lower acuity calls have been around 65% of all calls re-triaged. Support for the implementation of the ‘Well Led Review’ recommendations has concluded and the consultants engaged by commissioners have produced a final report. PELC has recruited its senior management team including a new Chair of the Council as well as Director of Nursing and Governance, Director of Operations and Chief Pharmacist. The CQC conducted an inspection of PELC services during the months of March and April 2017. The inspection report has not been published by the CQC as yet.

LAS: The LAS continues to be very challenged in their delivery of the 8 minute response standard, with the year-to-date for Redbridge CCG at 59.9% against a standard of 75%.

Details of the particular areas of concern are highlighted in the summary for each provider and full performance details are provided in the provider scorecards. At each provider’s monthly Clinical Quality Review Meeting (CQRM) the quality indicators are reviewed and areas of concern are addressed with providers.

Recommendations
The Governing Body is asked to:

- Agree the reported Month11 (M11) activity summary position for the two main acute and two main non-acute contracts.
- Review the performance against standards and requirements and agree remedial actions being taken.
- Agree any further risks that are to be added to the Assurance Framework.
1.0 Purpose of the Report
The purpose of this report is to inform the Governing Body on the contract activity and performance for M11 2016/17 for acute, community, mental health contracts including the LAS contract, and agree any actions required.

2.0 Background/Introduction
This is a report from the Chief Financial Officer, to inform the Governing Body of the position of acute, community and mental health contracts including the LAS contract at M11. It also states the position for the 2016/17 year-end agreement for the two main acute contracts.

3.0 Contract updates

BHRUT – Contract Value for Redbridge CCG - £93.6m (£91.4m inclusive of QIPP)
All reporting reflects the Trust wide position

All performance tables included in this report for acute services contain nationally published validated data. Where more up to date unvalidated data is available, this is referenced in the commentary of the report.

BHRUT Activity Summary
Below is an overview of the BHRUT activity at POD level (for activity tables refer to Appendix 2):

| Urgent Care | A&E activity is -2,052 (-3.8%) above plan while activity at Queen’s UCC is under plan by 223 (10.1%). Monthly emergency attendances (all A&E and UCC at Queen's) at BHRUT for Redbridge CCG are over plan by -1,829 (-2.1%).
Critical care is currently over plan with a forecast activity variance of -660 (-22.3%) and Hyper Acute Stroke Unit (HASU) is also over plan with a forecast variance of -275 (-39.4%).
Non-elective activity is currently under plan with a forecast activity variance of 1,738 (12.3%) while non-elective non-emergency is also under plan by 559 (13.4%). |
| Planned Care | Under planned care, the largest forecast activity variance from plan is in rehabilitation which is forecast to over perform by -332 (-7.0%).
This is offset by activity under performance in day cases which is forecast to be 587 (6.3%) under plan. |
| Outpatients | Outpatient activity is currently over plan with a forecast activity variance of -4,570 (-4.1%).
The majority of the over performance is seen in outpatient procedure follow ups with a forecast activity variance of -2,929 (-63.3%) and outpatient procedure first appointments at -1,475 (-28.0%).
This is partially offset by under performance in outpatient first appointments which is 3,476 (9.3%) under plan. |
| Other Activity | Other activity is forecast over plan by -57,065 (-3.3%) with the main driver of this position being direct access which is reported at -56,139 (-3.3%) over plan. |
3.1 A&E

The Trust reported a validated performance of 87.35% for February 2017 and unvalidated performance of 88.35% for March 2017. Although there is still an under performance against the improvement target trajectory of 91.50%, it represents a significant improvement from the January 2017 position of 78.29%. Performance by site shows that King George Hospital (KGH) achieved 93.13% in February and 92.23% unvalidated in March and Queens Hospital achieved 83.50% in February and 85.89% unvalidated in March.

Furthermore, a year-on-year (2015/16 versus 2016/17) A&E attendance comparison by site shows a higher growth at KGH compared to Queens Hospital, with KGH seeing 41% of total attendances in 2016/17 compared to 39.3% in 2015/16.

Factors affecting performance in February and March have included peaks of attendances in late evenings and increased pressure on resus beds, with potential impact on operational efficiency. There has been an increase in the proportion of ‘blue light’ ambulance conveyances and this could be a driver for the increased demand on resus beds. The main causes of A&E breaches remain as follows: wait for first clinician, wait for A&E triage and bed management.

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### KPIs

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<th>KPI</th>
<th>Site</th>
<th>National Standard</th>
<th>Performance</th>
<th>Jan-17</th>
<th>Feb-17</th>
<th>Unvalidated Mar-17</th>
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<td>% Ambulance handovers within 30 min KPI 2</td>
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<td>Performance V5 Trajectory</td>
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</tbody>
</table>
The Trust continues to face challenges linked to demand and the availability of a suitably skilled workforce.

### Risks to Delivery

Risks to delivery of the A&E target are as follows:

- Higher A&E attendances compared to prior year.
- ED staffing issues, in particular low proportion of medical rotas (Consultant and Middle Grade Doctors and bank nursing) that are filled with permanent staff.
- Recruitment and development of staff to support appropriately skilled workforce for the enhanced urgent care pathway.
- Delayed discharge from poor patient flow though hospital.
- High acuity of patients and increase in blue light conveyances.

### Mitigating Actions

The work streams of the Patient Flow Programme that support the improvement trajectory include: Enhanced UCC (urgent care centre) & Redirection; Streamlining Complex Discharges & Discharge to Assess and Early Discharge Planning and Seven Day Services. Actions in train within the work streams include:

- Recruitment and development of ACPs (Advanced Clinical Practitioners) to support the non-admitted pathway/Enhanced UCC.
- Continuation of redirect at front door of Queens for patients not in need of acute care.
- Maximising use of SAFER (Senior review, All Patients to have an expected discharge date, Flow of patients, Early discharge, Review) bundles of care on wards.
- Standardising use of Expected Discharge Dates to proactively manage patients to discharge.
- Rehabilitation beds are available to flex up to 10%, with pilot underway to flex criteria to support flow.
- Trust full capacity protocol in place to further support discharge where required, involving cancelling training/development and elective procedures to support the non-elective pathway.
- Weekly and monthly (multi-agency) Length of Stay (LoS) reviews underway to challenge assessments for longer LoS patients.

### 3.2 Referral to Treatment (RTT) and Diagnostics

<table>
<thead>
<tr>
<th>KPI</th>
<th>Site</th>
<th>Dec-16</th>
<th>Jan-17</th>
<th>Feb-17</th>
<th>2016/17 YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 Weeks RTT Admitted</td>
<td>BHRUT</td>
<td>Trust Performance</td>
<td>67.17%</td>
<td>67.87%</td>
<td>60.28%</td>
</tr>
<tr>
<td>18 Weeks RTT Non-Admitted</td>
<td>Trust Performance</td>
<td>67.64%</td>
<td>69.43%</td>
<td>81.05%</td>
<td>68.89%</td>
</tr>
<tr>
<td>18 Weeks RTT Incomplete Pathways</td>
<td>92%</td>
<td>Trust Performance</td>
<td>78.32%</td>
<td>83.60%</td>
<td>86.39%</td>
</tr>
<tr>
<td>Incomplete &gt;52 week waits</td>
<td>26</td>
<td>17</td>
<td>19</td>
<td>Performance Vs Standard</td>
<td>Performance Vs Trajectory</td>
</tr>
<tr>
<td>Performance Vs Standard</td>
<td>73.90%</td>
<td>76.30%</td>
<td>78.40%</td>
<td>79.98%</td>
<td>79.98%</td>
</tr>
</tbody>
</table>
Current Position

The Trust and commissioners have implemented a joint RTT and Improvement Programme with the support and oversight of NHS England and NHS Improvement. The implementation is being monitored via the RTT Programme Board.

The Trust returned to national reporting in November 2016, reporting October data. In February 2017, the reported performance for incomplete pathways was 86.39% against a planned recovery trajectory of 78.4%. Although the Trust continues to deliver improved performance ahead of the agreed recovery trajectory, current performance remains below the national standard of 92%. The total number of patients waiting >18 weeks reduced to 7,083 in January from 8,521 in December, as the RTT Programme continued to treat patients with long waits.

A total of 19 patients had waited >52 weeks on an incomplete pathway in February, representing a continuing reduction in the number of >52 weeks waiters. The RTT programme continues to monitor each patient who has waited >48 weeks (an indicator to inform of potential risk of breaching >52 weeks), to understand the reason for the delay and seek assurance that each patient has a plan to progress their pathway.

The RTT 18 Weeks Incomplete Pathways validated data for February shows a further improvement in performance to 86.39%.

Risks to Delivery

The key risks to delivery of the RTT Improvement Plan are:

- Inability of pressured specialties to increase capacity to the levels required within the recovery plan.
- Delay to recruitment of additional staff to core specialties where there are national and local shortages.
- Challenge to delivery of demand management assumptions through redirected activity and revised clinical pathways.

Mitigating Actions

A joint RTT Recovery Board Programme is in operation across the BHR health economy. The RTT Programme Board meets fortnightly to review progress and manage risk and is supported by the Programme Management Office (PMO), which reviews and manages the implementation of the agreed programme work streams.

The Trust continues to support the recovery trajectory through provision of additional activities (outpatient appointments and outpatient procedures both within the Trust and through outsourcing to the independent sector, with a total of 2,731 patient pathways/treatment cycles.

The Commissioners continue to support the RTT Recovery Programme through implementation of demand management schemes, e.g. diverting patients to alternative appropriate providers in the community and Independent Sector at the start of the patient pathway and introducing new clinically appropriate pathways for patient care outside of the acute sector.
### 3.3 Cancer Waits

<table>
<thead>
<tr>
<th>KPI</th>
<th>Site</th>
<th>National Standard</th>
<th>Performance</th>
<th>Dec-16</th>
<th>Jan-17</th>
<th>Unvalidated Feb-17</th>
<th>2016/17 YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Cancer Two Week Wait (2 Week Cancer Wait)</td>
<td>BHRUT</td>
<td>93%</td>
<td>Trust Performance</td>
<td>97.74%</td>
<td>96.46%</td>
<td>96.40%</td>
<td>95.01%</td>
</tr>
<tr>
<td>Two Week Wait for Breast Symptoms (where cancer was not Anti cancer)</td>
<td>BHRUT</td>
<td>93%</td>
<td>Trust Performance</td>
<td>97.09%</td>
<td>97.22%</td>
<td>95.50%</td>
<td>94.11%</td>
</tr>
<tr>
<td>31 Day Cancer Wait 1st Definitive Treatment</td>
<td>BHRUT</td>
<td>96%</td>
<td>Trust Performance</td>
<td>100.00%</td>
<td>98.71%</td>
<td>99.40%</td>
<td>98.58%</td>
</tr>
<tr>
<td>31 Day Standard for Subsequent Cancer Treatments - Surgery</td>
<td>BHRUT</td>
<td>94%</td>
<td>Trust Performance</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>99.48%</td>
</tr>
<tr>
<td>31 Day Standard for Subsequent Cancer Treatments - Anti cancer</td>
<td>BHRUT</td>
<td>98%</td>
<td>Trust Performance</td>
<td>100.00%</td>
<td>98.04%</td>
<td>100.00%</td>
<td>99.77%</td>
</tr>
<tr>
<td>31 Day Standard for Subsequent Cancer Treatments - Radiotherapy</td>
<td>BHRUT</td>
<td>94%</td>
<td>Trust Performance</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>99.33%</td>
</tr>
<tr>
<td>62 Day Cancer Wait GP Referral</td>
<td>BHRUT</td>
<td>85%</td>
<td>Trust Performance</td>
<td>80.65%</td>
<td>70.25%</td>
<td>70.50%</td>
<td>73.93%</td>
</tr>
<tr>
<td>62 Day Cancer Wait Screening Service</td>
<td>BHRUT</td>
<td>90%</td>
<td>Trust Performance</td>
<td>100.00%</td>
<td>96.08%</td>
<td>100.00%</td>
<td>93.95%</td>
</tr>
<tr>
<td>62 Day Cancer Wait Consultant Upgrade</td>
<td>BHRUT</td>
<td>No threshold</td>
<td>Trust Performance</td>
<td>86.73%</td>
<td>84.31%</td>
<td>89.90%</td>
<td>87.31%</td>
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</table>

**Current Position**

Validated January data shows that the Trust achieved 7 out of 8 cancer standards. In January, the Trust did not achieve the 62 day urgent GP referral to treatment standard (achieving 70.25% against standard of 85%) and also did not achieve the agreed recovery trajectory of 81%. However, this non-achievement was agreed by Commissioners, as is the continued unvalidated under performance in February.

In support of the recovery trajectory for the 62 day standard, the Cancer Recovery Programme Board monitors additional local measures to ensure patients are progressing appropriately along the pathway from referral to diagnosis and treatment. These measures include the number of patients who have waited >62 days with or without a Decision To Treat (DTT), the number of treatments undertaken, and median waits for first appointment.

A significant reduction in the number of patients waiting >62 days without a DTT was achieved from November 2016 to January 2017, due to the result of improvements to patients tracking process and clinical review agreed as part of the recovery plan. An increased target number of treatments per week were agreed with the Trust, to support the treatment of these patients and achievement of the 62 day standard in March 2017.
Risks to Delivery

The key risks to delivery of this standard are:

- Lack of capacity within core specialties (urology, lower/upper GI, lung) to deliver additional activity to reduce existing backlogs.
- Conversion of patients who have waited >62 days to be moved from the ‘suspected’ to ‘confirmed’ waiting list impacts on capacity at tertiary providers.

Mitigating Actions

The Cancer Performance Recovery Programme Board has been established with agreed Terms of Reference. The Board consist of BHRUT and commissioners and meets fortnightly with assurance via monthly meetings to NHS England and NHS Improvement.

A full recovery plan has been developed and requires recovery of the 62 day cancer standard by March 2017. The plan incorporates a number of work streams and addresses the core issues affecting performance at BHRUT, including: Patient Targeted List (PTL) management, diagnostics and histopathology – capacity, waiting times and reporting timescales, demand and capacity, administration, culture and communication and tumour site specific plans.

The implementation of the recovery plan is monitored weekly via Operational Stocktake meetings and reported to the Cancer Performance Recovery Programme Board for risk assessment, challenge and mitigation. As of end of February, out of 288 milestones, it is noted that 255 of the required actions contained within the recovery plan have been completed and 28 are on track for completion by the required date: However, the following five actions are overdue:

- Time and motion study (MDT Coordinators) – delayed due to recruitment and new staff starting in post to be completed February. Latest update is that the model is completed, results under review with NHSI.
- Gynaecology urgent pathway – implementation delayed to support clinical engagement – achieved January.
- Histopathology turnaround times from day 11 to day 9 – delayed due to resource and recruitment; clinical recruitment completed with expected start date April 2017.
- Urology - reduction in median waits in line with trajectory – delayed due to capacity, under review.

A Contract Exception Report was issued to the Provider in December 2016 due to its failure to achieve the recovery trajectory in October (October validated data reported December) and the continuing high number of patients without a decision to treat waiting >62 days particularly in urology. Outpatient attendances (OPA) capacity and booking under review and completed end January 2017. Monitored weekly at Cancer Programme Board.

A further urology specific recovery plan was agreed with the Trust and approved by the Cancer Performance Recovery Board. This specialty specific recovery plan is being monitored by the Board and includes the roll out of the London Prostate Timed Pathway.
3.4 Quality

Current Position

**MRSA** - There were no reported cases of MRSA bacteraemia occurrence in February and 1 reported in January. There have been 7 reported cases year-to-date.

**C. difficile** - There were no reported cases of C. difficile reported in February and 1 reported in January, with a year-to-date position of 27 reported incidents. The annual target is 30 or less.

**Mixed Sex Accommodation (MSA)** - There were no MSA breaches for February and 5 reported in January, with a year-to-date position of 7 reported breaches.

Risks to Delivery

**MRSA**
A total of 5 MRSA bacteraemia were reported by the Trust in 2015/16. In 2016/17, 3 incidents were reported during Q1, with 2 incidents reported in Q2, 1 case reported in Q3 and 1 case reported in Q4: 7 in total. All MRSA bacteraemia infections are subject to root cause analysis investigations to identify lapses of care, and these cases are reviewed at the monthly Joint Infection Prevention Committee (IPC) meeting and penalties applied where applicable. This risk has materialised and the tolerance of 0 has been surpassed for 2016/17.

**C. difficile**
BHRUT reported a total of 38 hospital-acquired C Difficile infections 2015/16, against a threshold of 30. In 2016/17, a total of 5 incidents were reported for Q1, with 13 incidents reported during Q2, 8 incidents reported in Q3 and 1 incident reported in Q4. All C. difficile infections are subject to root cause analysis investigations to identify lapses of care and these cases are reviewed at the monthly Joint IPC meeting. The tolerance for 2016/17 is 30 or less with 27 cases having been reported for the previous 11 months there is a real risk of the tolerance being surpassed.

**Mixed Sex Accommodation (MSA)**
As of February 2017 there have been 7 breaches for 2016/17 against a target of 0. This risk has materialised and the tolerance of 0 has been surpassed for 2016/17.

**Venous thromboembolism (VTE)**
The validated Q3 performance is 94.9%. The Q1 and Q2 performances in 2016/17 are 96.3% and 94.8% against a 95% threshold. VTE performance is discussed at CQRM and escalated to Service Performance Review (SPR) meeting.

Mitigating Actions

Each case of C. difficile is reviewed via a multi-disciplinary Root Cause Analysis (RCA) meeting incorporating clinical, microbiology, pharmacy, CCG, IPC and nursing teams. An action plan is held by each ward to facilitate learning outcomes and ensure patient safety.

The Trust has implemented a plan to improve performance of the 95% admission assessments for VTE.

The CQC improvement plan requires BHRUT to report on how they are reducing the risk of VTE in hospital by ensuring that VTE prophylaxis is offered to patients at high risk, and that patients are reassessed when their clinical or mobility conditions change. This is reinforced by NICE Quality Standards and should be incorporated into BHRUT’s VTE Prevention Policy. BHRUT have been meeting the 95% Standard for VTE between from July 2015 – June 2016.

However, the Q2 and Q3, 2016/17 performance fell just short of the 95% target at 94.8% and 94.9% respectively.
### Current Position

The Trust performance for A&E FFT has been steadily improving month-on-month throughout Q1 and Q2 2016/17. However, although Q3 has experienced a slight decline Q3 performance is higher than Q1. Proportionally, Q4 has reported a slight decline compared to Q3. Apart from the month of April, 80% or more of A&E patients would recommend the A&E service to their friends and family.

The Trust performance for inpatients has been maintained consistently through 2016/17 up to January 2017 at above 91% of patients who would recommend the service. There has been a slight decline in February 2017 to 90.85%.

### Risks to Delivery

The key risks to delivery of this standard are:

- Response rates of the FFT surveys.
- Trust capacity to conduct surveys for the FFT.

### Mitigating Actions

The Trust has been working in partnership with “I Want Great Care” for Friends and Family Test Surveys since April 2016 with the aim of providing:

- Real-time feedback.
- Different ways for patients to provide feedback, either hardcopy or online.
- New simpler booklet style surveys.
- One set of questions across may areas in order to provide benchmarking capability.

This also includes initiatives such as recruitment of further patient experience volunteers to assist patients, introduction of new tablets to capture FFT responses and the introduction of new FFT feedback boards displaying monthly results in a user friendly way.

The Trust also have a newly formed Patient Partnership Council (PPC) and acts as the patients’ forum which is a key mechanism to oversee patient and public involvement in the work of BHRUT.

FFT performance continues to be scrutinised at Divisional Performance Reviews, which are chaired by the Chief Operating Officer.
3.6 Summary Level Hospital Mortality Indicator (SHMI) – September 2015 to October 2016 (last reported data)

**Current Position**

The last Nationally recorded information shows that BHRUT’s Summary Level Hospital Mortality Indicator (SHMI) rate is 106.8 for the period between September 2015 and October 2016 respectively and Hospital Standardised Mortality Ratio (HSMR) is 109.34 for December 2016 for the last 12 months. Both SHMI and HSMR should be interpreted with care; the data should be used as an alert to prompt further investigation rather than as a judgement tool on performance and practice.

The data at the time of publication will be 6 months in arrears and is published by the Health and Social Care Information Centre (HSCIC).

SHMI and HSMR are routinely monitored at the Clinical Quality Review Meetings (CQRM).

**Risks to Delivery**

The key risks to delivery of this standard are:

- Accurate reporting of data, which are always contested.
  Staff recruitment, retention and training, which could adversely impact on patient care.

**Mitigating Actions**

The Mortality Assurance Group (MAG) have reviewed and rebuilt arrangements for mortality review within the Trust, restructuring the process to ensure:

- Identification of avoidable deaths.
- Lessons are learned from problems in care and contributory factors to the problems.
- Recognise mortality reviews as an untapped resource for quality improvement.

Progress to date includes:

- Quarterly mortality data reports to Trust Executive Committee, Clinical Quality Review Meeting, Quality Assurance Committee and Trust Board.
- Mortality Review Checklist introduced June 2015 for ‘first cut’ reviews at the time of death.
- Understanding avoidable mortality based on HOGAN score.
- Established mortality database, over 2500 deaths recorded to date.
- Progression of the Divisional Mortality Dashboards, shared with divisional teams August 2016.
- Rebuild of MDT MAG – focused remit to review data and drive actions.

The Trust carries out reviews of, and identifies learning from, all deaths within the organisation through the MAG, which updates the CQRM.

The Trust has introduced the mortality review checklist as this is an established method of data collection, which incorporates the Hogan Scoring System, to assess the quality of care and treatment being provided and to give an early warning signal if an avoidable death is suspected. Data accuracy is determined by Clinician Input. All pro-formas are reviewed weekly by the Clinical Outcome Manager and Associate Medical Director and escalated appropriately.
Below is an overview of the Barts Health Activity at POD level (for activity tables refer to Appendix 2):

| Urgent Care | The annual forecast variance for urgent care is reported at -1,131 (-2.5%) over plan.  
The main drivers of this position are occupied bed days at -912 (-92.7%), adult critical care bed days at -372 (-25.4%) and non-elective non-emergency at -369 (-10.0%).  
The over performance is partially offset by under performance in emergency excess bed days at 648 (12.2%). |
|-------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|
| Planned Care| Planned care forecast variance is 340 (2.8) under plan.  
Day cases is the main driver of this position with forecast performance of 418 (6.3%) under plan. |
| Outpatients | Outpatient activity is forecast to be -5,413 (-5.6%) over plan.  
The forecast over performance is predominantly driven by outpatient firsts at -3,581 (-18.2%) and outpatient procedures at -3,429 (-21.0%). This is partially offset by under performance in non-admitted face to face attendance at 2,094 (45.3%). |
The required national operational standard continues to remain unmet.

Barts Health overall and the Whipps Cross site failed to achieve the A&E All Types Standard in February 2017, with performance as follows:

- Barts Health - 82.58% (STF trajectory of 92.30%).
- Whipps Cross - 78.91%.

Provisional un-validate data for March 2017 indicates performance as follows:

- Barts Health - 85.72% (STF trajectory of 90.30%), resulting in performance of 86.06% for 2016/17.
- Whipps Cross - 84.26% (site level trajectory of 95.05%) resulting in performance of 82.72% for 2016/17.

### Risks to Delivery

A&E (all types) attendances are up by circa 4.3% year-to-date, compared with 2015/16 (2.9% at Whipps Cross).

Patient flow management in the hospital and congestion in the Emergency Department contribute to poor performance on the Whipps Cross site.
Length of stay and timely ward discharge are the most significant contributory factors to poor performance at Whipps Cross. This site reports the highest length of stay with the highest proportion of patients staying over 5 days occupying 63% of the Whipps Cross total bed stock (average of the last 4 week period, previously 71%).

Mitigating Actions

Following the Barts Health submission of an appeal for STF based on Quarter 3 (where attendances were 3.08% above plan and performance 3.87% below the STF trajectory of 89.14%), a joint letter was received from NHSE and NHSI on 9 March 2017, outlining revised access to STF through the alignment of actions to get A&E performance back on track. Targeted actions with a national focus include freeing up bed capacity through:

- Improving access to home care or care home places.
- 7 day discharge capabilities including trusted assessor and discharge to assess.
- Comprehensive front door streaming.
- Improved support for care homes.
- Access to clinical advice within the 111 service.
- Reducing ambulance conveyances through hear and see & treat care.
- Standardising urgent care pathways.
- Rolling out increased access to GP appointment at weekends and evenings.

The national importance of this programme is demonstrated by the allocation of the 30% performance element of the STF for 2017/18 focused on the urgent and emergency care agenda. National funds have also been allocated to support improvements in social care, streaming and 111.

Further correspondence on 17 March 2017, highlighted the national groupings of local urgent and emergency care systems. Barts Health has been allocated to group 2 as a system with a low level of performance and high breach volumes that require regional intervention and support. A pre-requisite of this group is having local system recovery plans and monthly review meetings with NHSE the first of which was held on the 6 April with the Barts Health Chief Executive Officer and CCG Chief Officers. In preparation for this, Barts Health has reset the recovery plans for each of its sites and revised the STF performance trajectory for 2017/18 delivering 90% by September 2017 and with a more ambitious recovery trajectory to achieve and sustain 95% by March 2018. There is a planned meeting with the Secretary of State for Health in May for which confirmation of date is awaited.

The revised trajectory has been signed off by commissioners and included in the operating plan submission uploaded on the 30 March 2017.
**Current Position**

Barts Health is currently non-compliant with the national referral to treatment waiting time standards at specialty as well as Trust aggregate level. In light of large scale data quality issues faced, the Trust board took the decision to suspend the monthly mandatory reporting of referral to treatment waiting times data.

In January 2017, the Trust reported performance of 81.25% (79.34% for Whipps Cross) against the 18 Weeks Incomplete Standard, a slight improvement on the previous month (81.20% Trust Wide).

The 52+ week position as at end of January, including ‘pop-ons’\(^1\), was 128. Specialties with the highest number of 52+ week waiters are Trauma and Orthopaedics (42), Plastic Surgery (19) and Oral Surgery (16).

As the PTL management, logic and validation programme continue to evolve, the data accuracy will improve and this will impact on the 52 week position as well as the rest of the PTL.

As agreed with NHS England (NHSE) and NHS Improvement (NHSI), the Trust continues to work to the timeline of October 2017 for the resumption of national RTT reporting (September data).

**Risks to Delivery**

Non-admitted backlog volumes are reported as the greatest concern with some patients receiving first outpatient appointments over 18 weeks. Newham Hospital outpatient volumes are increasing. Affected specialties include: colorectal, orthopaedics and gastroenterology. Cancer is being prioritised.

Barts Health reported to CRG in March that the orthopaedic demand and capacity exercise was completed on the 10 March. Other pressured specialties will be completed by the end of April. There is currently little evidence that the Trust is achieving the activity levels necessary to reduce the backlog and meet demand.

WELC CCGs have agreed additional funding to the Trust to expedite validation as part of the year-end contract settlement.

**Mitigating Actions**

**Data Validation**

In addition to the business as usual validation, the Trust has undertaken targeted validation of the un-validated cohort and the number stands at 29,826 (reported to RTT Recovery Board on 28 February 17). In order to construct a robust conversion ratio, the Trust has created a randomised sample of 10% of the original 69,831 un-validated backlog. To-date 2,731 sample pathways have been validated with a conversion ratio of 4.6%. In order to minimise patient risk, ongoing validation will be prioritised using a defined list of at risk patients (long waiters, higher risk specialties and children). A contract has now been agreed with Cymbio for off-site validation. The service mobilised in March with an estimated completion date of early May 2017.

**Return to reporting**

Once the Trust is in a position to report, there will be a process of external assurance that WELC CCGs will be leading on with NHSE and NHSI input. The process is key to providing system assurance around the Barts Health data quality and sustainability prior to giving the go ahead to resume national reporting. Newham CCG as lead commissioner will facilitate a meeting to agree the process and timeline for the external assurance process.

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\(^1\) ‘Pop-ons’ refers to patients previously not seen on the PTL and are usually due to validation of the pathway, through the data quality processes.
Following a bipartite meeting held on 28 February 2017, NHSE and NHSI requested a timescale in which they receive a recovery trajectory to achieve compliance against the RTT standard. A trajectory and roadmap to return to national reporting will be ready for review at the RTT Recovery Programme Board by 9 June 2017.

<table>
<thead>
<tr>
<th>KPI</th>
<th>National Standard</th>
<th>Performance</th>
<th>Nov-16</th>
<th>Dec-16</th>
<th>Jan-17</th>
<th>Feb-17</th>
<th>2016/17 YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust Performance</td>
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<tr>
<td>Performance Vs Standard</td>
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<tr>
<td>Trajectory</td>
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<tr>
<td>Performance Vs Trajectory</td>
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</table>

**Current Position**

The national standard was achieved in February 2017 with performance of 99.42%. This represented achievement of the standard for the eighth month in succession.

3.9 **Cancer Waits**

<table>
<thead>
<tr>
<th>KPI</th>
<th>National Standard</th>
<th>Performance</th>
<th>Dec-16</th>
<th>Jan-17</th>
<th>Feb-17</th>
<th>2016/17 YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust Performance</td>
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<tr>
<td>Performance Vs Standard</td>
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<tr>
<td>Trajectory</td>
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<tr>
<td>Performance Vs Trajectory</td>
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</tbody>
</table>

62 Day Cancer Wait Consultant Upgrade | No threshold    | Trust Performance | 90.32% | 86.17% | 85.40% | 87.66% |             |
Current Position

At Barts Health (other sites):
The cancer 2 week wait performance for February was 97.6% compared to the standard of 93% and this has been met consecutively for the last 21 months.

The 62 day urgent referral performance for February was 86.2% compared to the standard of 85%. The standard was not met in January 2017.

At the Whipps Cross site:
The cancer 2 week wait performance for December was 97.4% compared to the standard of 93% and this has been met consecutively for the last 20 months.

The 62 day urgent referral performance for January was 87.1% compared to the standard of 85%.

Risks to Delivery

Risks to delivery continue to include:
- Diagnostic delays
- Capacity delays
- Late referrals from other providers

Mitigating Actions

In response to the sustained poor performance, commissioners took a number of actions during 2014/15 and 2015/16, these included:
- Serving a Contract Performance Notice (CPN) which required the development of a Remedial Action Plan (RAP) for Cancer, RTT and Diagnostics. These are reported to the BH National Standards Performance Committee where senior level representation from WEL CCGs, NHS Improvement, NHSE Specialised Commissioning and the CSU hold the Trust to account.
- Many of the actions in the RAP have been completed and those that weren’t were rolled forward into the Service Development and Improvement Plan in the 2016/17 Contract.

To oversee the Cancer Improvement Programme the Trust has put in place permanent senior clinical and managerial resources; a Clinical Director of Cancer Performance & Improvement, a ‘managerial’ Director of Cancer Performance & Improvement, a General Manager for Cancer Performance and Data Analysts.

The SDIP programme includes a number of service developments and enhanced quality requirements:
- GP direct access or ‘straight to test’ diagnostic tests with targets for reduced reporting times.
- Reducing variation within pathways.
- Implementation of the Macmillan/NCSI ‘Recovery Package’.
- Adoption of stratified follow-up and self-management programme.

The 62 day trajectory for 2017/18 and 2018/19 continues to profile a non-compliant position for two months, based on actual outcomes, these months are now August and January where the highest impact of patient choice delays are expected.

Barts Health is working with BHRUT to improve late inter-provider transfers.

There are monthly Contract Technical Sub-group meetings, led by the WELC CCG collaborative, where performance is scrutinised.
The WELC CCG collaborative has engaged in NCEL sector fora with other commissioners, providers and other regional partners to improve inter trust referral transfer performance.

**Penalties**

A penalty position for the year has been incorporated into the 2016/17 year-end financial agreement with the Trust.
3.10 Community Health Services (CHS) – 16/17 Contract Value for Redbridge CCG £19.9m

**Current Position**

NELFT Key Performance Indicator (KPI) and CQUIN performance is reported quarterly in line with contractual targets and the quarterly service and performance review (SPR) closedown process.

**Performance Management (Q3)**

Q3 performance data has been received with the formal closedown position agreed at SPR on 10 March 2017. The highlights are set out below:

**KPIs:**
- All KPI targets have been achieved in Q3
- CTT numbers of new patients referred and conversion rate targets met. Number of referrals is 20% above the required target for new patients referred in the quarter, with acute conversion rate of 6% against maximum of 12%.
- Community bed transfer rates within the 72 hour (3 days) target across BHR - average 1.5 days
- IRS numbers of patients referred continues to over-perform across BHR, in Redbridge this represents 93% above target to date.
- No reported cases of MRSA or Clostridium difficile

**CQUINs:**
- To be reported in Q4, in line with National CQUIN timetable.

**Other Highlights:**
- Patient experience and satisfaction across CTT in Q3 was 100% based on 5x5 survey results.
- Patient experience and satisfaction across IRS in Q3 was 100% based on 5x5 survey results.
- Patient experience and satisfaction across Community beds in Q3 was 100% based on 5x5 survey results.
- LAC IHAs completed with 4 weeks = 86%.
- Child Protection Medicals completed with 48 Hours = 100%.

**RTT:**
- No reported breaches of the 18 week Referral to Treatment (RTT) complete/incomplete pathways across applicable NELFT services.

**Performance Management (M11)**

- % of Community Matron Care plans that have been agreed by patient /carer remains high during the month at 97%.
- Community Rehab Average Length of Stay (ALoS) generally remains within the benchmark position of 21 with average December position for Foxglove at 18 days and Japonica at 20.7 days.
- Occupancy rates for the General Rehab beds have increased in month and consistent with previous years averaging 96.1% across both Foxglove and Japonica wards.
- Stroke beds ALoS has seen an overall decrease compared previous months at 24.1 days when compared to 33.4 days in January and now below the benchmark of 28 days.
- Occupancy rates for stroke beds have decreased during the month with an average occupied bed rate of 90.1% (15 / 17).
- Community bed transfer rates within the 72 hour (3 days) target across BHR is an average of 2.52 days.
North East London Foundation Trust (NELFT)

3.11 Mental Health Services (MHS) - Contract Value for Redbridge £22.4m

Current Position

2016/17 Q3 closed down at SPR on 12 April.

Q3 KPI highlights are set out below. It should be noted that the Redbridge IAPT service has still not quite achieved its quarterly improving access to psychological therapies (IAPT) access targets, although current performance is much improved compared with last year. The Recovery target performance has slipped back.

<table>
<thead>
<tr>
<th>KPI Name</th>
<th>Borough</th>
<th>Target</th>
<th>Q2 Performance</th>
<th>Q3 Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>IAPT Access</td>
<td>Redbridge</td>
<td>3.75%</td>
<td>3.59%</td>
<td>3.24%</td>
</tr>
<tr>
<td>IAPT Recovery</td>
<td>Redbridge</td>
<td>50%</td>
<td>52.69%</td>
<td>48.24%</td>
</tr>
<tr>
<td>IAPT Waiting times: percentage of people referred to the IAPT programme begin treatment within 6 weeks of referral</td>
<td>Redbridge</td>
<td>75%</td>
<td>97.90%</td>
<td>96.70%</td>
</tr>
<tr>
<td>IAPT Waiting times: percentage of people referred to the IAPT programme begin treatment within 18 weeks of referral</td>
<td>Redbridge</td>
<td>95%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Child and adolescent mental health services (CAMHS):
It should be noted that the Redbridge CAMHS service has not met two KPIs for referrals to Tier 3 CAMHS.

<table>
<thead>
<tr>
<th>KPI Name</th>
<th>Borough</th>
<th>Target</th>
<th>Q3 Performance</th>
<th>Penalty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine referral to treatment waiting times for Tier 3 CAMHS.</td>
<td>Redbridge</td>
<td>95% in 18 weeks</td>
<td>92.0%</td>
<td>£18,796</td>
</tr>
<tr>
<td>Routine referral to treatment waiting times for looked after children (LAC) placed in borough to Tier 3 CAMHS.</td>
<td>Redbridge</td>
<td>95% within 4 weeks of becoming a LAC.</td>
<td>50%</td>
<td>There were two LAC referrals, but only one was seen within 4 weeks. Penalty: £18,796</td>
</tr>
</tbody>
</table>

All other Q3 mental health KPIs have been met including the EIP target of 50% of people experiencing a first episode of psychosis being treated with a NICE approved care package within two weeks of referral. The Q3 performance is 100%.
Q3 performance:

As reported at Q2, high pressures on inpatient occupancy of the psychiatric acute wards at Goodmayes Hospital continue. Rising demand on NELFT beds to levels consistently above 100% occupancy was occurring through 2016 until remedial actions were taken by NELFT (above 100% occupancy means that patients who are on trial home leave have their beds used by other patients).

Whilst the mitigating actions have moderated the bed pressures, the occupancy does still remain high. This persistent high demand for inpatient beds reflects trends across London. At times this requires placements by NELFT with alternative providers.

Risks to Delivery

a) There remains a key risk in relation to the IAPT Access and Recovery targets.

b) The Early Intervention in Psychosis (EIP) is a new target, with a high risk of achievement failure due to small numbers in patients in the service, which can be fewer than 10. This small demand can have a significant impact on provider percentage performance achievement, for only one patient breach.

c) A requirement to improve quality and safety risks was identified in the CQC report and recommendations made.

d) Pressures on the psychiatric acute ward beds are posing significant operational challenges.

Mitigating Actions

a) IAPT: The CCG has a project lead for IAPT performance and an action plan to address sustaining performance on IAPT Access and achieving IAPT Recovery targets. The single most important factor to achievement of this target is increasing referrals initiated by GPs. The project lead will continue to work with the GP mental health lead to engage local GPs to increase referrals.

b) EIP: There is an applicable contractual penalty in the event of quarterly failure. In order to develop an understanding of the reasons why targets may be missed, we have required NELFT to report on all cases where EIP patients were not seen within the specified standard timescale. This is enabling us to identify whether entering treatment after two weeks is a data recording issue, service delivery issue, or whether the specific circumstances of the particular cases suggest valid clinical reasons for delay.

c) Under the leadership of the Nurse Director, commissioners are supporting NELFT and seeking assurance that the requirements to improve quality and safety identified in the CQC report are being met.

d) In order to manage the sustained pressures on psychiatric ward beds, NELFT have had to start making placements into out of area hospitals for the first time in about ten years. Unlike most other areas in London, these out of area placements are paid for by the provider trust (NELFT) rather than the CCGs.
The PELC contract covers GP Out-of-Hours (OOHs), 111 and Urgent Care Centre (UCC) King Georges Hospital (KGH)

The first year of a 2 year contract (2016/18) has helped to stabilise PELC financially and enabled its accountability and sustainability. The contract value for BHR CCGs is £7,995k. It is on a cost and volume basis with a minimum income guarantee and marginal rates for over-performance. At M11, the 111 service has over performed by 14% and the activity in February was 13% more compared to same time in same in 2015/16. As per contractual agreement, a full year review of finance and activity with PELC is to follow after the year end.

Commissioners have continued to support PELC in the implementation of the ‘Well Led Review’ recommendations through consultants engaged by commissioners. The engagement of the ‘Support Team’ was extended beyond its original schedule to support PELC following the emergence of serious concerns regarding governance and departure of key senior members of staff, which has now concluded and the final report has been produced by the ‘Support Team’. PELC has made progress by making permanent recruitment to key senior posts except the Head of Human Resources for which interviews have been conducted.

3.12 PELC Performance

<table>
<thead>
<tr>
<th>Current Position</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>111</strong></td>
</tr>
<tr>
<td>The 111 contract is closely monitored by commissioners. Key Performance Indicators (KPIs) are also reviewed by NHSE on a weekly basis. 111 call volumes have increased by 13% in February 2017 compared to the same time last year. PELC’s performance for calls answered within 60 seconds was marginally below (93.1%) the 95% target. All other KPIs except ‘Time taken for call back &lt;10min’ have met the target in M11. Commissioners have been assured that the under performance of time taken to call back KPI did not create a risk to patients or adversely affect service delivery as PELC manage any extended waits by call backs to patients and clinical prioritisation.</td>
</tr>
<tr>
<td>The percentage of Green Ambulance re-triage has been consistently achieving around 65% in recent weeks and months as it continues to support LAS and prevent non-essential attendances to ED.</td>
</tr>
</tbody>
</table>

**Out of Hours (OOH)**

There has been significant decrease in OOH activity in February as it decreased by -38.31% in Redbridge compared to same period in 2015/16. Year to date activity across three CCGs has reduced by -18.44% (note that whilst OOH calls are routed through 111, they are only a proportion of 111 calls and changes in overall 111 activity can occur in a different trend compared with OOH).

The performance against KPIs has improved in February after a challenging December and January, but two KPIs were still Red in February. This was explored in March’s Service Performance Review (SPR). PELC stated that during busy periods, delays in contacting some of the lower acuity patients contributed to adverse impact on overall performance for the month.

Commissioners have been assured by PELC that calls are managed on clinical priority basis and any delays in call backs to patients are risk assessed and prioritised. The close monitoring of contract performance continues through monthly contract and quality review meetings.

**UCC**

The activity at King George Hospital (KGH) has decreased by -12.86% in February 2017 compared to the same period in 2015/16. The activity continues to fluctuate monthly and the average year-to-date variance in activity is -0.70% compared to same period in 2015/16. The issue of failure to report NHS numbers on all patients is being progressed and PELC has taken measures to improve reporting.
Overall utilisation at King George Hospital (KGH) UCC was 31.67% in February 2017.

Patients attending UCC are streamed by PELC at point of entry. A CCG led audit of streaming occurred earlier this year and opportunities to improve streaming and UCC utilisation are being pursued.

<table>
<thead>
<tr>
<th>Risks to Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Risk of departure key members of staff</td>
</tr>
<tr>
<td>• Difficulty in recruitment and retention of high quality staff</td>
</tr>
<tr>
<td>• Delay in fully implementing the Well Led Review recommendations particularly regarding governance</td>
</tr>
<tr>
<td>• Concerns in respect of adherence to good governance and practice in respect of medicines management</td>
</tr>
<tr>
<td>• Safety and Quality risk following recent CQC inspection</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mitigating Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Commissioners working with PELC to enable successful recruitment to key positions.</td>
</tr>
<tr>
<td>• Action being taken by commissioners to ensure the contractual requirement to implement recommendations of WLR is undertaken.</td>
</tr>
<tr>
<td>• Follow up of the recommendations made by the ‘Support Team’.</td>
</tr>
<tr>
<td>• Continuous support by CCG Quality Team in maintaining and improving quality requirements.</td>
</tr>
<tr>
<td>• Continuous support by Medicines Management Team in assessing risks and actions taken in respect of medicines management.</td>
</tr>
</tbody>
</table>
London Ambulance Service (LAS)
Contract Value for Redbridge CCG – £9.4m

3.13 LAS performance for Redbridge CCG

Current Position

LAS Performance for Redbridge CCG (see graph)
Performance in February 2017 for Redbridge CCG is reported at 58.1% of Category A calls responded to within 8 minutes (against the 75%) target. This is a favourable movement from the previous month’s performance. There has been a 8.7% increase in demand in February 2017 (inclusive of incidents, Hear & Treat and Surge) when compared to the same period last year, and the year-to-date demand has increased by 4.3%. Category A activity for Redbridge CCG for the year to date is 16,421 which is 1,056 above plan of 15,365. Category C activity for the year to date is 15,423 which is 518 over plan of 14,905.

LAS Performance Pan-London
LAS performance pan-London continues to underperform against the national target in 2016-17 and, for the fifth consecutive month, remains below the recovery trajectory. Category A performance in February 2017 is reported at 67.8% which is below the recovery trajectory of 72.0%. The most recent pan-London weekly Category A performance (13 – 19 March) is reported at 73.1% against a plan of 72.3%.

In view of the 6.5% increase in activity (Category A activity and Category C activity combined) seen against contract levels year-to-date, which is over and above the uplift of 4.7% included within the 2016/17 contract, the LAS have requested additional funding for Q2 and Q3, totalling £497k across BHR CCGs. The combined value for both Q2 and Q3 for Redbridge CCG is £178k. This is to cover costs of meeting performance trajectories. The LAS have stated that the cost of additional activity above plan was funded by the Trust in Q1 and that performance has been maintained in this period through the implementation of non-recurrent actions. The LAS have confirmed that this is not sustainable and have notified commissioners that if demand continues to rise, then the additional funding request for Q4 will be higher than Q2 and Q3.

The projected pan-London cost for Q4 is £3.2m with the Redbridge CCG share of this totalling £99k. In December 2016, the Chief Officer of the lead commissioner for the LAS contract formally wrote to collaborative commissioners to request that the LAS request for additional funds for Q2 and Q3 is granted. The BHR CCGs continue to challenge the additional activity funding.
Following the February CQC inspection, the LAS is awaiting the receipt of the formal report which is expected in May. There will potentially be a second quality summit in June 2017.

### Risks to Delivery

The key risks to delivery of this standard are:

- 111 conversions to 999 across London.
- Increased demand (and higher acuity calls).
- Ambulance handover times / job cycle time.
- Use of different UCC protocols used in the 2 UCC at Queens Hospital and KGH.
- Demand management schemes identifying a 2% reduction against a target of 5%.

### Mitigating Actions

One of the identified areas contributing to demand is calls from the London Metropolitan Police. The LAS has now set up a dedicated desk to triage and manage these calls. Calls from NHS 111 and Health Care professionals continue to be assessed in order to gain a better understanding of how these can be better managed.

Addressing hospital handover delays continue to be a key focus for the Trust, and an action plan has been developed to address issues relating to the Trust’s handover to green performance. The Trust continues to be involved and participates in discussions with system wide partners to improve overall hospital handover performance, however the lost time at hospital handover remains high.

In support of the required reduction in incidents, an STP level demand management approach has been adopted for North East London. A North East London STP demand management deep dive was held on 12 January 2017 with LAS. The meeting reviewed current schemes and factors contributing to the increased LAS activity and agreed a range of actions to be undertaken, outlined below. Requests have been made to LAS to provide information to support demand management for example frequent callers for clinical review.

Commissioners are committed to ensure that LAS is provided with up to date details of active Alternative Care Pathways (ACPs) within each borough.

A review of Category C3/4 incidents is to be undertaken between commissioners and LAS to determine the cause of the incidents and the appropriateness of the response as a conveyance. Following the review, the potential of decommissioning of Categories C3/4 incidents from LAS will be decided.

Part of the Urgent and Emergency Care programme a focus for 2016/17 has been the development of an enhanced Clinical Assessment Service (CAS) within NHS 111. The current pilot, introduced by the Healthy London Partnership (HLP) provides paramedics with direct access to the local NHS 111 service and provides fast track access to GP’s as a point of advice and specialised knowledge within the CAS to support conveyancing decisions and manage more patients within a community rather than acute setting. This is based on the NHSE concept of ‘no decision in isolation’. The pilot has been running for a period of 2 months and the service is being utilised with an average of 10 calls per day during weekdays and 13 calls per day over the weekend from paramedics to the CAS. The latest data set to assess impact of the pilot is awaited.

The BHR health economy continues to have in place services that support demand management and prevent conveyances. These schemes include the Community Treatment Team (CTT), the CTT/LAS Falls Car, and service developments at A&E to support resilient ambulance handover times.
4.0 Resources/investment

4.1 Resources/investment in each service/provider are highlighted for each individual provider as required, under the relevant sections of this report.

4.2 There are no financial, social or environmental impacts arising from this report.

5.0 Equalities

5.1 There are no equalities implications arising from this report.

6.0 Risk

6.1 Risks and Mitigations for each service are highlighted for each individual provider, under the relevant sections of this report.

7.0 Managing conflicts of interest

7.1 There are no conflicts of interest to note, related to this report.

Author: NEL CSU
Date: 18 April 2017
## Appendix 1

### BHR CCGs Contractual Actions taken for 2016/17 Contracts

<table>
<thead>
<tr>
<th>Provider</th>
<th>CPNs/AQNs/Exception notice</th>
<th>Issue</th>
<th>Current Status - Commissioner</th>
</tr>
</thead>
<tbody>
<tr>
<td>BHRUT</td>
<td>Venous Thrombo Embolism (VTE) - CPN</td>
<td>Trust not achieving 95% national target.</td>
<td>The Trust failed to achieve the October target but achieved the November target. Recommendation is for the CPN to remain open until the Trust establishes an achievement trend.</td>
</tr>
<tr>
<td>BHRUT</td>
<td>RTT Incomplete pathway - CPN</td>
<td>Percentage of service users on incomplete pathway waiting no more than 18 weeks, Trust not achieving target.</td>
<td>RTT recovery trajectory agreed jointly with all parties and has been submitted to NHSE as part of the RTT Recovery plan. Monthly monitoring of recovery performance against trajectory is ongoing. Trust returned to National reporting with October data. CPN to remain open and performance to be monitored through the return to National reporting.</td>
</tr>
<tr>
<td>BHRUT</td>
<td>A&amp;E - CPN</td>
<td>Trust non-achievement of the national target</td>
<td>A new Contract Performance Notice to be issued for October and November performance failing to meet the agreed STF trajectory. The CPN will be issued when the performance has been validated and a Contract Management meeting will be held and a RAP will be required.</td>
</tr>
<tr>
<td>BHRUT</td>
<td>Cancer 62 day – Exception Notice</td>
<td>Trust continued failure to achieve the 62 day standard within agreed timescales</td>
<td>A 2nd Contract Exception Report Notice was issued to the Trust on 27/1/2017 for failure to meet the recovery trajectory for 62 days cancer – GP Urgent Referral to Treatment. The CCGs have requested the Trust to share a weekly summary of cancer treatments and procedures undertaken by specialty, to enable the impact of recovery and its financial implications to be understood. The CCGs will be closing this exception report, subject to agreement of the Trust providing the requested additional information.</td>
</tr>
<tr>
<td>BHRUT</td>
<td>Cancelled operations - CPN</td>
<td>Trust breached the zero tolerance threshold for the number of Service Users who have operations cancelled who have not been treated within 28 days</td>
<td>The Trust continues to consistently underperform against the National Standard with 2016/17 Q1 Performance (96.1%) and Q2 Performance (95.9%) significantly under the 100% threshold. The Trust has failed to meet the standard for 5 consecutive quarters. A 1st Contract Exception Notice to be issued as the previously agreed RAP has failed to deliver improved performance.</td>
</tr>
<tr>
<td>BHRUT</td>
<td>MRSA (Methicillin-Resistant Staphylococcus Aureus) - CPN</td>
<td>Trust has breached the zero tolerance thresholds for incidences of MRSA.</td>
<td>There have been 5 reported breaches of MRSA between April and October 2016 against a zero tolerance standard. Recommendation is for the Trust to demonstrate 3 consecutive months achievement of this standard and</td>
</tr>
<tr>
<td>Trust</td>
<td>Category</td>
<td>Issue</td>
<td>Action</td>
</tr>
<tr>
<td>-------</td>
<td>----------</td>
<td>-------</td>
<td>--------</td>
</tr>
<tr>
<td>BHRUT</td>
<td>Mandatory Training - CPN</td>
<td>Provider failing monthly targets for Mandatory Training in the following areas; Safeguarding (Adults and Children), Information Governance, Appraisals, Resus</td>
<td>The Trust has responded to the CPN and was compliant on Safeguarding Training (85%). Progress and compliance will be monitored through the CQRM. Remedial Action (RAP) meeting for appraisal set up with the Trust. Recommendation is to continue monitoring against Remedial Action Plan for Q4 and will be reviewed at the next Clinical Quality Review Meeting (CQRM) meeting and escalated to SPR if needed.</td>
</tr>
<tr>
<td>BHRUT</td>
<td>Serious Incident Reporting</td>
<td>Failure to meet the 48 hour Serious Incident notification and 72 hour reporting of a Serious Incident</td>
<td>A Contract Management Meeting has been held and a RAP in currently in development. CCG recommended closure of CPN.</td>
</tr>
<tr>
<td>BHRUT</td>
<td>Clostridium difficile (C-Diff)</td>
<td>Monthly cumulative breaches above the agreed trajectory.</td>
<td>RAP sent by Trust and awaiting CCG's decision to accept or refuse contents. Monitoring of delivery of RAP to commence once CCG approved. March SPR advised CPN still open, pending a monitored sustained position of decreased C.diff incidences at the Trust.</td>
</tr>
<tr>
<td>PELC</td>
<td>SDIP requirements – CPN</td>
<td>Failure to comply with SDIP requirements regarding ‘Well Led Review’ Implementation</td>
<td>SPR meeting on 12 April noted performance now compliant. CPN now closed.</td>
</tr>
<tr>
<td>NELFT</td>
<td>Staff Appraisal</td>
<td>Failure to meet contractual target of 85% of staff receiving staff appraisals</td>
<td>Well Led Review (WLR) meeting on 31 March agreed to withdraw CPN</td>
</tr>
</tbody>
</table>
Appendix 2

Month 11 Activity Summary Tables

BHRUT

### Urgent Care

<table>
<thead>
<tr>
<th>BHRUT M11 Summary</th>
<th>Year to Date Activity</th>
<th>Annual Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Plan</td>
<td>Actual</td>
</tr>
<tr>
<td>Redbridge CCG</td>
<td>77,027</td>
<td>77,471</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>49,621</td>
<td>51,724</td>
</tr>
<tr>
<td>Urgent Care Centre</td>
<td>2,011</td>
<td>1,820</td>
</tr>
<tr>
<td>Non-Elective</td>
<td>12,959</td>
<td>11,391</td>
</tr>
<tr>
<td>Non-Elective Extra Bed Days</td>
<td>6,204</td>
<td>4,663</td>
</tr>
<tr>
<td>Non-Elective Non-Emergency</td>
<td>3,783</td>
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<tr>
<td>HASU</td>
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### Planned Care

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<tbody>
<tr>
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<td>Redbridge CCG</td>
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<td>Rehab</td>
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<td>Regular Attendees (Day &amp; Night)</td>
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### Outpatients

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<tr>
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<tr>
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<td>Redbridge CCG</td>
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<td>Maternity</td>
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### Other

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<td>Redbridge CCG</td>
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<td>Devices</td>
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<td>Cardiac Tests</td>
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<td>TIA</td>
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<td>Audiology</td>
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<td>Black</td>
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<td>543</td>
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<td>Patient Transport Services</td>
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## Barts Health

### Urgent Care

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<th>Annual Activity</th>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Plan</td>
<td>Actual</td>
<td>Variance</td>
<td>Variance %</td>
<td>Plan</td>
<td>Actual</td>
<td>Variance</td>
<td>Variance %</td>
</tr>
<tr>
<td>NHS Redbridge CCG Total</td>
<td>42,079</td>
<td>43,138</td>
<td>-1,059</td>
<td>-2.5%</td>
<td>45,993</td>
<td>47,124</td>
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<td>Accident and Emergency</td>
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<td>24,549</td>
<td>-385</td>
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<td>26,406</td>
<td>26,828</td>
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<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>Non-Elective</td>
<td>6,762</td>
<td>6,552</td>
<td>210</td>
<td>3.1%</td>
<td>7,396</td>
<td>7,156</td>
<td>242</td>
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<td>Excess bed days Emergency</td>
<td>4,844</td>
<td>4,251</td>
<td>593</td>
<td>12.2%</td>
<td>5,293</td>
<td>4,646</td>
<td>648</td>
<td>12.2%</td>
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<tr>
<td>Non-Elective Non-Emergency</td>
<td>3,778</td>
<td>3,721</td>
<td>-57</td>
<td>-1.5%</td>
<td>3,851</td>
<td>4,060</td>
<td>-309</td>
<td>-10.0%</td>
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<tr>
<td>Excess bed days Non-Elective</td>
<td>591</td>
<td>525</td>
<td>66</td>
<td>11.1%</td>
<td>646</td>
<td>573</td>
<td>72</td>
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<tr>
<td>Critical Care - Intensive Treatment Unit</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Adult Critical Care Bed Days</td>
<td>1,339</td>
<td>1,682</td>
<td>-343</td>
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<td>1,463</td>
<td>1,835</td>
<td>-372</td>
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<tr>
<td>Occupied Beddays</td>
<td>900</td>
<td>1,738</td>
<td>-838</td>
<td>-91.1%</td>
<td>984</td>
<td>1,896</td>
<td>-912</td>
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<tr>
<td>Hyper Acute Stroke Unit Bed Days</td>
<td>102</td>
<td>120</td>
<td>-18</td>
<td>-17.1%</td>
<td>112</td>
<td>131</td>
<td>-19</td>
<td>-16.9%</td>
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### Planned Care

<table>
<thead>
<tr>
<th>Barts Health M11 Summary</th>
<th>Year to Date Activity</th>
<th></th>
<th></th>
<th></th>
<th>Annual Activity</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Plan</td>
<td>Actual</td>
<td>Variance</td>
<td>Variance %</td>
<td>Plan</td>
<td>Actual</td>
<td>Variance</td>
<td>Variance %</td>
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<tr>
<td>NHS Redbridge CCG Total</td>
<td>11,114</td>
<td>10,806</td>
<td>308</td>
<td>2.8%</td>
<td>12,219</td>
<td>11,879</td>
<td>340</td>
<td>2.8%</td>
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<tr>
<td>Day Cases</td>
<td>6,013</td>
<td>5,534</td>
<td>479</td>
<td>6.3%</td>
<td>6,611</td>
<td>6,193</td>
<td>418</td>
<td>6.3%</td>
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<tr>
<td>Elective</td>
<td>1,387</td>
<td>1,248</td>
<td>139</td>
<td>10.0%</td>
<td>1,526</td>
<td>1,372</td>
<td>154</td>
<td>10.1%</td>
</tr>
<tr>
<td>Excess bed days EL</td>
<td>361</td>
<td>411</td>
<td>-50</td>
<td>-11.8%</td>
<td>397</td>
<td>452</td>
<td>-55</td>
<td>-11.8%</td>
</tr>
<tr>
<td>Regular Night EL</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>18.9%</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>19.9%</td>
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### Outpatients

<table>
<thead>
<tr>
<th>Barts Health M11 Summary</th>
<th>Year to Date Activity</th>
<th></th>
<th></th>
<th></th>
<th>Annual Activity</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Plan</td>
<td>Actual</td>
<td>Variance</td>
<td>Variance %</td>
<td>Plan</td>
<td>Actual</td>
<td>Variance</td>
<td>Variance %</td>
</tr>
<tr>
<td>NHS Redbridge CCG Total</td>
<td>87,472</td>
<td>92,425</td>
<td>-4,953</td>
<td>-5.7%</td>
<td>96,175</td>
<td>101,588</td>
<td>-5,413</td>
<td>-5.6%</td>
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<tr>
<td>Outpatient First</td>
<td>17,900</td>
<td>21,178</td>
<td>-3,278</td>
<td>-18.3%</td>
<td>19,696</td>
<td>23,278</td>
<td>-3,582</td>
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<tr>
<td>Outpatient Follow up</td>
<td>44,004</td>
<td>44,243</td>
<td>-239</td>
<td>-0.5%</td>
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<td>48,629</td>
<td>-234</td>
<td>-0.5%</td>
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<tr>
<td>Outpatient Procedures</td>
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<td>-3,120</td>
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<td>16,360</td>
<td>19,789</td>
<td>-3,429</td>
<td>-21.0%</td>
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<tr>
<td>Maternity Pathway</td>
<td>3,135</td>
<td>3,193</td>
<td>-58</td>
<td>-1.9%</td>
<td>3,426</td>
<td>3,510</td>
<td>-84</td>
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<tr>
<td>Regular Day Admission</td>
<td>3,348</td>
<td>3,510</td>
<td>-162</td>
<td>-4.8%</td>
<td>3,660</td>
<td>3,858</td>
<td>-178</td>
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<tr>
<td>Non Admitted face to face attendance</td>
<td>4,202</td>
<td>2,297</td>
<td>1,905</td>
<td>45.3%</td>
<td>4,618</td>
<td>2,525</td>
<td>2,093</td>
<td>45.3%</td>
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Executive summary

This report is written to provide assurance to the governing body that the Clinical Commissioning Group (CCG) constantly reviews the quality of our commissioned services to ensure all care is delivered in line with best practice as new guidance is published by relevant bodies such as the National Quality Board, and that we continue to oversee the quality of care delivery across our health system. Where necessary this may involve the performance management of our providers to improve the quality of the services we commission and to ensure they are delivered to the standard we expect. This enables us to constantly improve the quality of our services, including the experience for our patients.

The report is divided into two sections. Section 1 provides a system wide overview of specific quality indicators that underpin and assure all the CCG commissioning activities, such as assurance that we are continuing to implement our quality strategy and also the new “National Guidance on Learning from Deaths”, published in March 2017 by the National Quality Board. Safer staffing across all our main three providers is discussed here.

Section two focuses on the priority operational quality issues and challenges that the CCG continues to manage to ensure patient safety and that support a positive patient experience. This section also includes specific provider issues discussed at the Clinical Quality Review Meetings (CQRM).

Recommendations

The governing body is asked to:

- Review and discuss the quality matters outlined in this report
- Suggest any additional actions that are required for further improvements or assurance

1.0 Purpose of the Report

1.1 This report is presented to the governing body to ensure that members are fully briefed and assured on all the quality challenges and issues that the CCG is addressing through our commissioning activities. It also supports and builds on many of the issues and risks discussed in previous reports.

1.2 This covers both strategic and operational quality issues and details how they are managed so that our patients and residents receive the best possible care, delivered in a way that is safe and effective while providing value for money and a positive patient experience.

2.0 Introduction

2.1 Implementing our quality strategy and improving experiences for patients will continue to be a CCG priority, and many of our specific quality improvement and assurance activities are aimed at
doing this, particularly our actions that deliver improved provider quality performance, which we assure and monitor through our established contract monitoring processes.

2.2 This report is divided into two sections:

- **Section 1** - System wide quality performance which includes the CQC provider quality performance concerns, how we are implementing the “National Guidance on Learning from Deaths” and an update on the system wide recruitment and safer staffing issues that our three main providers are managing.

- **Section 2** – The quality performance of our main providers and the issues we are currently reviewing and addressing at the Clinical Quality Review Meetings (CQRM’s).

3.0 **Section 1: System Quality Performance**

**CQC Provider Quality Performance Challenges**

3.1 **NELFT CQC inspection.** It has now been a year since the CQC inspected NELFT in April 2016, although the final report was published in September 2016. In response to the report NELFT developed a Strategic Quality Improvement Plan and established internal governance arrangements to oversee and monitor the implementation of the plan. The Strategic Quality Improvement Plan detailed all the actions that NELFT are required to implement to address the enforcement actions and requirement notices that were issued to the Trust. These actions consist of a total of 137 “Must Do” and “Should Do” requirements.

3.1.1 Although NELFT have made consistent and steady progress in implementing the actions in their improvement plan, they are currently reporting that they are 40% behind the agreed implementation target date of 31 March 2017 that was agreed with the CQC for full completion of all actions. Progress reported on 31 March 2017 was 61% of fully completed actions (this equates to 84 of the 137 actions, which comprises of 35 “Must Do” and 49 “Should Do” actions). The number of partially completed actions totals 53 and NELFT are now reporting these as exceptions and expect to fully implement the majority of outstanding actions between April and June 2017. The CQC are fully aware of this position and have agreed the new dates with the Trust.

3.1.2 All outstanding actions have been fully risk assessed to provide assurance on the quality and safety of the services, and the Trust have assured commissioners at the CQRM that all risks have strong mitigating actions in place. The areas that we have requested further assurance on are the ligature work programme including the completion of ligature risk assessments, individual care planning and risk assessments, mandatory training, supervision and appraisals, the implementation of a restraint reduction strategy to reduce the use of restraint and prone (face-down) restraint and community access to psychological therapies. The CQRM will continue to review the Trust’s risk register and other available evidence for assurance purposes.

3.2 **BHRUT CQC mortality outlier alert.** The CQC issued the Trust with a mortality outlier alert for urinary tract infections on 4 May 2017. This follows a letter written to the Trust in December 2016 from the Dr Foster Unit at Imperial College London, regarding mortality rates for patients admitted with urinary tract infections. This alert has been issued as a result of an association between raised mortality and this group of patients and it acts as an early warning indicator to the Trust that work is required to understand what is causing this association. It is important to note that this notification is an alert and until the Trust have completed the required work to interpret the data we are unable to confirm with complete accuracy the level of elevated risk, if any, for patients.

3.2.1 The governing body received a report at the November meeting confirming that the Trust had an elevated clinical risk which the quality team was monitoring closely, due to an upward trend in the Summary Hospital-Level Mortality Indicator (SHMI). While this single measure of hospital
unexpected deaths should not be the only measure used to assess performance, it is a national mortality benchmark and should and has prompted further scrutiny.

3.2.2 The SHMI is an indicator which reports on mortality at trust level across the NHS in England using a standard and transparent methodology. It is produced and published quarterly as an officially recognised statistic by the Health and Social Care Information Centre (HSCIC). It is a ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

3.2.3 The Trust has reported monthly through the CQRM that the SHMI continues to show further deterioration in performance above the expected range of 100. Current performance for April 2017 is 106 and the organisation continues to be the highest reporter in London. The Trust has previously commissioned an independent review of the factors affecting the SHMI for pneumonia deaths. It was anticipated that this report would be available in February; however the Trust confirmed at the CQRM in May that this report has been reviewed internally with further information being requested from the authors. Once finalised it will be shared with the CCG.

3.2.4 In response to the SHMI rates and more recently the CQC outlier alert the Trust and CCG have implemented immediate actions, which include:

- CCG has formally identified concern about the current SHMI rate with the provider and requested an urgent clinically led meeting to discuss and agree immediate next steps. The Trust have agreed to this meeting
- Increased focus within the Trust to deliver the sepsis CQUIN requirements
- A change in the executive leadership of the mortality review work and the establishment of a formal programme to develop a detailed action plan. The Chief Nurse in now leading this work
- Implementation of a Mortality Surveillance Group, including standardised structure for reporting and monitoring
- Review of coding in accordance of good practice rules
- A retrospective review of 1800 reviews that have taken place over the past 12 months starting with the urosepsis cases
- NHSE/NHSI has been notified by the CCG at the Quality Surveillance Group.

3.2.5 The Trust must respond to the CQC by 1 June 2017 and the CCG will continue to implement elevated quality monitoring and will report to the Quality and Safety Committee.

3.2.6 In March 2017 the National Quality Board published the “National Guidance on Learning from Deaths”, which is a framework for NHS Trusts and NHS Foundation Trusts on identifying, reporting, investigating and leaning from deaths in care. This guidance aims to kickstart a national endeavour to review deaths, how the reviews are conducted and the degree of availability. Its purpose is to help initiate a standardised approach. We are working collaboratively with BHRUT to implement this guidance and the work we are completing on the morality reviews is the beginning of the implementation process.

3.3 BH NHS Trust CQC inspections. We have previously reported to the governing body that the CQC returned to inspect Whipps Cross University Hospital ((WXH) (and the Royal London Hospital)) to follow up on their previous inspections of the Trust in 2014 and 2015 where they found a number of concerns around patient safety and the quality of care provided by the Trust.

3.3.1 The CQC issued the Trust with seven requirement notices because of the breaches to the fundamental standards that were not being met. Included within the regulations are 12 “must do” and 21 “should do” recommendations that the Trust must meet. The Trust is currently developing their improvement plan in response to this report. This will build on the Safe and Compassionate
quality improvement plan that was reported at the last governing body meeting. Commissioners
have not yet been provided with a copy of the improvement plan and have written to the lead
commissioners to make a formal request for a copy of the plan. At the time of writing this report
we are still waiting for a copy of the improvement plan.

4.0 System Quality Improvement Action.

4.1 GP Service Alerts. The process for GP service alert reporting has undergone a further review
following concerns raised by clinical directors at governing body meetings. Although a robust
process has been agreed by the Quality and Safety Committee, in practice this has not been
working effectively. The purpose of the review was to understand why this has happened and
to devise an improvement plan.

4.2 The review has identified that there are multiple factors that have contributed to the failure of the
process and these include an email link that was not transferred to an nhs.net account when the
CCGs email systems were transferred to nhs.net, capacity to communicate the outcome of all
actions taken to individual GPs and BHRUT implementing a system of GP incident service
alerts developed in parallel to our system and process, but may have added some complexity in
determining which to use.

4.3 Now that the issues have been identified an improvement plan has been developed and some
immediate actions that have been taken include weekly monitoring of the GP services alerts by
the quality team, communication with clinical directors who are leading on the clinical areas for
the GP alerts and the reporting of themes and outcomes at GP training sessions.

4.4 Internal audit will be conducting a thorough review of the process in May 2017 and will report
the findings to the Audit and Governance Committee.

5.0 Section 2: Operational Quality Improvements and Challenges

5.1 Provider quality performance improvements and challenges addressed through the CQRM

5.1.1 BHRUT. Safer Staffing. Recruitment and retention of staff, across all disciplines continues to be
a risk that the Trust are managing, and this risk is reported monthly to their board through an
escalation process from their Quality Assurance Committee. Although retention and recruitment
for all staff groups remains challenging, the qualified nursing and midwifery workforce remains
the most challenging. The Trust are compliant with the national staffing recruitment requirements
and do report the aggregated registered nurse staffing levels, called ‘fill rates’ monthly. The
combined Trust fill rates for December were 87.59% compared to the November rates of 91.99%.
The December 2016 fill rate of 87.59% was the first time the Trust has failed to achieve the 90%
standard since September 2015, with the Trust reporting a similar fill rate of 87.6% in January
2017. Figures for February 2017 show an improvement to 91.12%, with King George’s fill rates
over that three month period remaining consistently between 87% and 89%, and the increase
from 87% to 92% at Queens Hospital.

5.1.2 Reported Registered Nurse vacancy rates have continued to rise since November 2016 (167
Whole Time Equivalent ((WTE)), and is now standing at 194 WTE reported in February 2017.
The Trust advised at the April CQRM that of their (total) 247 WTE vacancies, approximately 150
staff will be joining between now and September 2017. In addition, the Trust has now recruited
ten new paediatric nurses, with the new nurse recruitment lead’s initiative resulting in 54 student
nurses engaged from South Bank University (LSBU) as opposed to a historic rate of 20 per year.

5.1.3 BHRUT reported two new red risks related to safer staffing in April specifically about permanent
staffing levels on eight wards due to the high level of staffing vacancies and turnover. The Trust
reports a heavy reliance on temporary staff, a high turnover and difficulty in recruiting because of the workload.

5.1.4 Following on from the assurance provided to the CCGs and NHSI in January, the Trust reiterated and confirmed their mitigation at the April CQRM; commissioners were fully assured that there were no wards at risk on a daily basis due to the use of bank staff and moving more senior matrons across the wards to ensure that the right level of staffing was achieved.

5.1.5 The quality team confirmed to the Trust that this is an elevated clinical risk and that although the Trust is mitigating staffing numbers on the wards, the levels of nursing competency appears variable, as evidenced in a number of Serious Incident investigation reports which highlight that agency staff may not always be aware of tools used to flag deteriorating patients from observations or of escalation procedures to elicit support. The Quality Team has also highlighted that a number of recent pressure ulcers and falls-related serious incidents occurred on wards with high temporary staffing levels. Further assurances on safer staffing and actions the Trust are taking to ensure patient safety has been requested at the May CQRM.

6.2.3 The Trust continues to implement their Quality Improvement Programme and progress since the last report includes:

- Improvements in the Trust’s clinical governance and monitoring processes continue. Commissioners have seen a significant increase in incident reporting related to clinical care in the Emergency Department and also in diagnostics. The February SI report indicates a concomitant increase in Serious Incidents for these two categories (Clinical Care nine from two and diagnostics two from zero). These reports will be presented to the June 2017 SI Panel, where commonalities will be discussed.

- The Trust is improving the quality of their Serious Incident investigation reports, with two reports noted as good at the SI Panel. It is encouraging to note that the SI investigations are including ‘5 Whys’ and causal flow diagrams following a recent learning session conducted by the CCG Quality Team. Our expectations are that SI reports will continue to improve if these methodologies are followed.

- The Trust continues to report new risks with clearly articulated mitigating actions being put in place. The CCG will be requesting more focused risk reporting as part of the CQRM standing agenda from May 2017.

6.2.4 Never Events. BHRUT reported their third Never Event in April. This was a retained swab which was discovered two days after surgery. An initial investigation notes that the swab was retained following the formal counting process, and an immediate safety action has been put in place to hold observation audits of theatre practice on 3rd, 4th and 5th May. The Never Event has been reported to NHS Improvement. The Investigation report on the previous SI (retained dental micro-drill bit) was reviewed at the April 2017 SI Panel and approved. The actions from this report will be monitored to completion through the SI Panel process, and the final report will be noted at CQRM.

6.3.1 NELFT. Safer Staffing. The Trust report that their vacancy rates are showing significant improvement across the Trust, although the confirmed rate is 17% against a target of 12%. Staff turnover is reported as static at 15%, and this continues to be a cause of concern for commissioners, as the target is 10%. The Trust has a trigger point for safe staffing; where vacancy factors of 30% or above are reported, a quality visit is conducted by the Director of Nursing to assess the safety of the service.
6.3.2 The Trust has established an agreed reporting and quality assurance framework to ensure all quality and patient safety risks are reported to their board on a monthly basis. This reporting mechanism demonstrates an improvement in the way the Trust manage quality risks, escalating as necessary. Improvements are still required and this is evidenced in their recent well led review conducted by KPMG, which is with the Commissioners for review.

6.4 Barts Health. The Trust continues to progress slowly in improving their performance across a range of quality indicators and continue to be contractually and supportively managed by the lead commissioners. This report focuses on exception reporting for Whipps Cross Hospital as this is our main local hospital site. The quality indicators that we are supporting the Trust to improve are:

- A high number of Never Events with repeated incidents and poor evidence of learning. Following Redbridge CCG escalating concerns to the lead commissioner contractual action has been taken. BH have now developed and implemented a remedial action plan which includes a standardised risk assessment process for Never Events. Barts Health reported at the April 2017 CQRM that during 2016/17 there were 13 Never Events reported, 2 of these events occurred at Whipps Cross Hospital. There were no Never Events reported at WXH between November 2016 and March 2017, however, a Never Event was declared in April 2017. This was a Redbridge CCG patient.

- Non-compliance with the National Framework for the management of serious incidents. In December nineteen serious incident reports were overdue, which was a deteriorating position compared to the November data. Whipps Cross Hospital have confirmed that the governance team lack the capacity and capability to ensure all the serious incidents are closed on time. The Medical Director is now leading the improvement plan and a revised compliance trajectory has been agreed. Data reported at the April CQRM shows 14 open SI’s (within the deadline) with only 3 overdue. This is a much improved position.

- Inadequate complaints management and little evidence of organisational learning. As above a remedial action plan has been submitted by the Trust and was reviewed in January 2017 by commissioners. Commissioners were not assured that the plan would deliver the required improvements and escalated this quality risk to the Contractual Review Group. The Trust has subsequently shown significant improvement in reducing the number of overdue complaints from 62 in Q3 to 34 in Q4, with 2 complaints overdue in March. Governance team are reviewing complaints at day 15 to determine any risks to achieving deadline and appropriate escalation for issues related to lack of response.

- Friends and Family Test rate for the emergency department. The Trust has submitted an amended improvement action plan with a revised trajectory for compliance. This has been accepted by commissioners. The Trust has recruited a lead for patient experience and commissioners anticipate this will lead to improvements. Work has been on-going to improve the response rate in the Emergency Department at Whipps Cross to achieve the improvement trajectory agreed with the CCG. Data presented at the April CQRM provides a trajectory to improve FFT rates for the ED to 20% by August 2017. The Trust’s reported response rate is 3% as of February 2017.

- Non-compliance with regulation 20 the Duty of Candour. The requirement is 100% compliance and for November 2016 the Trust reported 65% compliance. This breach of contract has also been escalated by Waltham Forest CCG to the Contract Review Group as a breach of regulation. Data reported for January 2017 shows the Trust at 69.2% compliance with the WXH site at 54.5%. The improvement plan includes a daily review of incidents to ensure level of harm is correct and escalation for review at SIRMAP is timely.
Additional governance resource has been dedicated to support staff to ensure all elements of DoC are completed, and to ensure that performance reports are accurate. Further training to increase awareness around DoC, medical and nursing staff priority groups is planned to be completed before the end of June 2017.

6.4 **PELC.** Since the last governing body report PELC has demonstrated an improvement in their internal clinical governance processes and procedures, supported by commissioners. This improvement has been especially focused on improving incident and serious incident management to ensure patient safety. The next steps for quality improvement are to improve the organisation’s capability to undertake root cause analysis for investigating serious incidents and to ensure the learning from incidents is disseminated throughout the organisation.

7.0 **Resources/investment**

7.1 There are no additional resource implications/revenue or capitals costs arising from this report.

8.0 **Sustainability**

8.1 If we achieve the quality improvements detailed in this report the positive impact will be on sustained quality improvement and an improvement in patient experience.

9.0 **Equalities**

9.1 This report has considered the CCG’s equality duty and where relevant has identified relevant actions which address any likely impact on equality and human rights.

10.0 **Risk**

10.1 Failure to ensure that there are improvements to the quality performance of commissioned services may result in a failure to manage and mitigate risks with potential harm to patients and reputational damage to the CCG. The CCG quality surveillance and management system provides mitigation to this risk. The management of this risk is assured by the Quality and Safety Committee.

10.2 Some patients may not be receiving the quality of care at the level which the CCG commissions, and therefore may have a poor experience of using the services we commission.

10.3 Mitigating actions for the above risks have been specified in the body of the report.

11.0 **Managing conflicts of interest**

11.1 There are no conflicts of interest raised in this report.

**Author:** Jacqui Himbury, Nurse Director  
**Date:** 28 April 2017
To: Meeting of the NHS Redbridge Clinical Commissioning Group Governing Body
From: Marie Price, Director of Corporate Services
Date: 26 May 2017
Subject: Finance Committees – Proposals

Executive summary

The three BHR CCGs agreed revised terms of reference for the Finance Recovery Programme Board (FRPB) at the May governing body meetings.

In further reviewing financial governance arrangements it has become clear that there is some overlap between the Investment Committee (IC) and FRPB, and a need to ensure that there are not parallel processes operating. The IC was set up for good reason to enable decision making where the governing bodies were so conflicted so as not to be able to make decisions (generally due to clinical director/primary care issues). However the proposals in this paper to essentially wrap the function of IC into the FRPB with some additional lay member membership still enable such decision making to take place.

This paper also proposes some further amendments to the membership to enable quoracy to be maintained; so adds the lay member for governance, further clinical director (CD) members and additional lay members as required (where decisions with conflicts of interest (COI) are required). The current quorum for decision making remains appropriate, however an increased number of members will support that quorum to be present.

The changes proposed in this paper and in the attached terms of reference have been agreed by the FRPB, which in turn recommends them to this governing body for final approval.

Recommendations

The governing body is asked to:
- Agree to disestablish the Investment Committee and to incorporate its functions into the FRPB
- Approve the revised terms of reference for the FRPB.

1.0 Purpose of the Report

1.1 To seek approval for practical changes to the CCG’s financial governance arrangements and amended terms of reference.

2.0 Background/Introduction

2.1 Over the past year the CCGs have strengthened their governance with regard to financial recovery given the deteriorating financial position. Governance has become more integrated across the three CCGs, as recommended by externally commissioned reviews.
2.2 Last year the CCGs also established an Investment Committee as a means of making decisions where there were considerable conflicts of interest (COI) such that prevented the governing bodies from making such decisions.

3.0 Proposals

3.1 Investment committee/FRPB - merge functions into FRPB

3.1.1 Given that the CCGs’ focus on financial recovery, it is not good practice to have parallel committees both making investment/disinvestment decisions. However it is important to maintain arrangements for managing COIs in terms of financial decisions effectively.

3.1.2 It is therefore proposed to roll the functions of the IC into the FRPB, but to review the membership of the FRPB to allow for decisions where there are COIs to be taken. This can be achieved by including lay members as members of the FRPB for those decisions where there is a COI and invite them to attend the second part of the meeting – at least one will need to be present to enable a decision to be made (the three lay members, as agreed by the Audit and Governance Committee and GBs, are able to act on behalf of each other and for all three CCGs).

3.2 Membership of the FRPB

3.2.1 To ensure that there is always clinical representation at the FRPB, it is suggested that the membership include the chairs and two CDs from each CCG, with a minimum requirement that one for each CCG attends.

3.2.2 The lay member for governance is currently ‘in attendance’ at the meetings, but given the decisions required at the meeting, it is proposed that he become a formal member of the FRPB.

3.2.3 The members who are required to make decisions as currently outlined in the TORs are: Chief Officer, CFO, CD finance lead/s, Programme Director System Delivery, Nurse Director. The quorum is four members. This must include: the Chief Officer or Chief Financial Officer and a CD finance lead. It is proposed that the membership be amended to take on the suggestions outlined above. The quorum is proposed to remain as stated.

4.0 Resources/investment

4.1 This paper does not identify any specific financial resource requirements.

5.0 Equalities

5.1 There are no equalities implications arising from this report.

6.0 Risk

6.1 The risk in not amending the arrangements is that there is not one seamless system for agreeing investment and disinvestment decisions. To avoid the risks of conflicts of interest and quoracy issues, it is proposed to amend the membership as suggested.

7.0 Managing conflicts of interest

7.1 There are no conflicts of interests arising from this report.
Attachments:
1. Revised terms of reference – Financial Recovery Programme Board

Author: Marie Price, Director of Corporate Services
Date: 27 April 2017
# BHR CCGs

**Financial Recovery Programme Board**

## Terms of Reference

<table>
<thead>
<tr>
<th>Meeting</th>
<th>Financial Recovery Programme Board</th>
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<tbody>
<tr>
<td><strong>Role of the board</strong></td>
<td>The Finance and Recovery Programme Board (FRPB) has been established to lead and drive financial recovery of the CCGs such that they can return to recurrent financial balance within the NHS accounting rules as quickly as possible, consistent with patient safety and quality. The FRPB will do so by ensuring the overall System Delivery Plan (SDP), and in-year Financial Recovery Plan (FRP) and the capability and capacity of the CCGs are mutually consistent and aligned to that recovery.</td>
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<tr>
<td><strong>Duties of the board</strong></td>
<td>The FRPB will ensure that each of the transformation programmes is effectively led, directed and reported, and that they are mutually consistent and supportive in achieving financial delivery. The FRPB will:</td>
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<td></td>
<td>• Lead and direct the CCGs’ SDP, ensuring that it is consistent with and is supported by, the contracts which the CCG establishes, receiving regular written reports from the FRPDM which reports to it; the FRPB will sponsor the SDP ensuring that it retains a high profile within the CCGs, is well founded within Right Care principles and that it receives the resources it needs to deliver; the FRPB shall be the final approver for project initiation documents (PIDs) recommended to it</td>
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<td></td>
<td>• In considering PIDs the FRPB will take account of their impact on the local health and social care system.</td>
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<td></td>
<td>• Lead and direct the continuous review of the organisations’ capacity and capability such that the CCGs effectiveness as a commissioning collaborative is evaluated, that areas for development and improvement are identified and that interventions are designed to deliver improvement, receiving regular reports from the senior responsible officer (SRO).</td>
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<td></td>
<td>• Ensure that the importance of financial recovery is communicated to member practices and primary care networks so that they are engaged in this purpose, their ideas and requirements are responded to and that they are fully informed and equipped to play their part in the delivery of the SDP, contractual controls and demand management and fully involved in redesign and transformation, receiving regular reports from the SRO.</td>
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<tr>
<td></td>
<td>• Ensure through the Sponsor of Clinical Safety and Quality, that the CCGs’ financial recovery is safe and that clinical quality is a primary concern of all those promoting, designing and executing change</td>
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<td></td>
<td>• Ensure all appropriate impact assessments are completely, reviewed and levels of risk understood and as far as possible mitigated</td>
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<td></td>
<td>• Ensure that the importance of financial recovery is communicated</td>
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to patients and their representatives, articulating the importance of financial recovery, of Right Care and promoting the reputation of the CCG in achieving the highest standards of commissioning

- Challenge and verify all Programme Plans, through the SROs, to ensure that they are mutually consistent and supportive, realistic and robust
- Ensure the sub-group(s) reporting to it are working collaboratively and in a common direction, and that opportunities, risks issues and dependencies in each are known shared and managed
- Hold SRO and Clinical Responsible Owners (CROs) to account for their programme’s performance and for confirming that their programmes comply with agreed CCG processes and policies and supporting them in their roles
- Identify, monitor and manage risks, issues and dependencies within the overall SDP and recovery programme, considering an analysis of risk across the delivery of the overall programme
- Actively support all employees to promote openness, honesty and value for money
- Account to the CCGs’ Governing Bodies in the manner and at the frequency, it requires and report regularly to the Finance and Delivery Committee in order to support the latter’s assurance responsibilities

Chair
The FRPB shall be chaired by the Chief Finance Officer

Membership
SRO and CROs of the programmes shall attend to:

- present business cases
- present updates at set gateways; and
- by exception when a programme has missed three milestones or has a RAG rating which breaches agreed parameters.

The Nurse Director shall be the sponsor of clinical safety and quality. Other clinical or management experts may be also invited to support decision making or policy development.

Terms of Reference and membership will be reviewed as necessary

Members will be expected to attend 85% of all meetings, and nominate a deputy if not attending.

<table>
<thead>
<tr>
<th><strong>MEMBERSHIP</strong></th>
<th><strong>Nature of Membership</strong></th>
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<tbody>
<tr>
<td>Chief Financial Officer</td>
<td>Chair and Core Member*</td>
</tr>
<tr>
<td>Chief Officer</td>
<td>Core member*</td>
</tr>
<tr>
<td>Chairs (x1 per CCG)</td>
<td>Core Member*</td>
</tr>
<tr>
<td>Clinical director finance lead/s / nominated CD representative to committee (x2 per CCG)</td>
<td></td>
</tr>
<tr>
<td>Programme Director System</td>
<td>Member</td>
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</tbody>
</table>
Delivery

<table>
<thead>
<tr>
<th>Nurse Director</th>
<th>Member</th>
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</thead>
<tbody>
<tr>
<td>Lay member – governance</td>
<td>Member</td>
</tr>
</tbody>
</table>

For quorum – see below for numbers

In attendance:

- Director of Programme Management Office (PMO)
- Head of PMO
- Director of Corporate Services

The following will attend if required to present PIDs or update the Board on their projects/programmes:

- Senior Responsible Officer (SRO)
- Clinical Responsible Officer (CRO)
- Enabling leads

Additional members to support management of conflicts of interests – to attend as required:

- Lay members PPI x 3
- Where there is a conflict of interest a lay member will be invited to attend to take part in the decision-making process at a second part of the meeting.

Quorum

The quorum is four members. This must include: the Chief Officer or Chief Financial Officer and a CD member (from each CCG). To ensure business can always be transacted, members who have given their apologies must ensure that a nominated deputy empowered to vote on their behalf, attends in their stead.

A duly convened meeting of the FRPB at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the FRPB.

Decision-making

The chair will work to establish unanimity as the basis for decisions of the committee. If, exceptionally, the FRPB cannot reach a unanimous decision, the chair will put the matter to a vote, with decisions confirmed by a simple majority of those voting members present, subject to the meeting being quorate.

The FRPB will ensure that any conflicts of interest are declared and dealt with in accordance with the CCGs’ standards of business conduct policy.

Any investment/disinvestment proposals must be endorsed by the relevant CRO.
| **Frequency of meetings** | Meetings shall be held weekly.  
The Chair may call an extraordinary meeting of the FRPB at any time. |
|--------------------------|------------------------------------------------------------------|
| **Notice of meetings**   | Changes to meeting dates or calling of additional meetings should be provided to members and attendees within five days of the meeting.  
A minimum of two working days notice and dispatch of meeting papers is recommended noting the initial fast-paced position with regard to the development of the SDP. Where a paper is submitted later than this time will be given for the key details to be explained in the meeting.  
Notice of all meetings shall comprise venue, time and date of the meeting, together with an agenda of items to be discussed and supporting papers. |
| **Administration and minutes of meetings** | The finance administrator, or whoever covers these duties, shall be secretary to the FRPB and shall attend to take minutes of the meeting and provide appropriate support to the chair and members. |
| **Reporting responsibilities** | The FRPB reports to the CCGs’ Governing Bodies. It is an executive forum focussed on delivery of financial recovery. It is not intended to be a permanent addition to the CCG’s governance arrangements.  
Its activities support the Finance and Delivery Committee (FDC) in its assurance role, which the FDC retains in its entirety.  
A high level summary of the progress of recovery will be regularly provided to the GBs. In addition the FRPB will provide an assurance report in respect of Financial Recovery/SDP progress to the FDC. |
| **Accountability** | The FRPB is accountable to the governing bodies.  
The following groups are accountable to it: Financial Recovery Planning, Delivery and Monitoring (FRPDM) meeting.  
The Clinical and Executive Owners of each of the programmes are accountable to the FRPB |
| **Authority** | The FRPB is authorised by the governing body to investigate any activity within its terms of reference. It is authorised to seek any information it requires in this regard from any employee and all employees are directed to cooperate with any request made by the FRPB. The FRPB is authorised by the governing body to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.  
The FRPB will be responsible for determining any additional or reconfigured sub-structural arrangements to support fulfillment of the FRPB’s remit.  
The FRPB can authorise PIDs (investment and disinvestment) up to a value of £250k (value per CCG). This does not include PIDs with projects that are subject to public consultation, which will be considered by the governing body/ies (depending on whether one or two/three boroughs). |
Any schemes with a value of £250k or more must, after initial review at the FRPDM, be referred to the governing body for decision in line with the CCGs' prime financial policies as outlined in the CCGs' constitutions.

The PIDs considered at this meeting must also pass through the assurance gateway with consideration and approval at the FRPDM initially.

| Other | The FRPB shall at least quarterly review its own performance and terms of reference to ensure it is operating at maximum effectiveness and recommend any changes it considers necessary to the governing body for approval. |
To: Meeting of the NHS Redbridge Clinical Commissioning Group Governing Body

From: Marie Price, Director of Corporate Services

Date: 26 May 2017

Subject: The East London Health and Care Partnership (ELHCP) Agreement

Executive summary
The East London Health and Care Partnership (ELHCP) Board approved the Partnership Agreement on 29 March 2017 and agreed that the Agreement would go live on 1 April 2017. Member Boards/Governing Bodies are asked to review and sign up to the Partnership Agreement (formerly the MoU, renamed to highlight the focus on partnership working) for the governance arrangements of the ELHCP.

The Agreement is not legally binding, but is intended to ensure a common understanding and commitment between the partner organisations of the ELHCP about the governance arrangements, specifically:
- The scope and objectives of the ELHCP governance arrangements
- The principles and processes that will underpin the ELHCP governance arrangements
- The governance framework / structure that will support the development and implementation of the EL STP
- Confirming that the Governing Bodies/Boards are not being asked at this stage to delegate any decision making to the ELHCP other than for those things listed in section 8 of the Partnership Agreement

The Agreement was originally developed by the STP Governance Working Group, which was chaired by Marie Gabriel, Chair of East London NHS Foundation Trust, and involved nominated representatives with expertise in governance from across the partner organisations. It has since been presented (in its ‘MOU’ and latest form) to all members of the ELHCP Board during its development and iterated a number of times.

It is acknowledged the governance arrangements will continue to develop as the work of the Partnership unfolds and may need to adapt accordingly. It will therefore be reviewed on a quarterly basis, taking into account any feedback received, with changes proposed as appropriate. In the meantime the STP programme team ask that member organisations sign the Agreement in its current form to enable moving forwards.

The Agreement has been circulated to all North East London Trust Boards, CCG Governing Bodies and local authorities to take through the most appropriate local governance arrangements with a request that it is reviewed signed and with returned to the ELHCP office by the end of May 2017.

Recommendations
The Governing Body is asked to:
- Review and agree to sign up to the partnership agreement attached.
East London Health and Care Partnership

Partnership Agreement

Version 2.10

31 March 2017
1. Purpose

This Partnership Agreement describes how the health and social care partners in East London (EL) (listed in Appendix D) will co-operate as The East London Health and Care Partnership (ELHCP), setting out the partnership arrangements to support the implementation of the East London Sustainability and Transformation Plan (EL STP).

This Partnership Agreement, built on the EL STP Memorandum of Understanding (MOU), is separate to the East London Sustainability and Transformation Plan (STP). Sign-off or endorsement of the overarching STP will take place on an individual organisational or borough level.

PART 1 – PARTNERSHIP ARRANGEMENTS

2. Introduction

Delivering the Forward View NHS Planning Guidance 2016-17 to 2020-21 released in December 2015 set out a requirement for local areas to come together develop a shared five-year sustainability and transformation plan.

The launch of the sustainability and transformation planning process signalled a new paradigm, with a move towards greater local co-operation including the need to work in the partnership to develop strategy and change at a local level.

In response to this guidance 20 organisations across East London – in The City of London, Barking and Dagenham, Hackney, Havering, Newham, Redbridge, Tower Hamlets and Waltham Forest - have been working together to develop the EL STP:

- The EL STP describes how these Parties will co-operate to turn the ambitions of the NHS Five Year Forward View into reality and deliver the vision of better health and wellbeing, improved quality of care and stronger NHS finance and efficiency.

The EL STP acts as a system level plan for change supported by and aligned to a number of local plans to address certain challenges, such as:

- City and Hackney (CH): Hackney devolution pilot, bringing providers together to deliver integrated, effective and financially sustainable services.
- Barking and Dagenham, Havering and Redbridge (BHR): bringing together health and social care services under a single local accountable care system (devolution pilot)
- Newham, Tower Hamlets and Waltham Forest (WEL): “Transforming Services Together” programme to improve the local health and social care economy.

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An initial set of governance arrangements was established to oversee and manage the development of the draft EL STP that was submitted to NHS England and NHS Improvement on 30 June 2016.

Following this submission the programme moved into the next phase, focused on detailed planning and the mobilisation and implementation of the delivery programmes. The partnership arrangement now needs to be updated to reflect these changes agreed by the STP Board in focus and branding, so that it supports the prioritisation of the different elements of the EL STP projects.

3. Objectives of the ELHCP Partnership arrangements

The objectives of the ELHCP Partnership arrangements are to:

- Support effective collaboration and trust between commissioners, providers, people and carers to work together to deliver improved health and care outcomes more effectively and reduce health inequalities across the EL system
- Provide a robust framework for system level decision making, and clarity on where and how decisions are made on the development and implementation of the EL STP
- To review and ensure clinical sustainability of services at STP level
- Provide clarity on system level accountabilities and responsibilities for the EL STP
- Enable opportunities to innovate, share best practice and maximise sharing of resources across organisations in East London
- Enable collaboration between Parties to achieve system level financial balance over the 5 year STP timeframe and deliver the system control total (once agreed), while safeguarding the autonomy of organisations
- Ensure learning and capacity building across the three accountable care systems.

4. Scope of the ELHCP Partnership arrangements

4.1. In scope

- Partnership arrangements for the East London STP
- Partnership arrangements for the implementation of the STP schemes defined in the East London STP
- Alignment with the wider health system plans and partnership, including devolution programmes and regional boards
- Development and operation of the partnership arrangements for the EL STP Financial Strategy to achieve the system control total
- Support the development of Accountable Care Systems to enable working towards a sustainable health economy by moving away from tariff based system to a capitation based system to achieve financial stability and to incentivise the right clinical behaviours
4.2. Out of scope

- Organisational governance arrangements for CCG Governing Bodies, Provider Trust Boards and Local Authorities
- Local partnership arrangements for the delivery of local (non-East London wide) programmes:
  - Hackney devolution pilot
  - Barking and Dagenham, Havering and Redbridge (BHR) Accountable Care System (devolution pilot)
  - Transforming Services Together programme.

5. Principles for the ELHCP Partnership

The development of effective system level partnership arrangements, mobilisation and implementation of the delivery programmes in the EL STP requires collaboration and active engagement (where relevant) from all Parties to ensure the interests of all Parties are appropriately represented.

A key aspect of this process is the agreement of a common set of principles for partnership ways of working and culture. Accordingly, the Parties have adopted the following as a basis for collaborative working between the parties:

- ELHCP Principles (as set out below)
- ELHCP Financial Principles (agreed by the Finance Strategy Group in March 2017 as set out at Appendix B)
- The Nolan Principles (as set out at Appendix B)

**ELHCP Principles**

- **Participation**: Representation and ownership from health and social care organisations (‘The Parties’), local people and lay members to clearly demonstrate collaborative and representative decision making
- **Collaboration**: All Parties will work collaboratively to deliver the overall EL STP strategy, in the best interests of the wider system and local people
- **Engagement**: Local people will be engaged and involved in the ELHCP governance to ensure their views and feedback are considered in the decision making processes. This engagement should operate at 2 levels; individual level and organisational level (i.e. via patient representative forums and other local community groups)
- **Accountability**: Define clear accountabilities, delegation procedures, voting arrangements and streamlined governance structures to support continuous progress and timely decision making. Delegation of work to the groups with the relevant expertise and authority to deliver it
• **Autonomy:** Recognise the autonomy of the Parties (health and social care partners) of the ELHCP Partnership. Operate in a manner that is compliant with legal duties and responsibilities of each constituent organisation and the NHS and Local Authorities as a whole (e.g. legal responsibility for consultation on service changes). Ensure alignment with the local organisations’ governance and decision making processes recognising statutory and democratic procedures.

• **Subsidiarity:** Ensure subsidiarity so that decisions are taken at the most local level possible, and decisions are only taken at a system level where there is a clear rationale and benefit for doing so.

• **Professional Leadership:** Demonstrate strong professional leadership and involvement from clinicians and social care to ensure that decisions have a robust case for change and senior level support.

• **Accessibility:** Ensure complete transparency in all decision making to support the development of mutual trust and openness between organisations. Provide the necessary assurance to system partners on key decisions. Collaborative working and information sharing between working groups to ensure consistency.

• **Good Governance:** Recognise that good system level governance will require robust planning and horizon scanning to ensure that proposals are presented to the statutory organisations in a timely way, that align with their local governance and decision making processes. However, where necessary local organisations will try to be flexible to support the system level governance.

6. **Governance structure**

The current proposed governance structure for the ELHCP Partnership is included in Appendix A. This appendix also includes draft summary terms of reference for the key governance groups in this structure, which will be refined further by the groups.

7. **Voting rights and process**

Voting rights and processes will be defined in relevant terms of reference.

8. **Major system changes**

The key system level decisions that will fall under the scope of the ELHCP Partnership arrangements are outlined below. This list will be updated from time to time to reflect the latest set of EL system level decisions:

• Approval of the EL STP

• Budget for the EL STP programme

• System level financial strategy and system control total

• Whipps Cross Hospital re-development strategy
• Changes to King George Hospital Emergency Department
• The relevant elements of the East London Mental Health strategy
• The relevant elements of the East London Primary Care strategy
• East London system level estates plan
• The approach to specialised commissioning for the East London sector
• Risk pooling principles and financial arrangements
• Delegation in place to allow Tower Hamlets CCG Remuneration Committee to approve Very Senior Management posts on behalf of all the other ELHCP CCGs.
• Decisions about capital allocations

PART 2 – MISCELLANEOUS LEGAL PROVISIONS

9. Liability

This Partnership Agreement describes arrangements for aligned decision making of the Parties which they agree is necessary to achieve the objectives in Clause 3.

Parties agree that the governance bodies set up under this Partnership Agreement do not have any authority to make binding decisions on behalf of the Parties and that each Party (and not the governance bodies) will retain liability for the actions of the relevant Party.

10. Duration of the Partnership Agreement

This Partnership Agreement replaces shadow arrangement and takes effect from 1 April 2017.

The Parties expect the duration of the Partnership Agreement to be for the period of 2017-2021 in line with the duration of the STP or otherwise until its termination in accordance with Clause 14.

11. Effect of the Partnership Agreement

This Partnership Agreement does not and is not intended to give rise to legally binding commitments between the Parties.

The Partnership Agreement does not and is not intended to affect each Party’s individual accountability as an independent organisation.

Despite the lack of legal obligation imposed by this Partnership Agreement, the Parties:

• Have given proper consideration to the terms set out in this Partnership Agreement; and
• Agree to act in good faith to meet the requirements of this Partnership Agreement.
12. Subsidiarity

The Parties acknowledge and respect the importance of subsidiarity.

The Parties agree for the need for many decisions to be made as close as possible to the people affected by them.

13. Dispute resolution process

All Parties will make every effort to work collaboratively in the best interests of the East London system, and to avoid disputes. Should disputes arise the parties will follow the agreed dispute resolution process to resolve the disputes as quickly as possible and to minimise impact on delivery.

Individual Party’s concerns should be raised in the first instance with the Independent Chair of the ELHCP Partnership Board. This should be in writing clearly stating the basis of the concerns, including where applicable the concerns and the rationale behind the dispute.

The Independent Chair will endeavour to find an informal resolution to the dispute through discussion and mediation. Where agreement cannot be reached using informal resolution processes the Independent Chair will propose a formal resolution process, which may involve reference to national guidance and best practice.

14. Termination

Each Party may terminate its participation in this Partnership Agreement by giving the other Parties no less than 30 days’ notice in writing.

The Independent Chair will endeavour to find an informal resolution to the dispute through discussion and mediation. Where agreement cannot be reached using informal resolution processes the Independent Chair will propose a formal resolution process, which may involve reference to national guidance and best Practice. Parties may terminate the Partnership Agreement with the written agreement of all of the Parties.

15. Law

This Partnership Agreement will be governed by the laws of England and the courts of England will have exclusive jurisdiction.

16. Review process

This Partnership Agreement will be reviewed and updated from time to time to enable good practice governance to be recognised and built upon to identify and address areas for development.

17. Code of conduct
The Finance Strategy Group has agreed ELHCP principles which are listed in Appendix B.

The Committee on Standards in Public Life (Nolan Committee) has set out seven principles of public life which it believes should apply to all in public service. The seven Nolan principles are listed in Appendix B.

The Parties are asked to adopt these above principles as the basis for collaborative working across the partnership arrangements.

18. Amendment

Parties agree that this Partnership Agreement may be varied only with the written agreement of all of the Parties. Such amendments will be included in an addendum/appendix to this Partnership Agreement.

Appendices

Appendix A – Governance
Appendix B – Principles
Appendix C – Roles
Appendix D – Sign off by the Parties
Appendix A.1  Governance Structure for the East London Health and Care Partnership

**Governance structure**

- **Provider Trust Boards (x5)**
- **CCG Governing Bodies (x7)**
- **Local Authority Cabinets (x8)**

**Regulators**
- NHS E
- NHS I
- CQC

**Local Accountable Care Systems**
- BHR Integrated Care Partnership Board
- Hackney Transformation Programme Board
- WEL / TST Board

**ELHCP Mayors and Leaders Advisory Group**
- Political advisory leadership

**ELHCP Community Group**
- System wide engagement and assurance

**ELHCP Assurance Group**
- Independent assurance and scrutiny

**ELHCP Partnership Board**
- Independent Chair
- Strategic direction and programme leadership

**ELHCP Executive Group**
- Operational direction, delivery and assurance

**ELHCP Social Care & Public Health Group**
- Social care and public health leadership

**ELHCP Clinical Senate**
- Clinical leadership and assurance

**ELHCP Finance Strategy Group**
- Oversight and assurance of finance strategy

**Project Steering Groups established as required to deliver plans**
Appendix A.2 Draft Terms of Reference for ELHCP Governance Groups

A 2.1 Draft Terms for Reference for the ELHCP Partnership Board

Purpose

- To provide strategic direction to the ELHCP STP programme (based on the decisions by the statutory organisations)
- To oversee and assure the delivery of all elements of the ELHCP STP Plan
- To address / resolve escalated system-level risks and issues
- To generate effective partnership working and a sense of common purpose between the system partners
- To provide oversight and assurance of the funding for the ELHCP STP programme
- To approve initiatives/frameworks/tests/plans/collaborative commissioning/standards

Membership

- 1 x Independent chair
- 1 x ELHCP STP Executive Lead
- 1 x Chief Executive of Barts Health NHS Trust
- 1 x Chief Executive of the Homerton University Hospital Foundation Trust
- 1 x Chief Executive of Barking, Havering and Redbridge University Hospital NHS Trust
- 1 x Chief Executive of East London Foundation Trust
- 1 x Chief Executive of North East London Foundation Trust
- Nominated Representative/s of East London Commissioners (CCGs)
- 1 x Chair of Local Workforce Action Board\(^1\)
- 2 x Co-Chairs of the Clinical Senate
- 1 x Acute Sector Clinician\(^2\)
- 1 x Mental Health Sector Clinician\(^3\)
- 2 x Nominated representative from the Community Group
- 1 x Local Authority Chief Executive representative from Barking, Havering, Redbridge area
- 1 x Local Authority Chief Executive representative from City and Hackney area
- 1 x Local Authority Chief Executive representative from Tower Hamlets, Waltham Forest, Newham area
- 1 x Representative from the Mayors and Leaders Advisory Group
- 1 x Representative from a Director of The Social Care and Public Health Group

Additional Attendees / Advisory

- Representatives of GP federations
- 1 x HealthWatch observer
- 1 x representative from the ELHCP Finance Strategy Group
- 1 x NHS England representative (regulator)
- 1 x NHS Improvement representative (regulator)
- 1 x NHS England Specialised Commissioning representative
- 1 x Local Authority representative for prevention commissioning
- 1 x Health Education England representative
- 1 x UCLP

\(^1\) The chair of the Local Workforce Action Board (LWAB) will be represented as an accountable office of one of the Parties

\(^2\) Endorsed by the ELHCP Clinical Senate
Quorum

At least three quarters of the membership of the ELHCP Partnership Board, including:

- An Independent Chair (or an agreed deputy)
- 1 x acute trust representative
- 1 x mental health trust representative
- 1 x CCG representative
- 1 x Clinical Senate representative
- 1 x Local Authority representative
- 1 x Community Council representative

Voting arrangements

This is a unitary board, where motions will be passed by a majority vote, where a majority is defined as at least three quarters of the votes cast.

In advance of any vote all voting members must declare any potential conflicts of interest. The Independent Chair will decide on whether any potential conflict of interest should preclude a member from voting on a particular issue.

Reporting

This ELHCP Partnership Board reports and is accountable to the statutory organisations in the ELHCP system

Frequency

Monthly. Alternative month seminar meeting.

Under exceptional circumstances extra ordinary meetings of the ELHCP Partnership Board may be arranged.

Requests for extraordinary board meetings must be raised to the Independent Chair for consideration.
A.2.2 Draft Terms for Reference for East London Health and Care Partnership (ELHCP) Executive Group

**Purpose**

- Provide operational direction and assurance to the delivery of the STP plan, ensuring it provides high quality, sustainable integrated care for the people of East London (EL).
- Provide a forum for the Executive Group to identify and appraise solutions and options for addressing the major system-wide service, quality and financial challenges. Ensure a pipeline and forward plan/work programme of to take forward solutions.
- Provide oversight and assurance to the key governance groups in the ELHCP governance that report into the Executive Group, reviewing quality, operational delivery, transformation, performance and financial management.
- Hold Senior Responsible Officers (SROs) to account for the development and delivery of the STP delivery plans, addressing the service, quality and financial challenges.
- Ensure opportunities for bidding for transformational funding are maximised and provide oversight to bid.
- Provide oversight and assurance to the Finance Strategy Group in developing the financial strategy.
- Assure the collective delivery of Quality, Innovation, Productivity and Prevention (QIPP)/Cost Improvement Programme (CIP) across the system, providing oversight to the three system delivery Boards.
- Drive the delivery of the EL STP programme at pace.
- Manage risk and mitigation plans, escalating key risks and issues to the East London Health and Care Partnership (ELHCP) Board.
- Oversee the development of a programme of organisational development (at system level) to support the strengthening of the ELHCP and the delivery of the STP.
- Identify the key messages and communications required to enable local people and staff in EL to understand the ambitions and impacts of the STP on health and care services and outcomes.
- Ensure adequate resource is available to support the ELHC STP programme of work, including providing oversight to the sourcing of support external to EL from other parts of the wider system, e.g. Healthy London Partnership, NHS England/Improvement resources.
- Analyse the gap in the system.

**Membership**

- 1 x ELHCP STP Executive Lead (Chair)
- 1 x ELHCP STP Finance Lead
- 1 x Chief Executive, Barking, Havering and Redbridge University Hospitals NHS Trust
- 1 x Chief Executive, Homerton University Hospital Foundation Trust
- 1 x Chief Executive, Barts Health NHS Trust
- 1 x Chief Executive, East London NHS Foundation Trust
- 1 x Chief Executive, North East London NHS Foundation Trust
- 1 x Chief Executive, London Borough of Waltham Forest, ELHCP LA Lead & representing the Waltham Forest and East London (WEL) system
- 1 x Chief Executive, London Borough of Hackney, representing the City and Hackney system
- 1 x Chief Executive, London Borough of Havering, representing the Barking, Redbridge and Havering system
- 1 x Chief Officer, Barking, Havering and Redbridge CCGs
- 1 x Chief Officer, Newham CCG
- 1 x Chief Officer, Tower Hamlets CCG
- 1 x Chief Officer, City and Hackney CCG
- 1 x Chief Officer, Waltham Forest CCG
• 1 x BHR & WELC POD Director, North East London and Anglia Commissioning Support Unit
• 1 x ELHCP STP Programme Director
• 1 x ELHCP STP Director of Communications
• 1 x ELHCP STP Director of Provider Collaboration
• 1 x representative from the Clinical Senate

**Reporting**

Reports and is accountable to the ELHC Partnership Board

The following groups report to the Executive Group:

- Operating Planning Group
- Finance and Activity Group
- Transformation Steering Group (TSG) (N.B. The steering groups associated with the 8 delivery plan work streams report into the TSG e.g. Local Workforce Action Board, Digital etc.)
- The delivery Boards for the three systems: City & Hackney, WEL, BHR

**Frequency**

Monthly

**Quorum**

Chair of the group or the delegated member to represent the chair.

2 x Chief Executives of provider trusts

3 x Chief Officers of CCGs

1 x Chief Executive of LA

3 x ELHCP Directors

**Deputies**

Where members of the group are unable to attend a specific meeting, deputies with executive level accountabilities may be substituted.

**Standing Items**

Reports from:

- Operating Delivery Group
- Finance and Activity Group
- Transformation Steering Group (N.B. The steering groups associated with the 8 delivery plan work streams report into the TSG e.g. Local Workforce Action Board, Digital etc.)
- The delivery Boards for the three systems: City & Hackney, WEL, BHR
- Items as required on: communications and engagement, OD, governance
A.2.3 Terms for Reference for ELHCP Clinical Senate

Purpose

- To develop the clinical strategy that will deliver the requirements set out in the East London Sustainability and Transformation Plan, considering the three main areas that the STP addresses:
  - The health and wellbeing gap
  - The care and quality gap
  - The financial gap
- Not only addressing current issues but addressing needs beyond the horizon of the 5-Year Forward View
- To ensure that this strategy reduces the variation in care with the aim of giving every resident of East London access to the same standard of care and chances of good health and good healthcare outcomes; it being understood that local delivery systems will vary in structure and function
- The Clinical Senate will look for cost-effective solutions that free up resource to be directed to appropriate priority areas
- Their advice should support the development of appropriate commissioning and contractual arrangements
- To ensure that quality and safety of care is properly considered in its work and recommendations and provide relevant assurance especially around reconfiguration and service redesign
- To oversee arrangements for measuring the access to and quality of care on a systematic basis across key results areas to enable benchmarking
- Discuss options for changes to services, making joint recommendations to the Boards of the various NHS Organisations across East London, both commissioner & provider;
- To monitor system issues or vulnerable services
- To work together to identify system solutions
- To design and recommend clinical change to the Transformation Steering Group for initiative work-up

Principles

- To be ambitious for the population we serve and act as their advocates
- To be a collaborative coalition of professionals who can think, advocate and advice beyond the walls of our individual organisations to support this common purpose, in so doing gaining understanding of the whole care pathway
- Provide a forum where collective knowledge on clinical issues and strategic options for reconfiguration and transformation can be shared and discussed
- Provide a mechanism for increased participation and advice from clinicians and other professionals in strategic direction setting in East London
- Thus being able to lead transformational change across the whole care pathway
- To attend regularly, contribute regularly and be encouraged and supported to do so and to build a powerful, authoritative, collaborative body
- To be focused, use our time wisely and complete our business effectively
- Seek and commission expert advice from within East London and beyond as necessary and look to learn from successes here and elsewhere
- To commit to develop as leaders and visibly support the development of clinical leadership among the wider body of clinicians in East London
- To demonstrate that we can deliver recommendations for transformational change to build confidence in our capability
Membership
Co-chair, Appointed from CCG Chairs below
Co-chair, Appointed from Medical Directors below
CCG Chair, City & Hackney CCG
CCG Chair, Tower Hamlets CCG
CCG Chair, Newham CCG
CCG Chair, Waltham Forest CCG
CCG Chair, Havering CCG
CCG Chair Barking and Dagenham CCG
CCG Chair, Redbridge CCG
Medical Director, Barts Health NHS Trust
Medical Director, Homerton University Hospital Foundation Trust (HUH)
Medical Director Barking, Havering and Redbridge University Hospital NHS Trust (BHRUT)
Medical Director, East London Foundation Trust (ELFT)
Deputy Medical Director North East London Foundation Trust (NELFT)
NHS England Medical Director for North East London
NHS England Medical Director for Specialised Commissioning London
Director of Nursing, Barts Health NHS Trust
Director of Nursing, HUH
Director of Nursing, BHRUT
Director of Nursing, ELFT
Director of Nursing, NELFT
A GP provider lead – nominee to be agreed by GP Federations
A Director of Adult Social Services
Director of Public Health, Newham STP PH Lead
SRO, Transformation Programme ELHCP STP
STP and Accountable Officer BHR CCGs
Queen Mary University London Representative
UCL Partners
CAG Medical Directors Barts Health Hospital Sites (N=3)
Nurse Directors Barts Health Hospital sites (N=3)
Decision Making & Quorum

Quorum: At least 1 Co-chair 2 CCG Chairs and 2 Provider Directors (Medical or Nursing), SRO (or their representatives), and ensuring all three of the local areas are represented

Administration and Handling of Meetings

The ELHCP STP PMO will be responsible for providing administrative support to the meeting and for circulating agenda and papers at least seven days in advance of the meeting taking place.

Frequency, conduct and reporting of Meetings

- There should be an annual planned work programme that sets out the priorities based on the Sustainability and Transformation Plan that is agreed with the STP Programme Board.
- Meetings should be held 2-monthly to synchronise with the STP Board.
- In alternate months the Clinical Senate should meet to discuss key clinical issues related to other STP programmes, for political awareness and horizon scanning and to support its development.
- The Chair and the SRO for Transformation supported by any other Clinical Senate Members present, will present findings and recommendations to the STP programme board so that accountable officers can consider and enact them as individual organisations and in the collaborative systems emerging in north east London
- Each paper presented should have clear rationale in regard to the above and clearly set out what decisions are required
- A clear annual work programme based on transformation programme with clear links to STP deliverables; this should include “quick wins”
- Ensure appropriate interaction and alignment with other work programmes the particularly the Workforce Programme through specific papers but through regular updates and attendance which could be scheduled into the work programme
- The clinical senate should continuously reflect on its effectiveness and could briefly review this at the end of each meeting and could use local resources such as the Staff College to support this
- Action notes from each meeting will be taken and approved at the subsequent meeting. Action notes will be forwarded to the Integrated Care Coalition (ICC), Transforming Services Together Board (TSTB) and Hackney Health and Social Care Transformation Board.

Resources

- Members of the Clinical Senate will be supported in their attendance and work by their individual organisations and these roles are not additionally remunerated
- Administrative and analytic support will be provided by the STP Programme and through its PMO.
- The Co-chairs are expected to commit one day a month each to the programme, again resourced by
their organisation

**Accountability/Governance**

The clinical Senate is accountable to the East London Health and Care Partnership Board.
A.2.4 Terms for Reference for Social Care and Public Health Group

Purpose

• To provide professional leadership and assurance in social care and public health
• ToR to be confirmed by the Group in 2017.

Membership

• Directors of Public Health
• Directors of Social Care
• Other TBC

Quorum

To be confirmed

Reporting

Advisory to ELHCP Partnership Board.

The Group will provide a social care and public health view on all issues before these are presented to the ELHCP Partnership Board (and these meetings will be scheduled to enable this flow of business).

Frequency

To be confirmed
A.2. 5 Draft Terms for Reference for ELHCP Finance Strategy Group

Terms for Reference for ELHCP Finance Strategy Group

Purpose

• To lead the development of the ELHCP integrated financial strategy
• To provide strategic direction on the approach to achieving the overall system control total making recommendations to the ELHCP Board for onward recommendation to partner governing bodies/boards.
• To oversee and make recommendations on the allocation of the Sustainability and Transformation Funding including Estates and Technology Transformation funding
• To manage the central CCG risk pool and other matters as requested by the STP Board

Membership

• 1 x ELHCP STP Independent Chair
• 1 x ELHCP STP Executive SRO
• 1 x ELHCP STP Finance Lead
• 5 x Trust Directors of Finance
• 3 x CCG representatives
• 2 x Audit Chair
• 1 x NHSE London Finance Director
• 1 x NHSI representative
• 3 x nominated Local Authority Director of Finance

Reporting

Reports and is accountable to the ELHCP Partnership Board

Frequency

Bi-monthly / quarterly
A.2.6 Draft Terms for Reference for the ELHCP Community Group

Purpose:

The Community Group is established as a subgroup of the East London Health and Care Partnership. Representing key partners and stakeholders, community (patient and public involvement groups) and the Voluntary Community Social Enterprises sector, its purpose is to act as a reference group to the Partnership – helping it to develop strategies, plans and activities and recommending the most effective ways for it to communicate and engage with its target audiences.

The Group will be formed of key organisations and individuals, who through their pooled knowledge, skills and expertise of the east London health and care landscape, can bring a unique perspective on the changes that may be needed in order to achieve the Partnership’s goal of helping the people of east London live happy, healthy and independent lives.

In its capacity, the Group will have the scope to contribute to decisions taken at Board or Executive level, through Group member representation at the Board and any other relevant committees or groups.

Aims:

1. To collaborate with the wider Partnership (i.e. Board, other committees and member organisations) acting as a reference group for the development of strategies, plans and activities;
2. To recommend the most appropriate ways in which the Partnership should seek to engage, involve, consult and collaborate with local people;
3. To support effective Partnership communications and engagement activity, especially through the Group members’ existing channels;
4. To support the Partnership’s STP delivery plans and priorities

The STP delivery plans are: Delivery plan 1 - Promote prevention and personal and psychological wellbeing in all we do; Delivery plan 2 - Promote independence and enable access to care close to home; Delivery plan 3 - Ensure accessible quality acute services; Delivery plan 4 - Provider Productivity; Delivery plan 5 - Estates Infrastructure; Delivery plan 6 - Specialised Commissioning; Delivery plan 7 - Workforce; Delivery plan 8 - Digital Enablement

Objectives:

An initial objective of the Group will be to review and agree the purpose, proposed structure and ways of working. This will also be reviewed and agreed on an annual basis.

More broadly, and once the Group is formally established, its longer terms objectives as a reference group and communications and engagement network are outlined below.

1. Devise an effective working model for the Group to engage with the wider Partnership;
2. Ensure the interests of the organisations and groups/bodies the Group represents are epitomised;
3. Work closely with the Partnership’s communication and engagement leads to ensure information and communication/engagement activity and inputs are well designed and effective, adhere to best practice, and reach intended audiences;
4. Contribute to policy development through the creation of time limited reference groups, which considering how specific goals and challenges of the STP can best be met, taking information and views from external groups.
Accountability and Reporting Arrangements:

The Group is accountable to the Partnership Board.

The Group will have two nominated representatives at every Partnership Board; however, there may be occasions where representation from more than two Group members is required, for example, to present/update on a specific piece of work.

The Board will nominate one representative (other than the Group representative) to attend Group meetings. Equally, a nominated representative from one of the other committees may be required to attend Group meetings.

Membership:

The proposed membership takes account of the various patient/public groups, voluntary, community and third sector organisations, specialist charities, education, business and professional representatives (such as the Police). Each organisation is invited to put forward two members that will represent them at the Community Group. Members should be at a senior level within their organisations, and have a comprehensive understanding of the health and social care agenda, at a local, regional and national level.

The full Group will be expected to meet at least twice a year. Outside of the formal Annual General Meeting type meetings, there is an expectation that relevant members will meet to deliver or support more focused pieces of work, including undertaking equalities impact assessments e.g. around Prevention.

The membership has been grouped within their relevant sector.

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Nomination and the Role of the Chair, Vice Chair and Sub-Group Leaders:

The Community Group must nominate a chair and vice chair. It will ultimately be for the Group to decide the process for doing this; however a suggestion could be through a ballot process.

The Group might also want to nominate two chairs; one representing the patient voice and the second, representing the professional, statutory and business organisations. These are essentially the two overarching and distinct membership groups of the Group. They might comprise both a chair and vice chair.

The Chair/s or vice chair/s represent the Group at Programme Board level, and as such represent the interests and consensus view of the Group.

Sub-group leaders will be selected by members for discreet, targeted pieces of work. They will be responsible for leading the delivery for a specific project, and will feed back to the Programme Board and the wider Group on the outcomes/outputs of their work.

Quorum:

While the Group is not a formal decision making body, and more of a reference group, it is suggested there be a quorum for meetings of the whole Group – namely 50% membership, including at least the Chair or Vice Chair.

Frequency of Meetings:

It is suggested the Group will meet twice a year unless otherwise agreed. Any sub-groups of the Group may meet more often as appropriate.

Authority:

The Group is authorised to investigate any activity within its terms of reference. It is authorised to seek and may secure the information it requires from any Partnership organisation and all employees are directed to co-operate with any request made by the Group.

Monitoring Effectiveness:

In so far as is required, in order to support the continual improvement of the Group will complete an annual self-assessment of the effectiveness of the Partnership; present a report to each Partnership Board meeting; and undertake an annual review of the terms of reference for the Group, reaffirming its purpose and objectives. This Group will review the results of the assessment of its effectiveness and adjust its terms of reference accordingly.

Review of Terms of Reference:

The terms of reference will be reviewed annually and sent to the Board for ratification.

Additional:

The Partnership communications and engagement team will coordinate and provide administrative support to the principal meetings of the Group. However, any sub-groups of the Group may need to nominate one of its members (on a rotational or static basis) to coordinate and administer its own activities.
The Group will have access to the East London Health and Care Partnership’s dedicated online resource – the Briefing Room – and will be able to use all available materials for their communication and engagement activity. Members of the Group will be able to submit content to the Briefing Room but would need to adhere to the site’s editorial style and protocol and seek approval from the Partnership communications and engagement.

A small budget may be available from the East London Health and Care Partnership for the facilitation of meetings.
A.2.7 Draft Terms for Reference for ELHCP Assurance Group

Purpose

• To provide independent challenge and assurance to the ELHCP STP Board on the STP Plan and its delivery.
• To provide independent assurance to the constituent organisations within the ELHCP STP about the objectivity and transparency of the STP Plan and its delivery.

Membership

• NHS Trust audit chairs (5 members).
• CCG audit chairs (7 members, currently 4).
• Local Authority audit chairs (7 members).

Reporting

• To the ELHCP STP Board.
• To the Boards, Governing Bodies and Councils of the constituent organisations within the ELHCP STP. This would be through the audit chair of each organisation or other arrangements to be determined locally.

Remit

• Assess the effectiveness of the Board Assurance Framework established by the ELHCP STP, including commenting as necessary on developing governance and accountability arrangements.
• Assess compliance with the Memorandum of Understanding (MoU) agreed by the ELHCP STP.
• Assess the adequacy of the arrangements established to account for the funds available to the ELHCP STP from the NHSE and constituent organisations.
• Ensure that there are effective arrangements in place for the external and internal audit of the resources available to the STP.
• Assess the arrangements established by the ELHCP STP to secure economy, efficiency and effectiveness in the use of resources.
• Assess the effectiveness of the arrangements established to manage conflicts of interests that might arise.

The Group may, as necessary, request the attendance of any ELHCP STP officer or Board member to a `meeting of the Group to seek explanations about the issues under consideration.

Frequency

• At least four times a year.

Quorum

• A minimum of three members, including at least one audit chair from an NHS Trust, a CCG and a local authority.

Resources

• ELHCP STP officers to provide support and advice to the Group as requested.
A.2.8 Terms for Reference for Mayors and Leaders Advisory Group

Purpose

• To provide a forum to represent the views of political leaders in East London on the ELHCP Partnership
• To provide feedback to the ELHCP Partnership Board on elements of the plan
• To provide a forum for political engagement on the EL STP

Membership

• Leader or nominated representative of London Borough of Waltham Forest
• Mayor or nominated representative of London Borough of Hackney
• Chair of Policy & Resources Committee or representative of City of London Corporation
• Mayor or nominated representative of London Borough of Tower Hamlets
• Mayor or nominated representative of London Borough of Newham
• Leader or nominated representative of London Borough of Barking and Dagenham
• Leader or nominated representative of London Borough of Havering
• Leader or nominated representative of London Borough of Redbridge
• Independent EL STP Chair

Reporting

Advisory to the ELHCP Partnership Board

Frequency

Quarterly

1 To be nominated by the respective local authority
Appendix B – Principles

In addition to the ELHCP Principles in Section 5, the Parties have adopted the following:

- ELHCP Financial Principles (agreed by the Finance Strategy Group in March 2017)
- The Nolan Principles

B.1. ELHCP Finance Principles

The following principles were approved by the Finance Strategy Group in March 2017:

All members of the ELHCP Partnership pledge the following:

B.1.1 System Control:
Commitment to delivering a system control total.

B.1.2 Openness and transparency:
Openness and transparency, with all parties agreeing to share information.

B.1.3 Shared objectives:
A shared objective of mutual support. Joint and shared accountability for system income & expenditure (I&E) between providers and commissioners and shared mutual responsibility and accountability for the control of operational expenditure.

B.1.4 Accountability:
That providers and commissioners are equally accountable for planning and managing the delivery of care in a way that meets demand and delivers constitutional standards.

B.1.5 Clinical strategy:
That commissioning, service planning and transformation must be based on a clinical strategy that is constrained within a determined financial envelope.

B.1.6 Incentives:
Current payment systems do not incentivise delivery of improved outcomes. Changes to the reimbursement of patient pathways is needed to incentivise whole system efficiency and effectiveness and improved outcomes delivered through better system integration.

B.1.7 Transformation Programme:
A clinical transformation programme must be jointly owned by providers and commissioners. It must be operationalised and delivered by provider clinicians and operational professionals and they must be properly resourced, incentivised and held to account for delivery.

B.1.8 Compensation:
Where key strategic decisions may be in the best interests of the patient but may have a differential impact on individual organisations, the beneficiaries of any change must fairly compensate the losing entity.
B.1.9 Transitional support:

Transitional support must enable acute providers to deal with stranded costs associated with moving to new models of care.

B.1.10 Prevention:

Prevention and upstream investment need to be prioritised to enable our residents to lead healthier lives.

B.2 The Seven Nolan Principles

B.2.1 Selflessness:
Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other benefits for themselves, their family or their friends.

B.2.2 Integrity:
Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

B.2.3 Objectivity:
In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

B.2.4 Accountability:
Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

B.2.5 Openness:
Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

B.2.6 Honesty:
Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

B.2.7 Leadership:
Holders of public office should promote and support these principles by leadership and example.
Appendix C – Roles of the governance bodies

1. Partnership Board

The ELHCP Partnership Board will:

a) approve the EL STP;

b) review and update the EL STP, when necessary;

c) prepare a EL STP programme plan, which will:
   • convert the high level EL STP into individual projects;
   • prioritise the projects taking into the account, for example, the following:
     • **benefits** - which projects are "low hanging fruit", which can be implemented quickly and simply
     • to achieve a material benefit and which projects will lead to the greatest benefits;
     • **funding** - which projects do not require funding, which projects do require funding, but the
     • funding can be procured and which projects require funding and the funding will not be
     • available at this stage;
     • **dependencies** - which projects have dependencies upon the implementation of other projects;
     • **complexity** – which projects are complex and might be better implemented once the Parties have more experience of working together;
     • allocate projects to different phases, starting with phase 1;
     • offer an initial view as to which Parties may be interested in each relevant project or whose services may
     • be affected by the project e.g. if the project affects acute care;
     • communicate the programme plan and the reasoning behind it clearly to the Parties;

d) prepare a communication plan, which will generate effective partnership working and a sense of common purpose between the Parties;

e) circulate "Lessons Learned" reports from the ELHCP Project Boards, with its comments.

2. ELHCP Clinical Senate/ ELHCP Finance Strategy Group/ ELHCP Community Group/ ELHCP Assurance Group

The ELHCP Clinical Senate/ ELHCP Finance Strategy Group/ ELHCP Community Group/ ELHCP Assurance Group will:

a) provide advice to the EL STP on all matters referred to in Paragraph 1; and

b) on request, provide advice to the EL STP Project Boards.
Appendix D – Sign Off by the Parties

Through signing this East London Health and Care Partnership Agreement the Parties listed below will:

- Agree to the objectives in this document and work collaboratively to achieve these
- Agree to the partnership principles and processes outlined in this document
- Recognise the partnership structure outlined in this document for the ELHCP and support this locally

The signatories to this Partnership Agreement should be properly authorised to represent their respective organisations in entering into the commitments outlined in this document.

<table>
<thead>
<tr>
<th>Signed on behalf of</th>
<th>Signature:</th>
<th>Name:</th>
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ENDS
To: Meeting of the NHS Redbridge Clinical Commissioning Group Governing Body

From: Dr Mehul Mathukia, Clinical Director and Finance & Delivery Committee Chair

Date: 26 May 2017

Subject: Feedback report from the April 2017 BHR CCGs Finance & Delivery Committee meeting

Summary

The Finance & Delivery Committee meeting minutes are provided to each of the 3 CCGs Governing Body meetings. To provide additional assurance to the Governing Bodies, this brief feedback report provides key highlights from the meeting:-

Finance risk report - Committee members were given an update on the financial risks and the five main risk areas were discussed in detail. A separate update report was presented on Continuing Health Care (CHC) and the plans to deliver efficiencies during 2017/18 were noted. The Committee expressed their concerns about the overall challenging financial position facing the CCGs.

System delivery framework – The Committee members were presented with an update report which gave the position as of 26 April 2017. The Committee members welcomed the progress made, however, they expressed their concern about the slippage reported in some areas and acknowledged the work being done to address the issues.

Contracts position / deep dives

Updates on the contracts position together with an update on the reviews being carried out into contract renewals were given. Deep dives were presented on bariatric surgery and also B&D CCG’s expenditure relating to the Barts Health which had been highlighted at the last meeting as being higher than both Havering and Redbridge CCGs expenditure.

Recommendation:

- The Governing Body is asked to note this feedback report and the April Committee minutes which provide more detail on all the matters considered.

4 May 2017
Draft Minutes of the BHR CCGs Finance & Delivery Committee held on
27 April 2017 at Becketts House

Members:

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<tr>
<th>B&amp;D CCG</th>
<th>Havering CCG</th>
<th>Redbridge CCG</th>
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<tr>
<td>Dr Gurbir Kalkat (GK)</td>
<td>Dr Mehul Mathulia (MM)</td>
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<tr>
<td>Clinical Director</td>
<td>Clinical Director and F&amp;D Committee Chair</td>
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<td>Dr Atul Aggarwal (AA)</td>
<td>Dr Sarah Heyes (SH)</td>
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<td>CCG Chair</td>
<td>Clinical Director</td>
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<td>Dr Dr Mehul Mathulia (MM)</td>
<td>Dr Muhammad Tahir (MT)</td>
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<td>Clinical Director</td>
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<td>Kash Pandya (KP)</td>
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<td>Rob Adcock (RA)</td>
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<td>Sharon Morrow (SM)</td>
<td>Alan Steward (AS)</td>
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<td>Chief Operating Officer</td>
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Attendees:

Dr Anil Mehta (AMe) Chair, Redbridge CCG
Dr Ramneek Hara (RH) Clinical director, B&D CCG
Dr Kanika Rai (KR) Clinical director, B&D CCG
Ali Kalmis (AK) Director, Acute Contract Management- CSU
Frank O’Neill (FO) Interim Director Finance – CSU
Jeremy Cridland (JC) Associate Director, Business Intelligence - CSU
Anna McDonald (AMc) Business manager, BHR CCGs
Rob Meaker (RM) Director, Innovation, BHR CCGs
James Gregory (JGr) Interim Director, PMO, BHR CCGs

Apologies:

Dr Waseem Mohi (WM) Chair, B&D CCG
Dr Maurice Sanomi (MS) Clinical director, Havering CCG
Tom Travers (TT) Chief Finance Officer, BHR CCGs
Dr Alex Tran (AT) Clinical director, Havering CCG
Louise Mitchell (LM) Chief Operating Officer, Redbridge CCG

1.0 Welcome and apologies

The Chair welcomed everyone to the meeting and introductions were given for the benefit of AK who was known to the meeting. Apologies were noted as above.

Action
### 1.1 Declarations of interests

The Chair reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of BHR CCGs.

No additional declarations of interest were declared. The register of interests held for BHR CCGs Governing Body (GB) members and staff is available from the Company Secretary.

### 1.2 Minutes of the last meeting

The minutes of the meeting held on 21 February 2017 were agreed as an accurate record with the exception of one amendment.

### 1.3 Matters arising/actions log

2.1 There was an outstanding action for Gary Morris who has recently left the CSU. AK to complete the action by speaking to SM outside of the meeting.

2.1.1 Finance risk register - AS advised members that a fundamental review of the risk register is being undertaken and that Pam Dobson (PD) is arranging meetings with the appropriate people in order to completely refresh the risk register. The refreshed version will be taken to the next Joint Executive Committee (JEC). AA referred to the action in regard to the PMS risk and said it needs to say GMS as well as the risk is about both and the wording needs to be explicit. KP said he was concerned at the delay in getting the CHC risk added to the register. AMc fed back that PD had advised she has been asking to meet with Rob Meaker (RM) to get an update from him and agree the narrative. KP said it needs to be added without further delay.

3.1 RA advised that a board to board meeting with BHRUT is being set up and added that TT will be speaking to PwC on 28 April 2017.

3.4 Barking Hospital Birthing Unit – SM said this will be included in discussions will be held with the STP lead for maternity.

The Chair confirmed that the remaining actions were on the agenda.

### 2.0 Finance reports / risks

#### 2.1 Finance risk report

RA explained that as it was the end of the financial year, it would be helpful for the Committee to look at the risks in relation to the BHR wide plan for 2017/18. The CCGs are facing a very challenging financial position. The current level of activity is unaffordable and transformational change is required to aid the CCGs financial recovery. The CCGs are required to submit a view of risks and mitigations to NHSE and the position reported within the 30 March 2017 Operating Plan for BHR CCGs was demonstrated within the report. A breakdown of individual CCG risks was also provided. The five main areas of risk were discussed:

**Delivery of QIPP** – the QIPP requirement for 2017/18 is £45.1m and the risk covers both the full year impact of 2016/17 schemes and new schemes
for 2017/18.

**Acute contracts** – this risk includes RTT at the main providers and risk of contract growth above plan. The RRT risk is assumed to be £3m across BHR CCGs. There is a risk that the high level of overspend against acute contracts seen in 16/17 will continue into 17/18. Each CCG assumes a 1.5% risk against the total acute budget.

**Continuing Health Care** – growth has occurred over the last two financial years as a result of price increases and activity increases above demographic levels. There is a risk that growth could be in excess of the demographic and non-demographic growth built into the budget. The percentage risk applied to Havering CCG is higher than B&D CCG and Redbridge CCG as Havering has a higher level of over 65s.

**Prescribing** – this budget includes both activity and price growth, the latter is agreed nationally. The risk built into the operating plan is 3% of the budget per CCG.

**Property services** - the risk is the move to market rent. The assumption in the budget is that this risk will be fully mitigated by national funding, however, if the national funding doesn’t match the level of spend incurred, this will result in a financial pressure to the CCGs. The total risk and contingency for property services is £2.3m across BHR CCGs.

AM asked for a view on whether we will be able to close the gap and RA stressed that the QIPP target is extremely challenging. JGr reported that the QIPP schemes have been assessed as to how deliverable they are. A list of the schemes was provided in the document for discussion under Item 2.2.

*Dr Rai joined the meeting.*

AA referred to the new standard contract and said there may be financial risks involved in implementing it. A discussion took place about out-patient electronic discharge letters and out-patient medication. AMe raised concerns about the implications of these elements within the new standard contract and said urgent action is needed. Committee members were informed that Barking, Dagenham and Havering Local Medical Committee (LMC) has sent a letter to BHR CCGs about the new standard contract and AS said he would arrange for the response back to the LMC to be shared with the Committee.

AK said she would consider the issues raised and provide a response to Committee members outside of the meeting. SH said this will be the same for the Barts Health (BH) contract and AK confirmed that she covers that contract as well.

KP referred to RTT in relation to the deficit and recommended that RTT is separated out in the papers that are presented to NHSE. RA agreed and confirmed that RTT is separated out in the paper that goes to the Governing Bodies. The RTT standard was discussed and AK said she would provide clarity in regard to the national standard for RTT at the next meeting.

The Committee noted the report, the risk updates and the mitigating actions, which will continue to be provided to the Governing Bodies and the F&D Committee.

**2.1.1 Finance risk register**

See update given under Item 1.3.

*Dr Hara joined the meeting.*
A discussion took place around the risk relating to CAMHS and SM reminded members that the children & young people’s mental health transformation plan was presented at the Governing Body meetings in November 2016. SM to forward a copy of the plan to AMe. Committee members agreed that this is a very important area and SM suggested that perhaps a more detailed presentation could be given at one of the weekly informal JEC meetings. AS reported that forward plans for each of the transformation programmes are being agreed and said it would be really helpful to have real focus on CAMHS. AMe referred to the good work being undertaken by Tower Hamlets CCG.

*Rob Meaker joined the meeting.*

### 2.2 System delivery framework

JGr presented an updated paper, which gave the position as at 26 April 2017 and reported that the total level of identified QIPP schemes is £44m. There is some slippage due to pipeline schemes and this has been escalated to Jeff Buggle, Acting Chief Executive at the Trust and others where appropriate. A separate process is being followed to close the gap at BH Trust. Details about investments the CCGs are making will need to be given at the next assurance meeting with NHSE.

*Dr Tahir joined the meeting.*

A list of the critical issues were listed within the report. AA advised that the clinical cabinet is not up and running yet and referred to a recent London wide CCGs Chairs meeting that he had attended where they had discussed clinical cabinets and suggested to JGr that he looks at Richmond CCG’s clinical cabinet terms of reference. The Chair questioned what the process is for schemes that have failed to deliver after 3-6 months and JGr confirmed that transformation teams will be asked to provide recovery plans which will be taken to the Financial Recovery Planning, Development & Monitoring meeting (FRPDM) and the Financial Recovery Programme Board (FRPB). SH asked about QIPP schemes at BH and JGr advised that the Trust has recently started to provide the information. AK advised that a meeting with BH is being set up and SH asked to be included in the meeting. KP asked what impact the election on 8 May 2017 might have on the schemes. JGr advised that it could potentially affect schemes that involve engagement that hasn’t already started. In regard to service restrictions, it was noted that the election will have an impact on phase 2. AMe raised concerns about the level of clinical engagement in the transformation programme for planned care and the delays and said he felt that accelerated movement is required. AS advised that a joint executive team meeting had been arranged with BHRUT for 3 May 2017. KR updated the Committee on the first network council meeting that was held on 26 April. She said the ideas and plans are there but a structure for the networks needs to be in place in order to keep GPs and stakeholders involved. She reported that the network council doesn’t know what funding there is to support the delivery or what level of support the borough teams will provide. AMe suggested the need to concentrate on transformation of care and the other CDs present agreed. KP suggested this message needs to be conveyed to the Governing Bodies as a key message. AS reminded Committee members that the transformation programme is about looking...
across the system as a whole and highlighted the need to understand the differences between networks and localities.

*James Gregory left the meeting.*

### 2.3 Continuing Healthcare (CHC) update

RM presented a report which updated the Committee on the current position, plans for improving the CHC service and also clarified the position in regard to expenditure. He explained that there are four core work streams for 2017/18 that are anticipated to deliver £2m QIPP and said he feels confident that the service will achieve its budget for this year. In 2017/18, all Personal Health Budget (PHB) cases will be managed by CHC services and all packages will be placed by the CCGs CHC service. Work is continuing with the London Borough of Redbridge to resolve issues over historic invoices that they have submitted during the past 3 years which have resulted in incorrect and double charging. An update on the review being undertaken of learning disability cases was given. MT gave an example of a case he is aware of and stressed the need for the process to be done speedily to avoid additional hardship to families. Questions were asked about the difference between Any Qualified Provider (AQP) and non-AQP and RM advised there is very little difference in terms of cost and added that the AQP network carry out independent quality checks.

The Committee noted the updates and the plans to deliver efficiencies during 2017/18.

The Chair asked RM to meet with Pam Dobson to agree the narrative for the CHC risk so that it can be added to the register as a priority.

*Rob Meaker left the meeting.*

### 3.0 Contracts position / deep dive reports

#### 3.1 Contracts position

It was agreed that the majority of the items contained in the report had been discussed so members were asked if they had any further questions. AMe referred to the Redbridge section of the Associate and Independent contracts table and queried the statement about gastroenterology at the Homerton being overspent. It was confirmed that the statement referred to bariatric patients. AMe asked for that to be made clear in the report going forward. AMe also queried why the capacity of Healthbridge Direct has been reducing. RA confirmed the contract agreed with the federations was for a set amount of activity and that Healthbridge Direct had been over performing in the early part of Qtr1. AMe requested a report clarifying payments to the federations for the next meeting.

AA referred to the Executive summary on slide 7 in regard to the Royal Free Hospital and asked if a reduction in activity is being seen at Queen’s Hospital. It was explained that the increase in activity at the Royal Free in regard to urology was a result of the RTT issue at Queen’s. AA noted that ENT activity was also mentioned and reminded members that there are ENT services locally. AA also referred to robotics at UCLH and it was confirmed that robotic urology will become specialist commissioning next year and sit with NHSE. A deep dive into gastroenterology, ENT and urology referrals was requested for

*AK/CSU*
the next meeting. RA advised that a meeting with AK will be taking place to look at how the contract report needs to be formatted going forward and suggested that AA could be included if he wanted to attend.

### 3.2 Contract renewals

AK advised the Committee that the report was for information only. KP said the Audit & Governance Committee were very concerned about the number of tender waivers presented to them at the meeting on 24 April 2017 and as Chair of that Committee, he said he doesn't want to see any tender waivers going forward unless it is absolutely essential. SM reported that a difference approach to contract renewals is being taken which will look at tri-borough contracts rather than individual contracts per CCG. Views were given about some of the reviews that have been completed and AS reminded members that the report was for information only at this stage and that no decisions have been made. It was agreed that clinical input is absolutely essential when making the decisions and FO confirmed that clinical input is given at the FRPB meetings. AMe said we need to have standardised contracts across the 3 boroughs and gave the post-operative wound care review as an example.

The Committee noted the contracts that require commissioning decisions within the next 6 months and agreed to receive a further report in due course from the FRPB which will include recommendations.

#### 3.3 B&D CCG’s expenditure relating to the Barts Health contract – deep dive

The deep dive had been carried out following a request at the last meeting where it was noted that expenditure for B&D CCG was higher than expenditure for Havering and Redbridge CCG. The report provided a detailed analysis and demonstrated that the increase in costs is due to complexity shifting. AK confirmed that a decrease in non-elective admissions has been seen at BHRUT.  

*Ali Kalmis left the meeting.*

#### 3.4 Bariatric surgery – deep dive

The analysis was requested at the last meeting following concern regarding increasing bariatric surgery activity, which is currently funded by NHSE. The analysis was reviewed and concerns were raised that BHR CCGs have the lowest number of referrals. AMe added that we need to be benchmarked against the 7 CCGs as part of the Sustainability & Transformation Plan (STP). RA confirmed that bariatric surgery will be coming back to the CCGs.

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<th>4.0 Locality updates</th>
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<th>5.0 Items for noting</th>
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<td>F&amp;D committee sub-group notes – the minutes were noted by the Committee.</td>
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<td>BHR Local Estates Forum – the minutes were noted by the Committee.</td>
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<th>6.0 Any other business</th>
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<td>Draft annual accounts - KP expressed his thanks to the finance team for meeting the draft annual accounts deadline. It was noted that Barking &amp;</td>
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Dagenham and Redbridge CCGs have achieved a breakeven position and Havering have a £4.76m deficit due to the exposure of BHRUT’s position.

**e-mail re cancellation of courier services** – AMe referred to an e-mail that had been sent out by BHRUT to all practices about the courier service. RA confirmed that the e-mail was in-correct and that the service will continue to operate as usual.

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<td><strong>F&amp;D Committee sub-group</strong> – 25 May 2017</td>
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<td><strong>F&amp;D Committee</strong> – 28 June 2017 – Imperial Offices 1.30pm.</td>
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To: Barking & Dagenham, Havering and Redbridge CCGs
From: Kash Pandya, Chair of Audit & Governance Committees
Date: May 2017 Governing Body meetings
Subject: Feedback from the 24 April 2017 Audit & Governance Committee meetings

The Governing Body’s (GB) attention is drawn to the following key matters discussed at the Audit and Governance Committee meetings on 24 April 2017:

- The BHR CCGs are currently at risk of not meeting mental health constitutional and financial targets. The Committee recommends that these be escalated to the corporate risk register and appropriate mitigations developed.

- The external auditor has advised the Committee that he intends to issue a section 30 report to the Department of Health on Havering CCG because it has failed to contain its 2016/17 spend within its resource limit. The external auditor is also minded to issue a qualified value for money conclusion on the BHR CCGs because of the scale of the financial challenges that need to be addressed.

- The Head of Internal Audit has advised the Committee that, subject to no new issues emerging, he intends to state in his 2016/17 opinion that ‘the organisation has an adequate and effective framework for risk management, governance and internal control. However, our work has identified further enhancements to the framework for risk management, governance and internal controls to ensure that it remains adequate and effective.’

- The Committee received the draft 2016/17 financial statements and annual reports for the three BHR CCGs. These documents are still subject to audit. The account state that for 2016/17 Barking & Dagenham CCG and Redbridge CCG have met statutory financial targets but Havering CCG had an overspend of £4.76m against its resource limit for the year. It should also be noted that the BHR CCGs had to rely on risk pooling from the North East London STP CCGs to achieve this position. The Committee thanked the officers for their efforts in producing these draft documents in almost complete state in a timely manner and to a good standard.

- The Committee remain concerned at the number of tender waivers being drawn to its attention. The Committee has asked the CFO for a report on the action being taken to address deficiencies in the procurement which are necessitating tender waivers and an update on the finalisation of the Procurement Strategy.

Kash Pandya
BHR Audit & Governance Committee Chair
11th May 2017
Draft Minutes BHR Audit Committee 24 April 2017 v1

Present – Members

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<th>Name</th>
<th>Role and Details</th>
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<tr>
<td>Kash Pandya (KP)</td>
<td>BHR audit chair, lay member for Audit &amp; Governance</td>
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<tr>
<td>Khalil Ali (KA)</td>
<td>Lay member PPI Redbridge CCG</td>
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<tr>
<td>Charles Beaumont (CBe)</td>
<td>BHR co-opted member for Audit &amp; Governance</td>
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<tr>
<td>Sahdia Warraich (SW)</td>
<td>Lay member PPI Barking &amp; Dagenham</td>
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<td>Richard Coleman (RC)</td>
<td>Lay member PPI Havering</td>
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In attendance – Officers

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<tr>
<td>Tom Travers (TT)</td>
<td>BHR chief financial officer</td>
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<tr>
<td>Rob Adcock (RA)</td>
<td>BHR deputy chief financial officer</td>
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<tr>
<td>Nick Christolides (NC)</td>
<td>NELCSU interim financial controller</td>
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<tr>
<td>Marie Price (MP)</td>
<td>BHR director of corporate services</td>
</tr>
<tr>
<td>Anne-Marie Kelliris (AMK)</td>
<td>BHR company secretary</td>
</tr>
<tr>
<td>Sharon Morrow</td>
<td>SRO Mental Health</td>
</tr>
</tbody>
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In attendance – auditors

<table>
<thead>
<tr>
<th>Name</th>
<th>Role and Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kevin Suter (KS)</td>
<td>External auditor, Ernst &amp; Young</td>
</tr>
<tr>
<td>Stephen Bladen (SB)</td>
<td>External auditors, Ernst &amp; Young</td>
</tr>
<tr>
<td>Charlie Nicholls (CN)</td>
<td>LCFS, RSM</td>
</tr>
<tr>
<td>John Elbake (JE)</td>
<td>Internal auditors, RSM</td>
</tr>
<tr>
<td>Ziear Eagling-Rana (ZE)</td>
<td>LCFS, RSM</td>
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</tbody>
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Apologies

<table>
<thead>
<tr>
<th>Name</th>
<th>Role and Details</th>
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</thead>
<tbody>
<tr>
<td>Gemma Higginson (GH)</td>
<td>LCFS, RSM</td>
</tr>
<tr>
<td>Nick Atkinson (NA)</td>
<td>Internal auditor, RSM</td>
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</tbody>
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Action

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
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<tbody>
<tr>
<td>9.00-9.30</td>
<td>Committee Members held a short private meeting and IA and EA then joined for a short private session.</td>
</tr>
<tr>
<td>13/17</td>
<td>Welcome and Apologies for absence</td>
</tr>
<tr>
<td></td>
<td>Apologies for absence were received from Nick Atkinson and Gemma Higginson.</td>
</tr>
<tr>
<td>14/17</td>
<td>Declaration of Interests (DOI)</td>
</tr>
<tr>
<td></td>
<td>No further declarations of interests were declared other than those on the three registers presented.</td>
</tr>
<tr>
<td>15/17</td>
<td>Minutes of meeting held on 14 February 2017.</td>
</tr>
<tr>
<td></td>
<td>The minutes of the previous meeting were agreed subject to minor typographical errors which the Chair would share with the Company Secretary after the meeting and would be signed by the Chair as a correct record.</td>
</tr>
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</table>

KP/AMK
16/17 | Matters Arising |
---|---|
The log indicated a number of completed actions and updates that were being provided at the meeting, in addition;

14/02/17 Training session - training completed and shared.

05.4/17 Well Led Review – Well Led Review report was expected this week, once actions agreed this will be presented back to the audit committee to ensure it is implemented.

06.1/17 IA BHR Progress report – COI working group meeting shortly to review latest policy and a report will be presented to the May committee.

06.2/17 CSU report - GP alert – it was noted that the internal audit review had been scoped and the Chair will provide names of GPs who have raised concerns.

10/17 Innovation Directorate-Toolkits - Training on risk appetite – MP to confirm date of training.

17/17 | Directorate risk briefing |
---|---|
SM presented a directorate risk briefing for the mental health transformation programme.

SM reported that mental health and learning disabilities requirements are directed by a national strategy and the CCG are developing a local programme to deliver these requirements.

It was noted that risks to the programme include investment in mental health services and there is still a gap in resources. There had been a £3.1m growth in mental health services across BHR which are now at risk due to recently issued financial directions. Transformation priorities are also at risk which are mitigated by the FRPB process.

The Chair questioned if there will be penalties against the CCG if it doesn’t meet the target. TT responded that ordinarily there would be penalties but as the CCG is in deficit this would not apply.

KA commented that this is long standing issue and questioned if there has been any impact assessment of decisions made to explore the effect on other services. SM responded that this is difficult to evidence but part of the business case process is to try to evidence impact on other services. TT added that the new financial governance process and FRPB assess any impact.

RC referred to the FRPB and questioned if final decisions should be made by the governing body to ensure complete transparency. MP reported that revised ToR for the PRFB are being prepared to expand membership adding that due to the pace of change required, but agreed there is need for a clear and transparent process.

The Chair questioned if there was any update on Meadow Court. SM reported that the PID will be presented to the FRPB adding there is a reduced forecast saving for 17/18 due to a delay in consultation following the announcement of the forthcoming general election.
SM referred to IAPT and reported that the CCG were exploring discussions at an STP level. It was noted that B&D had met their target but Havering and Redbridge had not. The Chair questioned if the risk of not meeting targets are on the risk register. SM confirmed they have been escalated to the corporate risk register.

The committee thanked SM for her update.

### 18/17 Internal Audit

#### 18.1/17 BHR Progress report
JE presented the progress report highlighting that 3 audit reports have been finalised. It was noted that the reports on Caldicott Guardian and CHC are still in draft and awaiting management feedback. The following updates were provided:

- **Information governance** – 2 actions raised one low and one medium. The Chair suggested that TT follows these up. The Chair asked that the risk register and assessment recommendation (4.8) is brought forward as he felt 31 July was too long.

- **COI** – it was noted that it was a positive report with only one medium action due to a delay in NHSE guidance being issued. MP reported that she welcomed the report and was on track to implement the new guidance and the draft policy would be presented to the meeting in May.

- **BAF** – it was noted it was overall a positive report with a couple of areas for development. MP welcomed the report adding that the new risk register format would be ready for the July governing body meetings and an update would be presented at the audit committee in May. The Chair requested that the risk register is presented to the audit committee more frequently given the current financial position.

The Chair questioned how the action on the apprentice levy will be picked up. MP reported that her team were liaising with HR.

The Chair requested an update from the IGSG on cyber-attacks.

The Chair requested feedback on GDPR when reviewed.

KA questioned if there is future planning from internal audit around financial planning. TT reported that the risk register will be presented to the audit committee more frequently along with financial governance review which will provide assurance to the governing body.

The Chair requested a report on FRPB savings to the July committee.

#### 18.2/17 CSU Progress report
JE presented the CSU progress report highlighting that 27 out of the 30 management actions require follow up.

KA was pleased to note the Waltham Forest CHC/personal budget’s reasonable assurance and suggested reviewing if any learning or good practice could be shared. The Chair agreed and suggested we obtain the report and this be reviewed for good practice i.e. medicines management.
### 18.3/17 Draft HOIAO B&D

JE presented the draft HOIAO for Barking & Dagenham, Redbridge and Havering CCGs highlighting that QIPP and cyber security both have partial assurance. TT commented that he was comfortable with the report.

The Chair noted that observations from the nurse director are still required on the Data Confidentiality – Caldicott and Continuing Healthcare reviews and the Director was to be reminded.

The committee **noted** the draft HOIAO for the Barking & Dagenham, Redbridge and Havering CCGs.

### 18.6/17 RSM Conformance

The committee **noted** the RSM Conformance with IA standards.

### 19/17 LCFS update report

CN presented the LCFS update report highlighting that only one referral to the service has been carried forward into the current year. It was noted that overall the CCG has an amber rating with actions in place for any red ratings.

CN referred to contract management and reported on NHSP recommendations on reviewing anti-fraud and corruption arrangements of providers.

CB referred to new requirements with a red rating and questioned how long have the CCG been aware of these. CN responded that changes by NHSP in requirements have been recent. TT expressed frustration at the changes required due to national changes and would be responding appropriately.

KA asked what advice can be given to move rating from amber to green particularly around strategic governance. CN responded that the rating is due to having to submit a number of self-referral reports and BHR were not an outlier.

The Chair questioned if arrangements have been finalised for 17/18. CN responded that it is now what is expected and have developed a positive working relationship with NHSP to receive feedback on rating.

The Chair commented that the committee need to be aware of requirements so they can support appropriately and requested information on what a CCG rated as green has done differently. MP commented that a narrative is also required for the annual report.

The Chair requested details on the investigation referred to in the report. CN reported that this was active and would provide an update outside of the meeting.

The committee **noted** the report.

### 20/17 External update report

KS presented the external update report highlighting the concerns relating to the standard of evidence required for primary care commissioners. He also reported that concerns had been raised to NHSE on Capita’s performance.

KS reported that further understanding is required how Barking & Dagenham and Redbridge CCGs have met their statutory target and will be issuing a Section 30 referral to the Secretary of State for Health on Havering CCGs position. He added that consideration needs to be given to how finances were achieved and the
significant pressure on next year due to legal directions and a qualified value for money conclusion would need to be considered.

The Chair commented that the committee observed the issues to be tackled but asked that external audit did not lose sight of the legal directions issued for RTT which have now been removed. KA agreed and added that nationally the non-reporting of RTT data has had the outcome that funds have been spent and have been left with no other option.

The Chair requested that the management response will be sent as soon as possible.

### 21/17 Finance

#### 21.1/17 Tender waivers
TT presented a number of waivers. SW expressed concern at the high number. TT acknowledged these concerns and reported this was partly due to an issue of management by CSU who have developed an action plan to resolve. He added that commissioners also input into the issue and an investigation is being undertaken to explore reasons.

The Chair shared the concerns raised which he believed stemmed from the lack of an agreed procurement strategy and asked when this would be finalised. TT reported that this is with CSU and will be discussing this shortly. The Chair requested that a strongly worded message is sent from the committee requesting immediate action.

- Community Dermatology providers (BHR) – This has now been approved by the governing bodies on 20 April 2017
- Jayex patient check in hardware warranty (BHR)
- Community Ophthalmology service (Havering) – The Chair commented that value of waiver needs to be included. CB highlighted the COI issue. The Chair acknowledged this but reported that this has been recognised and managed appropriately.
- Quality improvement & leadership development programmes (BHR)
- Wheelchair service (Redbridge)
- Community Anticoagulation (BHR) – The Chair highlighted that COI had not been included as 2 clinical directors own PCP.
- Patient video consultation software (BHR) – it was noted that this is a service development add-on to a previously secured system.

The Chair requested a report to the next meeting including an action plan and timeline to implement the procurement strategy as the number of tender waivers is becoming increasingly unacceptable.

#### 20.2/17 CCGs draft annual accounts
TT presented the draft annual accounts and thanked the finance team for meeting the deadline. It was noted that Barking & Dagenham and Redbridge have achieved
a breakeven position and Havering has a £4.76m deficit due to the exposure of BHRUT’s position.

The Chair asked how the risk pool was used and reflected in the accounts. TT reported that this is reflected in the increased resource limit, each CCG received a different amount but overall this was £16.1m after the 1% reserve.

KS commented that to ensure transparency a narrative in the annual accounts should be included to show how the break even position was reached.

TT reported on the PWC Well Led Review which has pulled together a comprehensive action plan which will be tightly managed by a project manager to hold the system to account on its recommendations. He added that the independent forensic financial review of the BHR system will be extended to NELFT to inform the board to board meeting with BHRUT planned for early June.

He also reported on the cap expenditure approach programme which is a national programme for challenged STPs. It is expected that north east London will be in the second phase of this programme.

The Chair questioned if the PWC forensic review is binding. TT confirmed it was and would be finalised in 2-3 weeks.

The Chair thanked the finance team and asked that committee members submit their comments on the draft annual accounts to the finance team by 8am on Monday 8 May 2017.

22/17 Governance

22.1/17 Committee insert for annual report/self reflection
The Chair requested that members return their self-reflection along with feedback on the annual report to MP and highlighted the need to reflect on procurement and how we look more closely in the coming year at probity and self-awareness.

The Chair reported that his conclusion will pick up key areas of concern the committee need to tackle in the coming year.

The Chair asked KS to feedback how this compares to other CCGs.

22.2/17 Progress on review of risk management
MP reported that the risk management report will be presented to the next meeting.

22.3/17 Progress on implementing new COI, gifts and hospitality, sponsorship and whistleblowing policies and processes
MP reported that the COI working group will be meeting again shortly and the revised draft policy will be presented to the next meeting.

22.4/17 CCGs draft annual reports
MP presented the draft annual report for comment and thanked Rowan Taylor and the governance team for their input.

CB welcomed the reports and suggested for overall balance, challenges should be highlighted and a reflection of the difficult year ahead.
Discussion ensued on including a balance of achievements and challenges and also reflecting the recently implemented changes along with clinical input and achievements. KA suggested that more plain English is used.

MP agreed to send the latest revised version of the annual report to members by the end of the week for comment by 8am on Monday 8 May 2017.

<table>
<thead>
<tr>
<th>23/17 Minutes to note</th>
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<tbody>
<tr>
<td>23.1/17 BHR CCG assurance group minutes held on 3 March 2017</td>
</tr>
<tr>
<td>23.2/17 Draft quality and safety committee minutes held on 28 February 2017</td>
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It was noted that the IGCG minutes were missing and would be presented to the next meeting. AW

<table>
<thead>
<tr>
<th>24/17 Closing Matters</th>
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<tbody>
<tr>
<td>24.1/17 Messages for the Governing Bodies</td>
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<tr>
<td>The Chair would discuss the key messages with the committee secretary. They would include:</td>
</tr>
<tr>
<td>• Risk on mental health</td>
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<tr>
<td>• Draft IAO – observations around sharing good practice</td>
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<tr>
<td>• LCFS</td>
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<tr>
<td>• External audit – actions required on financial position and VFM concerns</td>
</tr>
<tr>
<td>• Governance – annual accounts</td>
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<tr>
<td>• Procurement concerns</td>
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24.2/17 Any Other Business

It was noted that the recruitment of the secondary care consultant for Barking & Dagenham and Havering CCGs had been paused until the well led review had been finalised.

<table>
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<tr>
<th>25/17 Date of Next Meeting</th>
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<tr>
<td>The next meeting was arranged for 24 May 2017.</td>
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Signed……………………………………………………..Date…………………………..
Executive summary
During 17/18 BHRCCGs are required to deliver £45m of savings, in year. As of 9 May over £30m of savings scheme opportunities have been approved by the CCG. A pipeline of new opportunities is identified and a series of workshops to develop further opportunities is in progress. To provide assurance around the delivery of the approved schemes a new process for review of schemes that are in delivery has been put in place, under this process projects are reviewed on a weekly basis and any exception are escalated to the FRPB for action.

Recommendations
The Governing Body is asked to note the report

1.0 Purpose of the Report
1.1 To update the Governing Body on the progress of the 17/18 Financial Recovery Programme and work of the FRPB.

2.0 Background/Introduction
2.1 The financial challenges facing the BHR health system, following agreement of 2017-19 NHS contract values, are now significant, requiring BHRCCGs to save £45m to deliver a planned £10.2m deficit across BHR. Work is in progress under the direction of the Financial Recovery Program Board (FRPB) to deliver savings schemes to meet this target.

2.2 Under the FRPB’s Terms of Reference a high level summary of the progress on the financial recovery will be regularly provided to the Governing Bodies.

3.0 Report Content
3.1 Significant progress has been made during since the beginning of the financial year. 34 savings schemes are now approved by the CCG and the total assured savings figure is £30,665,000.

3.2 Work is continuing within the CCGs and with providers to identify new savings opportunities. Part of this identification work has been through review of opportunities identified through benchmarking as part of the RightCare program. A program of workshops involving CCG Clinical Directors and provider clinicians to develop the identified opportunities into viable projects is underway.
3.3 The process through which all identified saving and investment proposals are taken for review and approval is in operation as part of the FRPB. A pipeline of future schemes to be brought to the FRPB is held by the PMO.

3.4 To provide assurance around the delivery of the 17/18 financial recovery a more rigorous project review process has been put in place through the PMO. The objective of this review process is to provide a quicker escalation of issues to the EMT and FRPB so that remedial actions can be agreed and delivery assured. The project review and reporting process is set out in figure 1, below. Under this process all projects will be reviewed on a weekly basis. Exception reports are triggered should a project not complete critical actions in line with its project plan, miss a KPI (key performance indicator) target, raise a new ‘red’ risk or if a risk goes live. The process is designed to allow quick detection issues and escalation to EMT as appropriate while not generating significant additional unnecessary administrative output for the transformation team which are leading project delivery.

![Figure 1 PMO Reporting Process](image)

Note: Friday will be used by the PMO for internal review/planning for the week ahead

4.0 Resources/investment
4.1 There are no additional resource implications/revenue or capitals costs arising from this report.

5.0 Equalities
5.1 There are no additional equalities implications arising from this report. All savings scheme are required to have an Equalities Impact Assessment completed as part of the approval process.

6.0 Risk
6.1 Identify here any risks relating to the report or arising from any proposed action.

7.0 Managing conflicts of interest
7.1 There are no conflict of interest in regards to this paper.

Author: Jeremy Kidd, Head of PMO
Date: 09.05.17
<table>
<thead>
<tr>
<th>B&amp;D CCG</th>
<th>Havering CGG</th>
<th>Redbridge CCG</th>
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</thead>
<tbody>
<tr>
<td>Sadiah Warraich, Lay Member PPI, B&amp;D CCG (SW)</td>
<td>Richard Coleman, Chair, Lay Member PPI, Havering CCG (RC)</td>
<td>Khali Ali, Lay Member PPI, Redbridge CCG (KA)</td>
</tr>
<tr>
<td>Kash Pandya, Lay member, Governance, BHR CCGs (KP)</td>
<td>Kash Pandya, Lay member, Governance, BHR CCGs (KP)</td>
<td>Kash Pandya, Lay member, Governance, BHR CCGs (KP)</td>
</tr>
<tr>
<td>Sarah See (SS) Director of Primary Care, BHR CCGs (SS)</td>
<td>Sarah See (SS) Director of Primary Care, BHR CCGs (SS)</td>
<td>Sarah See (SS) Director of Primary Care, BHR CCGs (SS)</td>
</tr>
<tr>
<td>Sue Elliott, Deputy Nurse Director, BHR CCGs (SE)</td>
<td>Sue Elliott, Deputy Nurse Director, BHR CCGs (SE)</td>
<td>Sue Elliott, Deputy Nurse Director, BHR CCGs (SE)</td>
</tr>
<tr>
<td>Dr Adedayo Adeji (AA), GP B&amp;D CCG</td>
<td>Dr David Derby (DD) GP Havering</td>
<td>Dr Shabnam Ali, GP Redbridge CCG (SAli)</td>
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</tbody>
</table>

**In attendance:**
- Dr Tina Teotia (TT)  LMC, Barking, Dagenham & Havering
- Rob Dickenson (RD)  Senior Accountant BHR, deputising for CFO
- Dr Waseem Mohi (WM)  Chair, B&D CCG
- Dr Anil Mehta (AM)  Chair, Redbridge CCG
- Matthew Cole (MC)  Director, Public Health, LB B&D
- Vicky Hobart (VH)  Director, Public Health, LB Redbridge
- Alison Goodlad (AG)  Head of Primary Care, NHSE
- Gohar Choudhury (GC)  Asst. Head of Primary Care, NHSE
- Anne-Marie Dean (AMD)  Chair, Healthwatch Havering
- Natalie Keefe (NK)  Head, Primary Care Transformation, BHR CCGs
- Angela Ward (AW)  Company Secretary, BHR CCGs

**Apologies:**
- Conor Burke (CB)  Chief Officer, BHR CCGs
- Tom Travers (TT)  Chief Finance Officer, BHR CCGs
- Jacqui Himbury (JH)  Nurse Director, BHR CCGs
- Dr Atul Aggarwal (AAg)  GP, Chair, Havering CCG
- Dr Gurkirit Kalkat (GK)  Clinical Director, Barking & Dagenham CCG
- Dr Amrish Shah (AS)  LMC, Redbridge
- Dr Terilla Bernard  LMC, Barking, Dagenham & Havering
- Cathy Turland (CT)  CEO, Redbridge Healthwatch
<table>
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<tr>
<th>Item</th>
<th>Action</th>
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<tbody>
<tr>
<td>1. <strong>Welcome and apologies</strong></td>
<td>The Chair welcomed those present and apologies for absence from those listed above were noted.</td>
</tr>
<tr>
<td>2. <strong>Declarations of conflicts of interest</strong></td>
<td>The Chair reminded members of their obligation to declare any interest they may have on any issues arising at the meeting which might conflict with the business of the primary care committee and clinical commissioning group. Declarations declared by members are listed in the CCG’s Register of Interests. The Register is available either via the secretary to the committee.</td>
</tr>
<tr>
<td>3.1 <strong>Minutes from 7 December 2016 meeting</strong></td>
<td>The minutes of the previous meeting were agreed as a correct record subject to a minor change of the spelling of Gohar Choudhury’s name. AMK</td>
</tr>
<tr>
<td>3.2 <strong>Matters Arising/Actions Log</strong></td>
<td>Committee members noted the actions that had been taken and the following updates were noted: 72 QOF performance-a report would be provided to the May meeting. There was a Part 2 report on practice achievement, as declared, that would be validated by September. Open. 76 Budget Paper- Discussion was continuing with the NHSE Finance Team and detail awaited. Open. 78 Core Opening Hours- Information was awaited from the national team and this will be deferred until received. Open. 78 Special Allocation Scheme-Work was progressing on both short and longer term arrangements and an update report was on the agenda. Closed. AG TT SS/AG</td>
</tr>
<tr>
<td>3.3 <strong>Risk Register</strong></td>
<td>PMS- There was a report on the Part 2 agenda. Barking Riverside- NK updated that meetings had been held with two Thames View practices and estates issues had been overcome. The next stage was to establish the IT infrastructure but it was planned mobilisation could begin in Qtr.2.</td>
</tr>
<tr>
<td>4.0 <strong>Budget Update</strong></td>
<td>RD attended on behalf of Tom Travers and provided an update on primary care commissioning budgets at M10. A break even position was forecast across BHR for year-end and the Committee noted APMS and PMS had overspends whilst GMS and Other Medical Services (e.g. discretionary payments, sickness absence etc.) had underspends culminating in a forecast underspend of £356k. KP questioned if QIPP savings could be impacted by business rate changes and AG responded to confirm that rates were increasing and this needs to be considered. SS added that there were a number of cost pressures that had come out of the 2017 contract changes that will need to be considered by the CCG. Details of these have been circulated to the committee for information. The Committee <strong>noted</strong> the updated the financial update and level of financial risk this year.</td>
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## 5.0 Special Allocations Scheme (previously violent patients scheme)

GC emphasised that it was a statutory requirement to provide access to a Specialist Allocation Scheme previously known as the Violent Patient DES. There were some long standing arrangements based on historical guidance and there were currently two providers for BHR, Kings Park a PMS contract for B&D/Havering and the Larkshall Medical Centre in Waltham Forest (WF) for Redbridge patients.

WF CCG had given notice to the Larkshall Medical Centre and planned to procure a new service just for WF residents but due to a failed procurement Larkshall Medical Centres contract has been extended. Additionally the Kings Park service required re-procurement as the new APMS contract did not cover the SAS function.

A number of examples of schemes were shared with the group, and the committee agreed that an STP wide; BHR with WF scheme should be explored as the number of patients on the scheme are small. It was also suggested that others providers would be best placed to manage the scheme - e.g. mental health service providers who had much experience of violent and intimidating behaviours.

The clinicians present stressed the difficulties such patients raised in a practice and distress and safety issues caused to staff and other patients, it was also noted that the same group of patients also regularly accessed OOH, 111 services and a whole system approach is required.

MC added that following a meeting with the probation service a new model was being developed and health was seen as a critical partner to share such common issues. There was a workshop across the 3 boroughs with representation from health, housing and MC requested nominations. It was confirmed this would include GC, someone from local CCG primary care team and some CD leads. VH added that there were a raft of complexities and various cohorts. These included recently released offenders and those on probation and it was important for connectivity, noting the SAS catered for one element and she proposed linkage with the NHSE offender health team.

SS emphasised that this was a mandated service to enable all residents to receive core primary care services. The recommendations to agree to commission a pan-BHR service, from one or more locations, subject to confirmation of a recommended commissioning route, was agreed. Further consideration would be given to the options generated today. It was agreed that the project plan, draft specification including budget, communications and engagement plan are to come back to the PCCC for review and approval.

### 6.1 NHSE and BHR CCGs Named GP Safeguarding Memorandum of Understanding (MOU)

SE presented a report requesting approval of a named Safeguarding GP MOU for each of the BHR CCGs and with NHSE (London). The report clarified that the legal responsibility for safeguarding in primary care rested with the NHSE but the management would rest with the CCGs, if approved. The arrangements were supported by funding. Currently B&D and Havering have a 2 session named GP and Redbridge had a post for 3 session GP, however the latter was still a vacant post. Whilst an appointment continued to be sought a nurse consultant was covering this role on an interim basis.
VH added that the borough, whilst recognising difficulty in recruiting, would welcome a permanent solution to filling this vacancy around safeguarding children. KP questioned management capacity and who held the risk in the interim. SE responded that there was capacity and the nurse position could become permanent if a GP could not be found.

The Committee agreed the recommendation to approve the MOU for the named GP safeguarding.

6.2 NHSE and BHR CCGs Primary Care Commissioning & Finance Team MOUs

SS tabled a report that described how the 5 STPs have worked with NHSE London to consider how to maximise benefits of co-commissioning. They have reviewed primary care commissioning and contracting functions, including the associated functions of the NHSE London primary care finance team. The report detailed how the work had been undertaken in 4 phases since last summer.

The outcome had included agreement that Newham CCG would be the NEL STP lead and host the aligned team. BHR CCG would provide hot desk facilities to accommodate the visiting team members. Subject to legal advice and agreement by all NEL CCGs this would go live in May 2017. There had been some delay in sorting premises, IT infrastructure and sharing of the costs. The MOU was an agreement between BHR CCGs and Newham CCG as the host. SS added that new substantially differing costs had just been received required further consideration.

The Chair noted there were still some issues to resolve and that sign off may be required before the next PCCC meeting. In response WM’s questioned the impact on practices, SS added that the small team would be better able to visit practices directly and be more visible, which would be beneficial. WM requested a write-up to ensure practices were fully informed. KA requested that it be made clear that the STP was not a statutory organisation in the MOU. VH and MC referred to vaccs & imms screening in terms of responsibility and proactive performance management and it was confirmed that no changes were envisaged. SS requested that the MOU capture what was included at the London level.

The Committee noted the contents of the report and that final costs were to be confirmed. The Committee agreed the MOU in principle and would recommend this to the GB for approval but this was subject to further legal advice and confirmation of costs being satisfactory.

7.0 Merger Policy

As requested previously, the draft policy had been shared with the local LMCs. Feedback from Redbridge LMC was provided and there was no further comment from the B& D and Havering LMC. The report provided responses to the comments from Redbridge LMC. The Committee were being asked to review the policy and specifically the support already offered to practices under 3.1 and proposed support in 3.2. Expectations from practices were covered under 3.3.

The Committee agreed the additional support to practices as outlined in section 3.2 of the policy.
<table>
<thead>
<tr>
<th>Section</th>
<th>Committee Name</th>
<th>Details</th>
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<tbody>
<tr>
<td>8.0</td>
<td>Redbridge Primary Care Commissioning Committee</td>
<td></td>
</tr>
<tr>
<td>8.1</td>
<td>Courtland Surgery Remedial Notice-Chairs Action</td>
<td>CQC inspection took place in January 2017 and the practice were placed in special measures. Chairs Action was agreed on 11 March 2017 and a remedial notice was issued. SS would check whether support offered pre CQC inspection had been taken up by the practice. The Redbridge Committee noted the Chairs Action that had been taken.</td>
</tr>
<tr>
<td>8.2</td>
<td>Palms Medical Centre-Update</td>
<td>The practice had received a CQC rating of ‘requires improvement’ in October 2016. The Committee noted that wider performance at the practice was found to be below average and it was of particular concern that this was a teaching practice. The London Deanery had conducted an ‘urgent concerns review’ but initial feedback was that there were no significant issues affecting their training status. The PCCC had agreed a review visit to determine any contractual actions that occurred in February 2017 and the report included those findings. The Redbridge Committee agreed that the performance concerns did not warrant further contractual action.</td>
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<tr>
<td>9.0</td>
<td>Barking &amp; Dagenham Primary Care Commissioning Committee</td>
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<tr>
<td>9.1</td>
<td>Abbey Medical Centre -Update</td>
<td>This practice had been placed in ‘Special Measures’ in May 2015 following a CQC inspection, and had also received three remedial notices. In August 2016 CQC re-inspected the practice and they were taken out of special measures and rated ‘Good’. The Committee commended the good work to turn this practice around and achieve a ‘good’ rating from the CQC. Particular mention was given to Dr Anju Gupta and her excellent team for this achievement. The Chair had written to thank her for her work and SS added that there was also an excellent PPG and there had been a good news article in the local media. The B&amp;D Committee noted that the Remedial Notices and Action Plan at the practice were now satisfied and, as above, the Committee acknowledged and commended the hard work carried out by the practice in moving from special measures to a ‘good’ rating.</td>
</tr>
<tr>
<td>9.2</td>
<td>Five Elms-Update</td>
<td>This practice had been placed in ‘Special Measures’ following a CQC inspection and issued with a remedial notice in September 2016. There was a progress visit led by NHSE in December and whilst noting some improvements, they noted some leadership issues and the need for some practice manager support. A re-inspection by CQC occurred in February 2017, but to date the report is not published. The B&amp;D Committee noted the outstanding issues of leadership and management of the practice, that whilst awaiting the CQC feedback, the quality development actions are undertaken by the practice to develop systems and processes. It was</td>
</tr>
</tbody>
</table>
agreed that a further visit would be undertaken within 3 months of the CQC report being published, to understand if any further development is required.

10.0 GMS contract changes and implication for commissioner

The BMA GP’s Committee with NHS Employers have agreed changes to the GP contract around increased focus on the most vulnerable patients. It also covers access/opening hours and eligibility of patients from the European Economic Area. The report outlined the associated investment and was part in support of addressing past under-investment in general practice and acknowledged rising costs such as CQC inspection and indemnification.

The Committee noted the changes to the GMS contract for 2017/18.

(Dr Teotia from the LMC left the meeting)

11.0 Questions from public

There were no members of the public present.

12.0 Any Other Business

There was no other business

13.0 For Information

13.1 Summary of health care complaints

SS advised that the information was limited to complaints handled by NHSE whereas most complaints would be dealt with directly by practices.

SS requested the LMC stress to their Members that responding to an Ombudsman investigation was mandatory and the Ombudsman had the power to make Directions and asked for this to be shared at PLEs. These NHSE complaints also included dental, pharmacy and optometry. Key issues were more around communication/attitude and practice management than clinical issues.

The information provided was noted.

13.2 Update on GP premises development-ETTF & LIG

The report provided gave a summary of Estates, Technology Transformation Fund (ETTF) and London Improvement Grant LIG) for London. For the NEL STP, under the ETTF there were currently 11 schemes approved and 59 awaiting confirmation to progress. Details were available in the report. Some schemes would shortly move from pipeline to development.

The Committee noted progress being made on the two pipelines schemes.

14.0 Next Meeting

The next meetings were confirmed as 10 May and 14 June 2017

Signed………………………………………………………..Date………………………….
Draft Minutes of the BHR CCGs Quality & Safety Committees held on 25 April 2017 at Becketts House 1.30pm - 3.30pm.

<table>
<thead>
<tr>
<th>B&amp;D CCG</th>
<th>Havering CCGG</th>
<th>Redbridge CCG</th>
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<tbody>
<tr>
<td>Ah-fee Chan (AFC) secondary Care Consultant – Chair</td>
<td>Sue Elliott (SE) Deputy Nurse Director – rep JH</td>
<td>Sue Elliott (SE) Deputy Nurse Director – rep JH</td>
</tr>
<tr>
<td>Dr Anju Gupta (AG) Clinical Director</td>
<td>Dr Maurice Sanomi (MS) Clinical Director</td>
<td>Dr Muhammad Tahir (MT) Clinical Director</td>
</tr>
<tr>
<td>Sarah D-Souza (SD) Deputy Chief Operating Officer – rep SM</td>
<td>Dr Ann Baldwin (AB) Clinical Director</td>
<td>Dr Sarah Heyes (SH) Clinical Director</td>
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<tr>
<td>Alan Steward (AS) Chief Operating Officer</td>
<td>Louise Mitchell (LM) Chief Operating Officer</td>
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In Attendance:
Christine Kane (CK) Deputy Director Quality Assurance, BHR CCGs
Mark Gilbey-Cross (MGC) Designated Adult Safeguarding Manager, BHR CCGs
Belinda Krishek (BK) Chief Pharmacist, BHR CCGs
Karina Christensen (KC) Deputy Director, Contracts - CSU
Anna McDonald (AM) Business Manager, BHR CCGs

Apologies:
Jacqui Himbury (JH) Nurse Director, BHR CCGs
Dr Ravi Goriparthi (RG) Clinical Director, B&D CCG
Sharon Morrow (SM) Chief Operating Officer, B&D CCG
Erin Brennan-Douglas (EBD) BHR Quality Assurance Manager, BHR CCGs

1.0 Welcome and apologies
The Chair welcomed everyone to the meeting and apologies were noted as above.

1.1 Declarations of interest
The Chair reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of BHR CCGs.

No additional declarations of interest were declared. The register of interests held for BHR CCGs Governing Body (GB) members and staff is available from the Company Secretary.
### 1.2 Minutes of the last meeting

Minutes of the meeting held on 28 February were agreed as an accurate record.

### 1.3 Matters arising / actions log

#### 33 Quality Strategy implementation

CK apologised on behalf of JH that the document was not provided this month and gave assurance to the Committee that it would be completed and circulated for the next meeting.  
*Action open.*

#### 64.1 Community services boundaries

SM provided the following update by e-mail in advance of the meeting as she was unable to attend:

“There have been no boundary changes to the community services contracted from NELFT, which continue to be aligned to GP practices. NELFT took over the management of the integrated health and social care team (HASS) in April 2016, which highlighted that the NHS and social care operate within different boundaries (community health services are organised around GP registered lists and social services operate within borough boundaries). This has always been the case. In Redbridge there are some practices on the Essex boundary who have a number of registered patients who live in West Essex and NELFT and Redbridge commissioners have been in discussion with colleagues in Essex CCG to explore the opportunity for agreeing a cross boundary arrangement. These discussions are ongoing”.

AB explained that this is also an issue in Havering where they have up to 20,000 registered patients that Havering Local Authority won’t fund as they live outside of the borough boundary. MT said it has been an on-going issue for some time at his practice where it affects 25-30% of patients. AG talked about the cross boundary issues experienced by her practice with the boroughs of Newham and Redbridge. The Chair suggested raising it via the GP Alerts system, the Clinical Directors (CDs) present confirmed they have been doing that. Committee members agreed that it is an issue that needs to be escalated without further delay and agreed that JH needs to raise it at the next Joint Executive Committee (JEC) meeting and ensure that it is escalated to the Integrated Care Partnership meeting and provide feedback to the Committee.  
*Action open.*

#### 77.2 RTT Clinical Harm and Barts Health

LM explained that this had not been discussed with her, it had only recently been brought to her attention. She explained that Barts Health (BH) doesn’t have the same governance structure for RTT and Clinical Harm that BHRUT has. CK confirmed that they do have the same Clinical Harm panel. LM gave her view that the Barts Health (BH) Clinical Quality Review (CQRM) meeting is where the assurances requested by the Committee should be sought and asked for confirmation as to who attends the meetings. CK confirmed that either JH or a member of the Quality Team attends when possible. SH said she has raised the issue about lack of attendance at the CQRM on previous occasions and stressed the importance of having representation there and said she would always try to attend if she was given advance notice that no one else could. LM added that it is stated in the Governing Body Assurance Framework that we attend the meetings. SE to feed back the concerns about attendance to JH and it was agreed that JH would need to seek the assurances that were requested by the Committee from the BH CQRM.  
*Action open.*
81 **Concordia** – a copy of the final medical director’s report on clinical harm is still awaited.  
*Action open.*

90.1 **Paediatric Rheumatology** – SE confirmed this is underway and that the action could be closed.  
*Action closed.*

24 **NHS111** - CK confirmed that the outcomes of the two investigations will be available for the next meeting.  
*Action open.*

## 2.0 Quality Strategy Implementation

Discussed under agenda item 1.3.

## 2.1 Quality Risk Register

CK talked through each risk in turn giving updates where required since the register was issued. The discussion points were:-

**Ref 003 BHRUT radiology** – SE advised the committee that assurances will be sought on the radiology process as a whole at the next CQRM and feedback will be provided to the Committee. AS referred to the outsourcing that is taking place as part of BHRUT’s improvement measures and confirmed that the clinical governance of the outsourcing process sits with the organisation that is doing the outsourcing and that quality must always remain the priority.

**Ref 038 F1 trainees not supported** – AS queried the high risk score. MT gave his view that it should remain high and SH agreed adding that it is a major concern. SE explained that the Trust has been asked to complete an action plan and to take it to the CQRM. AS asked how the risk relates to King George Hospital (KGH) and MS agreed saying this needs to be looked at wider than just F1 trainees and that a drill down at the CQRM needs to be carried out in order to give assurance to the Committee.

**Ref 039 DN capacity** – LM said in her view, this should not be on the risk register as it has not been quantified. AG said if it remains on the register, it needs to include GPs. AS added that capacity in the community and primary care is a risk that should be managed by the Financial Recovery Programme Board (FRPB) and the CDs who attend should raise their concerns there. SE to feed back to JH and consider how the risk can be reworded.

**Ref 040 – Increase in demand for Quality Team activities** – LM queried this risk and said the wording doesn’t capture the fact that additional resource has been identified and commissioned which needs to be reflected in the narrative.

**Ref 041 – Inability to provide safe and consistent staffing** – AS said this goes beyond the 8 wards that are on the Trust’s risk register, more needs to be added. SE advised the Committee that this has been escalated to the CQRM following the SI Panel meeting with BHRUT on 24 April 2017. Assurances will be brought back to the Committee. MT asked if the Trust undertake exit interviews and SE confirmed that they do.

## 3.0 Bed occupancy risk at NELFT

The CSU provided a report for the meeting but it was un-clear who was presenting it. As it was regarding an issue that SD was aware of she updated the Committee on the current in-patient capacity. There has been commissioning investment and NELFT investment based on ward environment and therapeutic environment in 2016/17 and NELFT has a crisis pathway for 2017/18. In addition, they now
have flex beds to cope with spikes in pressure. It has been noted from the STP work that an increase in demand is likely. The Committee noted the actions being taken to date to mitigate quality risks to patients and the Chair thanked SD for the update she provided in addition to the report.

4.0 Nursing homes – quality issues and themes

MGC presented his report which provided an update on quality assurance monitoring of care homes with nursing across BHR:

**Alexandra Court (B&D) nursing home** – the initial outcome of the CQC inspection was an overall rating of inadequate and they were considering de-registering the home. The CCG and the Local Authority expressed surprise at the outcome as significant improvements had been noted following previous quality assurance monitoring visits. A benchmarking exercise was undertaken which looked at the CQC’s concerns compared to intelligence gained during the CCG’s quality assurance visits with the Local Authority which has resulted in the CQC re-considering representations made by the provider. The nursing home is in the process of being taken over by Bond Healthcare. They will receive their new CQC registration within the next few weeks and the CQC will review the home under the new registration, with the historic concerns kept on file for reference. The takeover of Alexander Court by Bond Healthcare will see the nursing home coming out of administration and the CCG and LA have agreed to maintain current levels of quality assurance monitoring in the interim period.

**Hanbury Court nursing home (B&D)** – no current concerns to report.

**Meadow Court nursing home (Redbridge)** – a joint un-announced visit with the Local Authority took place on 17 March 2017 and no concerns were reported. However, following the visit, MGC explained that he was contacted by a relative of one of the residents requesting a meeting. Concerns were raised at the meeting relating to general care issues that had been previously raised with the home but were unresolved. The Regional Manager has agreed to address the issues and feedback to the family and the CCG on the actions that have been taken.

**The Willows nursing home (Havering)** – following a quality assurance visit in March 2017, a restriction of a maximum of two admissions has been issued and the Local Authority are continuing an enhanced level of quality monitoring.

The Committee noted the updates.

*Dr Baldwin left the meeting. Havering CCG remained quorate in her absence.*

*Dr Gupta left the meeting and it was noted that B&D CCG would not be quorate until she returned.*

5.0 Unwell baby audit report

KC joined the meeting and tabled the audit report that had been commissioned in order to resolve the long standing commissioner challenge regarding the Trust’s ‘un-well baby’ reporting. The main highlights were given and in particular, KC drew the Committee’s attention to point 5.4 on page 7 relating to Intrauterine Hypoxia which has a higher rate than normal. The audit has been shared with the Trust and a meeting will be held with them in the next few weeks. KC recommended that this item is added to the next CQRM agenda.

JH/CK
<table>
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<tr>
<th>6.0</th>
<th>NELFT Quality Account</th>
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<tr>
<td>CK explained that this was the first time that the Commissioners statement has been shared with the Committee for comments. SH questioned why NELFT hadn’t made any reference to their CQC inspection undertaken in 2016. Committee members agreed that it needs to be included and NELFT should be asked to include what they are doing to improve on the CQC report. SH referred to page 12 and said they need to cross reference the ratings and be specific about what improvements they are putting in place to improve them. It was acknowledged that NELFT did receive a number of ‘goods’ in the overall rating. CK to reflect the Committee members comments in the final version of the Commissioners statement.</td>
<td>CK</td>
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<th>7.0</th>
<th>Adult safeguarding policies</th>
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<td>The Committee members were asked to comment on the three adult safeguarding policies. SH commented that the web links included at the back of the policies were helpful. No other comments were given and all three policies were approved. MGC to arrange for them to be published on the CCGs websites.</td>
<td>MGC</td>
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<th>8.0</th>
<th>De-brief on visit to Moore Ward</th>
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<td>EBD had been unable to attend the meeting but had advised that the formal report was pending sign-off. MGC gave a brief update on behalf of EBD and advised that there were no immediate concerns to report. Three B&amp;D patients had experienced a delayed discharge and SM was informed. A high level of treatment and care is being provided to patients and staff are motivated. There was a minor issue about access to outside space. SD added that the CCG was made aware of the issue with the delayed discharge of the three patients before the visit took place, however, they were not made aware that the ward had closed to new admissions which is being picked up.</td>
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*Dr Tahir left the meeting.*

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<tr>
<th>9.0</th>
<th>Items for information</th>
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<tbody>
<tr>
<td>9.1</td>
<td>Safeguarding Assurance Committee Minutes  - noted</td>
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<tr>
<td>9.2</td>
<td>BHRUT SI Panel Meeting Minutes – the Chair referred to page 5 item 4.10 and questioned ‘deferred to April meeting’ under the outcome column. CK explained that the SIs are looked at collectively at the meetings and then a key line of enquiry (KLoE) covering them all is instigated.</td>
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<tr>
<td>9.3</td>
<td>NELFT SI Panel meeting Minutes - noted</td>
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<td>9.4</td>
<td>BHRUT CQRM Minutes - noted</td>
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<tr>
<td>9.5</td>
<td>NELFT CQRM Minutes - noted</td>
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<tr>
<td>9.6</td>
<td>WX CQRM Minutes - noted</td>
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<tr>
<td>9.7</td>
<td>Q&amp;S draft inset for the annual reports – The Chair explained that the extract would be included in the CCGs annual reports for the last financial year and</td>
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asked if anyone had any comments or anything to add under the Committee effectiveness heading. She said she felt that attendance has improved and that the meetings have more focus. SH agreed that the meetings have improved on last year. The Chair continued by thanking the Committee members and attendees for the work achieved during 2016/17. No additional comments were given for inclusion in the extract.

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<th>10.</th>
<th>Any other business</th>
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<td>IT system at BH – SH reported that there has been a significant IT problem at BH since 20 April which was impacting on pathology results. She read out an e-mail she had received and the Committee deemed from that that the Trust had put their contingency plan in place.</td>
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<tr>
<th>11.</th>
<th>Date of next meeting</th>
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<tr>
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<td>27 June 2017</td>
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Minutes of the meeting

Present:
Lorraine Silver (LS) PEF Chair, Fairlop
Vivien Nathan (VN) PEF Vice Chair, Cranbrook and Loxford
Howard Clarke-Melville (HC-M) PEF member, Seven Kings
David Lyon (DL) PEF member, Fairlop
Dee Datta (DD) PEF member, Cranbrook and Loxford
Khalil Ali (KA) Lay member
Elaine Freedman (EF) PEF member, Seven Kings
Boba Rangelov (BR) PPE Advisor BHR CCGs
Swati Vyas (SV) Health Partnership manager, Redbridge CVS
Christine Lewis (CL) PEF member, Wanstead and Woodford
Jean Cowie PEF member, Fairlop
Karen Douglas Uniting Friends, support worker for Mr Elliff
Kenneth Turner (KT) PEF member, Cranbrook and Loxford
Naina Thaker Redbridge Healthwatch
Raina Gee (RG) The Redbridge Youth Council Co-ordinator
Vanessa Madu The Redbridge Youth Council rep
Nancy Palumbo The Redbridge Youth Council rep
Filiz Zaman (FZ) PEF member, Fairlop
Louise Mitchell (LM) Redbridge CCG Chief Operating Officer

Apologies:
Harjit Sangha (HS) PEF member, Cranbrook and Loxford
John Elliff (JE) Uniting Friends, LD representative
Andrea Leathers Uniting Friends, LD representative
Jon Abrams (JA) Redbridge Forum representative
Michelle Greene (MG) PEF member, Wanstead and Woodford
Tahir Mahmud (TM) PEF member, Seven Kings
Dr Jyoti Sood Redbridge CCG Clinical Director

Absent:
Shani Fooker (SF) PEF member, Seven Kings
Chandrakant Patel PEF member, Wanstead and Woodford

Item | Action
---|---
1 | Welcome and apologies
Chair welcomed everyone, introductions were made and apologies accepted.
LS expressed her sadness over the passing away of Mr Jay Solanki,
previous PEF member.
The PEF congratulated BHRUT on being taken out of special measures. KT suggested sending a letter to the BHRUT CEO and congratulating him on this achievement.
**ACTION:** BR to draft the letter on behalf of PEF

### Minutes and matters arising (including PEF log)

#### 2

#### 2.1 Minutes
Minutes were approved as a correct record of the meeting.

#### 2.2 Matters arising
Matters arising: All actions completed.

#### Sustainable Transformation Programme (STP)
BR confirmed that the STP event that was planned to take place on 27 March has been cancelled.

**ACTION:** NT to send information to BR about Waltham Forrest STP event to circulate it to the PEF.

#### 2.2.1 KA and VN
KA and VN provided an update on the latest Chairs/Vice-Chairs and Lay members’ meeting. BR explained the structure of the B&D PEF and Havering PERF.

**ACTION:** BR to chase up with BHRUT the response for VN regarding staff assaults.

The PEF discussed the issues raised by the Age UK Voices of Experience patients’ group that have been to the Redbridge PEF. The members agreed that it would be more appropriate and in line with the PEF constitution to create a separate log of issues being raised by this and other community groups. This log would be called “The Community log”.

**ACTION:** BR

### 3.0 Redbridge CCG Lay member report

#### Khalil Ali

#### 3.1 KA presented his report.

#### 3.2 KA pointed out the rating given for our CCGs’ PPE work by the NHS England. We scored “green” rating across BHR CCGs, which is a good achievement. However, KA said that there is always room for improvement.

### 4.0 Healthwatch Redbridge report

#### Naina Thaker

#### 4.1 VN asked if they did any work regarding older people being re-admitted after being discharged. NT replied that they emailed care homes and asked about discharge. KT congratulated Healthwatch Redbridge on organising the event in Stratford which was very useful.

### 5.0 The Youth Council - Vanessa Madu and Nancy Palumbo with Raina Gee, YC Co-ordinator

#### 5.1 The young people provided an update about the recent activities of the RYC.

### 6.0 “Spending NHS money wisely” Louise Mitchell, Chief Operating Officer, Redbridge CCG

#### 6.1 LM gave a brief overview of the current challenging situation regarding the financial position of the BHR CCGs.
The launch of the consultation is next week. A proposal is to stop some services; restriction of the eligibility who can access those services. LM said that we have to utilise public money and use it wisely. We have to protect some essential services (emergency services, life threatening conditions etc.).

There is a clinical exception: Individual Funding Request (IFR). There is a panel that makes decisions if the funding can be provided. The outcome must be good for the patient.

An engagement document has been written up and it was sent to all our PEF/PERF Chairs and Vice-Chairs for their comments. It is important to get
views of local people.

HC-M asked what would be the impact if we don’t save 55 million pounds and also why the consultation is for 8 weeks and not 12 weeks, as usual. LM replied that regulator can take decisions away from us and there are situations when the consultation can be shorter. We wrote to the Compact if they are going to support an 8 week consultation. ZA added that there is no national guidance as to how long the consultation should last.

DD asked how much cost saving will be made with the health tourism. LM said in terms of medication review, LM said that if people are affected significantly they will consult with the group.

VN asked if they had a conversation in regards to the termination of pregnancy. LM replied that this has not been discussed.

VN asked how effective will the questionnaire be on line. LM replied that they will also conduct face to face consultations. ZA added that they will also use social media. LM said that this consultation will affect specific groups of patients and that there is no saving per person.

DL asked how the 55 million pound deficit compared with the CCG budget. LM replied that this sum is about 5% of the total CCG budget. It is rare to achieve a 100% saving.

KT stated that the patients who are waiting for cataract operations and hip replacements are groups that will certainly be affected. LM said that the POLCE policy is an existing policy and it is important to implement it properly.

SV asked what the cut-off date is for the consultation. LM replied that anything new that will be subject to restriction or cessation will take effect from 1st July this year.

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<tr>
<th>7.0</th>
<th>PPG Log</th>
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<tr>
<td>7.1</td>
<td>BR went through the log. Nearly all the issues and responses have been received and presented to the PEF.</td>
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<th>8.0</th>
<th>AOB</th>
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<tr>
<td>8.1</td>
<td>DD mentioned patients being discharged from clinics because they didn’t attend their appointment. <strong>ACTION:</strong> DD to email NT regarding this issue</td>
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<tr>
<th>9.0</th>
<th>Forward Planner</th>
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<tr>
<td>9.1</td>
<td>All the topics requested by the PEF members have been added to the Forward Planner.</td>
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<tr>
<th>10.0</th>
<th>Close and date of the next meeting</th>
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<tr>
<td>10.1</td>
<td>LS closed the meeting and thanked everyone. <strong>The next meeting is on Tuesday, 9 May 2017, Becketts House, Ilford, IG1 2QX, 2nd floor, boardroom A.</strong></td>
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**Dates of the PEF meetings in 2017:**
- Tuesday, 11 July 2017
- Tuesday, 12 September 2017
- Tuesday, 14 November 2017

All meetings are held 5-7pm in Becketts House, 2nd floor, boardroom A

**Glossary**
- PEF: Patient Engagement Forum
- CCG: Clinical Commissioning Group
- YC: Youth Council
- CVS: Council for Voluntary Service
- PPE: Patient and Public Engagement
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tr>
<td>PPG</td>
<td>Patient Participation Group</td>
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<td>BHR CCGs</td>
<td>Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups</td>
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<td>IAPT</td>
<td>Improving Access to Psychological Therapies</td>
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<td>BHRUT</td>
<td>Barking Havering and Redbridge NHS Trust</td>
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<td>CAMHS</td>
<td>Children and Young People Mental health services</td>
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<td>RTT</td>
<td>Referral to treatment</td>
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<td>AIS</td>
<td>Accessible Information Standard</td>
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<td>DNA</td>
<td>Did not attend</td>
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<td>CQC</td>
<td>Care Quality Commission</td>
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<td>ECTC</td>
<td>Elective Care Treatment Centre</td>
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<td>STP</td>
<td>Sustainable Transformation Programme</td>
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<td>LD</td>
<td>Learning Disability</td>
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Joint Executive Committee  
9 February 2017  
MINUTES

<table>
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<tr>
<th>Present</th>
<th>Title</th>
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<tbody>
<tr>
<td>Dr Waseem Mohi</td>
<td>Chair – Barking and Dagenham CCG</td>
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<tr>
<td>Dr Gurkirit Kalkat</td>
<td>Clinical Director – Barking and Dagenham CCG</td>
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<tr>
<td>Dr Kanika Rai</td>
<td>Clinical Director – Barking and Dagenham CCG</td>
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<tr>
<td>Dr Rami Hara</td>
<td>Clinical Director – Barking and Dagenham CCG</td>
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<tr>
<td>Dr Ravi Goriparthy</td>
<td>Clinical Director – Barking and Dagenham CCG</td>
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<td>Dr Jagan John</td>
<td>Clinical Director – Barking and Dagenham CCG</td>
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<td>Dr Anju Gupta</td>
<td>Clinical Director – Barking and Dagenham CCG</td>
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<td>Sharon Morrow</td>
<td>Chief Operating Officer – Barking and Dagenham CCG</td>
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<td>Dr Atul Aggarwal</td>
<td>Chair – Havering CCG</td>
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<tr>
<td>Dr Maurice Sanomi</td>
<td>Clinical Director – Havering CCG</td>
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<td>Dr Alex Tran</td>
<td>Clinical Director – Havering CCG</td>
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<td>Dr Ranjan Adur</td>
<td>Clinical Director – Havering CCG</td>
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<td>Alan Steward</td>
<td>Chief Operating Officer – Havering CCG</td>
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<td>Richard Coleman</td>
<td>Lay Member – Havering CCG</td>
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<td>Dr Anil Mehta</td>
<td>Chair – Redbridge CCG (meeting Chair)</td>
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<td>Dr Sarah Heyes</td>
<td>Clinical Director – Redbridge CCG</td>
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<td>Dr Mehul Mathukia</td>
<td>Clinical Director – Redbridge CCG</td>
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<td>Dr Jyoti Sood</td>
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<td>Dr Syed Raza</td>
<td>Clinical Director – Redbridge CCG</td>
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<td>Dr Anita Bhatia</td>
<td>Clinical Director – Redbridge CCG</td>
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<tr>
<td>Khalil Ali</td>
<td>Lay Member – Redbridge CCG</td>
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<td>Louise Mitchell</td>
<td>Chief Operating Officer – Redbridge CCG</td>
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<td>Conor Burke</td>
<td>Chief Officer – BHR CCGs</td>
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<td>Tom Travers</td>
<td>Chief Financial Officer - BHR CCGs</td>
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<td>Marie Price</td>
<td>Director of Corporate Services – BHR CCGs</td>
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<tr>
<td>Jane Gateley</td>
<td>Director of Strategic Delivery</td>
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<td>Steve Ryan</td>
<td>Secondary Care Consultant – B&amp;D and Havering CCGs</td>
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<td>Kash Pandya</td>
<td>Lay Member – BHR CCGs</td>
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**In attendance**

- Gina Shakespeare Programme Director (item 4.0)
- Alastair Finney Barts Health - Whipps Cross Strategy Programme Director  (Item 6.0)
- Kirsty Boettcher Deputy Director of Strategic Delivery (item 6.0)

**Apologies**

- Dr Ann Baldwin Clinical Director – Havering CCG
- Dr Gurdev Saini Clinical Director – Havering CCG
- Dr Ashok Deshpande Clinical Director – Havering CCG
- Dr Shabana Ali Clinical Director – Redbridge CCG
- Dr Shujah Hameed Clinical Director – Redbridge CCG
- Dr Muhammad Tahir Clinical Director – Redbridge CCG
1.0 Welcome, Introduction and apologies
The Chair welcomed members to the meeting and apologies were noted.

2.0 Declarations of interest
There were no new declarations of interest declared.

3.0 Minutes from the previous meeting
The minutes from the previous meeting were agreed.

4.0 Financial Recovery and system delivery plan
Conor Burke introduced the paper and provided an overview of the background and the current challenge, highlighting the requirement for a credible system financial recovery plan to be agreed and submitted to regulators by 28 February 2017.

Conor outlined the programme management office arrangements and introduced Gina Shakespeare, who will be working alongside Jane Gateley, acting jointly as programme co-directors for the system delivery framework. Conor confirmed that the single BHR delivery plan will be the main focus for the CCGs for the next 12 months and stressed the importance of clinical leadership in the support, development and implementation of all projects. In order to support this it is proposed that going forward a weekly meeting is held to ensure there is clinical input into plans and to allow members to be briefed on progress and for the Clinical Directors to raise any related issues so that they can be resolved quickly. Conor advised it has been suggested that a joint meeting of the Board of BHRUT and the CCGs governing body members be arranged for March and this will be critical to the sign off of the joint plan with the trust.

Dr John asked for it to be noted that if there are any clinical leads involved in projects that are not Clinical Directors, they also need to be involved in relevant meetings.

Dr Tran raised concerns of patient safety with some of the proposed schemes but was assured that following a quality impact assessment should there be any impact on clinical risk and patient safety then these would not go ahead.

Dr Heyes requested a communications strategy to help members deal with queries raised by their patients and asked for learning from other CCGs that have already been through this process to be fed in. It was agreed it would be useful for relevant staff from those CCGs to be invited to present at the PLE/PTI GP learning events.

Dr Rai requested that going forward, when the questions are proposed to bidders in the tender process that there is more of a clinical focus than this is currently.

Gina Shakespeare presented the system delivery framework slides which provided an overview on the principles of the BHR Systems and Delivery Performance Board, ICP governance arrangements, current position and assurance rating of each scheme.

Steve Ryan commented that we need to be mindful of BHRUT and NELFT’s own financial plans. Kash Pandya asked about the gap between QIPP savings plan and cost improvement plans. Conor advised there will be further work and analysis to ensure alignment and reconciliation of these. It was also noted that while BHRUT is the main priority that work with other providers and partners will develop going forward.

There was a query raised about provision of back fill payments to surgeries to allow Clinical Directors to be involved with this work but Conor advised that their current sessions under their
existing contract need to be fully utilised before any additional payments will be considered.

Conor confirmed that to support the delivery of the transformation programmes there has been a proposed change to the structure to formally align management resource to the transformation programmes, which includes the development of the existing primary care team to further support practices. Marie Price confirmed the staff consultation closes on Friday 17 February and any comments should be sent to her in advance of this date.

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<th>5.0</th>
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<td>5.1</td>
<td>Collaborative risk log</td>
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<td>Members were asked to note the risks outlined.</td>
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<td>Alastair Finney gave a brief overview of the case for change and vision for redevelopment of the Whipps Cross hospital site, including history of the site, current and predicted patients numbers and next steps. This includes a Strategic Outline Case being finalised and endorsed by North East London STP Partner organisations, before an Outline Business Case is developed. Redbridge residents make up over 25% of the patients to the hospital so it is important that the BHR CCGs are fully engaged in any redevelopment plans.</td>
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Some of the comments and points noted from members were:
- When the focus is now on community care why develop a hospital?
- There needs to be a clinical strategy for Barts Health and the system with all partners in North East London, which needs to be flexible enough to change based on long term requirements
- There should be learning taken from past hospital developments
- Need to be smarter around awareness of possible technological advances and how this could have an impact on future requirements
- Having the flexibility of bed status is important
- Barts Health has one of the biggest financial deficits in the country and there could be a risk that there is a request for commissioner contribution in the future

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<th>7.0</th>
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<td>It was noted that Dr Adur is retiring as a Havering CCG Clinical Director and a GP.</td>
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<th>8.0</th>
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<td>Thursday 13 April 2017, 1.30-3.30pm at Becketts House</td>
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