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## Register of interests 2015/16

### Declaration of governing body members

**Last updated: April 2016**

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<tr>
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<th>Nature of interest</th>
<th>Amendment and date</th>
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<tr>
<td>Dr Waseem Mohi</td>
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<td>Markyate Surgery</td>
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<td>Jacqui Himbury</td>
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Item | Action
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1.0 | Welcome and apologies
The Chair welcomed members to the meeting.
Apologies for absence were noted.

1.2 | Declarations of conflicts of interest
There were no additional declarations of interest. It was noted that SW was no longer a member of Healthwatch Newham.

1.3 | Minutes of the last meeting
The minutes of the meeting held on 26 January 2015 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:
- Clinical director elections
- 360 survey
- Kings Fund clinical leadership programme

The Chair thanked Dr Mohan for his commitment to Barking & Dagenham and wished him well during his retirement.

The governing body noted the report.

2.2 Chief Officer's report
The chief officer presented his report covering the following areas:
- Devolution/Accountable Care Organisation (ACO)
- Urgent and emergency care vanguard
- Primary care transformation
- Health & Wellbeing Board
- Sustainable Development update

The governing body noted the report.

3.0 Governing body assurance

3.1 Governing body assurance framework
GH 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 performance for the 62 days target
4. Improved access to psychological therapies (IAPT)
5. Quality, innovation, productivity and prevention (QIPP) delivery
6. Barts Heath contract financial risks

KP suggested that in the next version of the GBAF a review of risk target date and timelines as it is unlikely that some risks will be mitigated by the stated date. The chair agreed adding it was important to give assurance that risks will be mitigated.

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 that 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 by the Integrated Care Coalition and System Resilience Group.

The CCGs are working closely with the Trust Development Agency (TDA) and NHS England (NHSE), as well as local partners as the "system leader" to ensure that performance is recovered and then sustained.

A&E – BHRUT had performed reasonably well over the Christmas and new year period, however January, February and March have seen a significant rise in demand and decrease in performance which has also been the national picture. Colleagues focussed on emergency care transformation exploring how to support and manage this rise in demand.

RTT – The Trust Board report had attracted media attention due to significant numbers of patients waiting over 52 weeks for treatment. Strengthened programme board arrangements have been established to review all specialities and to manage this ongoing issue.

Cancer - The target is being well managed although the Trust did not implement its plan by January and has now agreed delivery by May. The Chair questioned if there is anything the CCG can do to support the Trust. CB responded that the Trust have invested in a cancer management team which is delivering and will continue to support the Trust but expect it to remain an issue for the foreseeable future.

SR referred to the clinical harm review process and questioned if it has been adapted given the number of patients awaiting treatment. CB responded that he had received assurances around the clinical
harm review process but was engaging a third party to review patients but no significant clinical harm issues have been identified.

MC asked if the GP alert system is in place. The Chair confirmed that the new system will be live from April.

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

### 3.3 Delivery of IAPT operating plan standards

GH presented a report which provided an update on actions that are being taken to improve performance against the Improving Access to Psychological Therapies (IAPT) standards.

Although the CCG did not deliver the access standard in 2014/15 or in Quarters 1 and 2 of 2015/16, it did meet the standard in Q3 following the implementation of a recovery action plan to increase activity into the service. The CCG is predicted to achieve the access standard again in Q4, with January’s performance being very close to the target (1.24% against target of 1.25%) and the expectation that this slight underperformance in January will be recovered in February and March. The CCG has seen underperformance against the recovery standard of 50% in 15/16. Current waiting times for B&D are less than 5 weeks.

SW expressed concern around access to the IAPT service. CB responded that Barking & Dagenham CCG are meeting the target and understands that there have been issues with access in Redbridge which are being dealt with separately. He added that Barking and Dagenham treatment outcomes are the best in London and was assured that a good service was available for Barking and Dagenham residents.

The Governing Body noted the recent performance against the IAPT standards and the actions being taken to recover performance in quarter 4.

### 3.4 PMS services review update

The Chair, RA and JJ declared an interest in the item as PMS contract holders at their GP practices.

CB presented a report which updated the position regarding the Personal Medical Services (PMS) review, namely:

- the ‘London offer’ agreed between NHS England (London) and London’s Local Medical Committees and
- the draft commissioning intentions and the overall funding position for the CCG.
• advise that a Equality Impact Assessment (EIA) is being completed.

JJ commented that Barking and Dagenham has the biggest risk across BHR for practices to close down and was concerned there had been no communication with regard to this. He added that a number of practices have contacted the LMC to report they have no confidence in the future viability of their practices. He did acknowledge the support that Sarah See had offered but wanted to highlight the real concern around the future of some practices. SW reported that the patient engagement forum echoed these concerns.

CB acknowledged the concerns highlighted and agreed that more engagement with practices and the public was needed which will be led by the Primary Care Commissioning Committee.

KP referred to the impact of the budget shortfall and if this is until 2021. TT responded that it is proposed to reinvest the premium so as not to cause a pressure and 2021 is included to recognise the risk and proposal of transition arrangements. CB added that this will be included in the risk register for Barking & Dagenham so an update will be given at each meeting.

The Governing Body noted the agreed ‘London offer’ for PMS agreements and agreed that review and discussion on these matters including the impact at individual practice level take place at the Primary Care Commissioning Committee.

### 4.0 Corporate strategy and planning

#### 4.1 Operational planning 2016/17 update or submission

GH presented a report which provided a narrative summary of the draft Operating Plans submitted on the CCG’s behalf on 8 February and 2 March 2016 and describes the next steps required to develop plans for the full and final submission on 11 April.

It also provides an update on the Better Care Fund Plan submissions in March and the next steps required to develop plans for the final submission on 25 April.

SW expressed concern that the anticipated drop in activity cannot be reached. GH responded that this reduction is expected due to the significant transformation in activity due to the vanguard. TT added that the CCG have been mandated to achieve this reduction in activity. SR suggested that learning from the IAPT programme could be taken forward into demand management.

JH reported on the work to develop plans for transforming services for patients with learning disabilities and the engagement to collect views of patients to shape these services.

The governing body:

- Noted the information given regarding the draft Operating
Plan submissions already made, and the final 11 April submission
- Noted the information given regarding the draft BCF Plan submission already made, and the second draft due on 21 March and final 25 April submission
- Approved to give delegated authority to the BHR CCGs’ Chief Finance Officer and Chief Officer to sign off the final submissions ahead of the 11 April and 25 April submission dates.

4.2 2016/17 Financial planning report

TT presented an update on the 2016/17 Financial Plan.

The draft plan sets out a planned 1% surplus of £2,703k, with the CCG planning to achieve the surplus in line with the required statutory duty. The paper identifies key assumptions and risks to achievement of the CCG’s financial targets in 2016/17.

The draft plan assumes achievement of business rules in relation to:
- 1% Surplus
- 0.5% Contingency.

The plan currently includes a significant level of financial risk as highlighted in Section 5 of this report.

The main risk factors include:
- Acute activity growth above the planned demographic levels.
- The current significant gap between CCG and provider positions in the 16/17 contract negotiations.
- Current business rules limit the scope to apply contract levers.
- The risk of QIPP schemes not delivering to the expected and planned levels.
- Additional costs associated with constitutional standards.
- Other risks include potential for Prescribing and Continuing Care costs to exceed planned levels.

The only reserve mitigation to these risks is the 0.5% contingency within the plan. The QIPP requirement in the plan is £7.6m (3%).

KP questioned if NHSE are aware of the difficulties the CCG are facing and that we may not meet our financial targets. TT confirmed that NHSE have been briefed on the deficit budget and was continuing discussions with them on this issue.
The Chair questioned how the CCG will manage if the RTT issue is not resolved. TT responded that discussions continue to explore if the 1% uncommitted reserve across the patch could be used to offset the risk.

KP questioned what progress has been made for next years QIPP plan. TT responded that progress continues with a confirm and challenge session being held shortly.

The Chair questioned if there is any flexibility to manage RTT in a different format. TT responded that the clinical reference group has been set up and will be looking at referrals and volumes into the Trust. He added that the group would also be looking at alternative provision from the independent sector.

The Governing Body noted the high level of financial risk and approved the draft financial plan for 2016/17 which is consistent with the latest Operating Plan submission to NHS England (NHSE).

A further Operating Plan submission will be sent to NHSE in early April.

An updated set of financial plans/budgets will be presented to the next Governing Body meeting. These will be consistent with the updated Operating Plan.

### 4.3 Primary care strategy update

CB presented a report on progress with the primary care transformation strategy and the timetable for its completion to enable assurance that there is sufficient stakeholder engagement in the review and refinement of the strategy prior to formal governing body review in May 2016.

MC welcomed the update and highlighted the need to have localities that work geographically and the importance of understanding what makes people unwell and how the self-care model can support primary care. He also highlighted that variation in performance across practices needs to be explored.

The Chair welcomed these suggestions and public health support to work closely with the CCG on the locality model.

JJ suggested that the growing need in Barking Riverside needs to be fed into the locality planning. GK agreed adding that the changing demographic and growing population highlighted the need to improve and increase services at Barking Riverside which have limited health services available.

The governing body:
- Noted the contents of this progress report;
• Agreed the programme of stakeholder engagement planned to review and refine the strategy proposals so that the strategy can be finalised; and receive the final strategy at its meeting in May 2016.

4.4 **CCG strategic direction 2016/17 and onwards**

CB presented a report which provided an overview of the overall strategic direction for the coming years, both for the CCG and the wider BHR health and social care economy.

The governing body noted the update.

## 5.0 Service transformation and development

5.1 **Improving patient flow - front of A&E and supporting discharge business case**

JJ presented a business case to recurrently fund additional nursing and occupational therapy support that has been funded to date through non-recurrent operational resilience (winter pressures) money, and which have demonstrated system benefits since they commenced in November 2014.

The operational resilience money was used to fund additional nursing staff to work with Emergency Department in Queen’s hospital to support achievement of the 4 hour wait target by identifying patients who are appropriate for community support and safely discharging them from A&E, and for additional nurses and occupational therapists to in-reach into wards to reduce length of stay.

The business case indicates that the enhancement of support in the front of A&E has led to 402 avoided admissions (with an estimated saving of £366k). The in-reach service has achieved a reduction in the the total length of stay equivalent to a saving of 46 beds (compared to 2014).

If funding was ceased for these services then length of stay may increase and directly impact on patient flow and A&E performance. The business case sets out a preferred option to maximise benefits and minimise cost.

The Chair questioned if there is any feedback on patient experience of the service and if community providers have responded with suggestions to build on the service. JJ confirmed that patient experience was excellent and future redesign of services was ongoing with support of the vanguard process.

CB summarised that the service has been in existence for two years on a non recurrent basis. He added that performance of the scheme has been good and supports that the scheme continues and proposals around future redesign. SR referred to the 46 bed
saving and suggested that a deep dive could be explored to understand where these savings are and quality gains.

The governing body agreed to continue to fund these services in 2016/17.

5.2 Response car – London Ambulance Service and Community Treatment Team business case
JJ presented a business case to continue funding the London Ambulance Service and Community Treatment Team service which was established in October 2014 and was funded from 2014/15 Operational Resilience Funding (the cost of the car was covered by the London Ambulance Service (LAS) from October to December 2014). It was set up by LAS and the Community Treatment Team (CTT) from NELFT to support the reduction in admissions/attendances and conveyances to an Emergency Department. Funding was agreed for 2015/16 through the System Resilience Group.

The service consists of an ambulance car, staffed by a paramedic and a CTT nurse and responds to appropriate falls calls (criteria including the patient being over 65) identified by the LAS Control Centre. The team then do a full assessment of the patient in their own home and where possible keep the patient at home and avoid unnecessary conveyance.

From April 2015 to January 2016 the team visited 1,150 patients and managed to keep 818 of these at home (71%) avoiding the need for an emergency ambulance, A&E attendance and admission (where that would have been appropriate) and it is estimated that there is a net saving of £390,827 as a result of the service being in place.

The governing body agreed to continue funding for this service in 2016/17.

6.0 Quality and performance

6.1 Patient experience report
SW 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 last patient engagement forum (PEF) meeting and activities of PEF members.
- International Day of Disabled People 2016 planning
- The stroke rehabilitation consultation
- Progress in developing our new engagement strategy
- Progress in our Equality and Diversity Standard 2 (EDS2) work
The Chair asked if there was any update on future use of patient stories. MP responded that this was being explored as part of the patient engagement strategy to ensure these add value.

The governing body noted the report.

6.1 Finance and activity report

TT presented the month 10 finance and activity report highlighting that the CCG has agreed a revised risk assessed forecast outturn of £3,352k with NHSE. This represents a 1.14% surplus rather than the original planned 2% surplus. The revision to the forecast was based on a risk assessed view of the underlying data driving the month 6 year to date and forecast positions. As at the end of January (Month 10) the position has remained stable and the CCG has maintained a 1.14% forecast surplus. At month 10 this represents year to date slippage of £1,623k against the original year to date planned surplus of £4,417k and £1,948k slippage against the original planned full year 2% surplus.

Further mitigating actions will be required and implemented over the rest of the financial year. Trends of activity are being closely monitored to inform the on-going management of this risk assessed position, and the recurrent impact upon the 2016/17 position.

In previous months a risk range including a downside scenario has been presented to the Governing Body. Risks identified have spread across a number of areas including acute activity, prescribing and continuing care. The main driver behind the reported position is Barts Health, where a significant over performance is reported. The latest risk assessed forecast overspend is £2,470k or a 14% contract pressure.

The resource limit for 2015/16 is now £295,522k. The Month 10 budgets have been increased to reflect five allocations this month totalling £1,696k.

Reported figures are based on the Month 9 monitoring data from providers and adjusted for outstanding challenges, contract penalties and fixed price contract agreements.

Barts Health - The Month 9 data before adjustments indicates a high level of year end over performance. The Barts Health contract continues to present the largest financial risk to the CCG. The latest data received from the Trust highlights over performance reported across a range of points of delivery, including non-elective, critical care, elective care, maternity pathway, outpatient procedures, high cost drugs and treatments and unidentified QIPP schemes. A number of challenges have been made and the reported position includes assumptions that a number of challenges are successful,
and that the worsening activity trends are mitigated. The CSU have carried out further analysis of the Barts position and risk rated the issues identified, to further inform the reported outturn position.

BHRUT – A fixed price contract has been agreed with BHRUT for 2015/16, including non-recurrent funding to support the delivery of the QIPP schemes and the achievement of key performance indicators, ensuring system sustainability in the coming years. The fixed price also includes funding to ensure operational resilience during winter and meet the targets set to address the RTT backlog at the Trust. The 2015/16 contract is being managed under full PbR rules, as in previous months there were a number of issues with the Month 9 data and the finance and activity plans. These are being flagged for correction with the Trust through the TSG and SPR meetings.

As highlighted in previous reports the CCG faces a number of risks that may further impact the financial position. These include: further acute activity growth above planned levels, continuing care growth and prescribing growth. A number of mitigations are in place attempting to off-set these risks and include robust contract management, PMO QIPP process and on-going review of investments.

KP welcomed the report and was pleased to note the Barts Health position. He questioned if the issue of the BHRUT extra charges had any impact. TT confirmed there was no additional impact in 15/16.

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

6.3 Quality in commissioning report

JH presented a report which provided assurance that the CCG continues to implement the recommendations and requirements from the Transforming Care Programme (previously referred to as Winterbourne View) recommendations, quality and safeguarding improvement plans, actions to reduce health inequalities along with new initiatives around compliance with Francis.

The following specific areas were covered:

- Transforming Care Programme
- Safeguarding
- Special Educational Needs and Disability (SEND)
- Maternity commissioning
- Quality of care in Care Homes (with Nursing)
- Frances Report – Duty of Candour
- Berwick/Winterbourne

The governing body noted the report.

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<th>7.0 Development/governance</th>
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<td>7.1 Revisions to committee terms of reference and establishment of an auditor panel</td>
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MP presented a report which requested approval to amend membership of the following committees of the governing body:

- **Audit and Governance Committee**: The secondary care consultant was included as a member of the committee in 2013 initially because there was a concern that the committee may struggle for quoracy. It was acknowledged that this was not the best use of secondary care consultant expertise. The meeting has not been inquorate in the three years that it has been in operation. It is therefore recommended that secondary care consultant be removed as a member.

- **Remuneration and Workforce Committee**: See above for rationale. There is not an additional co-opted member on this committee, but again there have not been issues with quoracy. It is therefore recommended that secondary care consultant be removed as a member.

- **Investment Committee**: because the committee deals with matters where there are conflicts of interest there is a greater risk that this committee could be inquorate on occasion. It is therefore proposed that the quorum be amended to enable members of other CCGs e.g. lay member for PPI, chair or secondary care consultant from another CCG to be included as a substitute member should there be a quoracy issue for one or more of the CCG committees (recognising that this is three committees meeting as one). This is in line with how we have made decisions previously where one or members have not been able to take part in a discussion or decision due to a conflict of interest.

- **Primary Care Committee**: The terms of reference have been updated in line with the recommendations to this governing body on 20 January 2016.

- **Quality and Safety Committee**: That the Redbridge secondary care consultant continues to act as chair of the committee for 2016/17. That the CCG chairs nominate
attendees for 2016/17 who can commit to the schedule of meetings as outlined.

- **Establishing an auditor panel:** The Local Audit and Accountability Act 2014 requires CCGs to appoint an auditor panel, which will advise on the appointment of external auditors for 2017/18. The governing body must decide how it appoints the panel and it can be an existing committee. Nationally, draft TORs have been prepared that assume the audit committee will perform this function. It is therefore recommended that our existing Audit and Governance Committee act as the auditor panel.

The governing body approved the recommendations and agreed that the Audit and Governance Committee act as the auditor panel.

### 7.2 Finance & delivery committee report

The chair presented a report which provided key highlights of the finance and delivery committee held on 16 February 2016.

The governing body noted the report.

### 7.3 Audit & governance committee report

KP presented a report which provided key highlights of the audit and governance committee held on 19 January and 8 March 2016.

The governing body noted the report.

### 7.4 Minutes of sub committees:

The governing body noted the minutes of:

- Executive committee held on 17 February 2016.
- Patient engagement forum held on 17 January 2016.
- Joint executive team committee held on 14 January 2016.
- Primary care commissioning committee held in December, January and February 2016.
- Investment committee held in October 2015 and February 2016.

### 8.0 AOB

There was no other business.

### 9.0 Questions from the public

Mr Henry Dodds asked the following questions:

“Back in January 2015, I asked what plans are to be formulated in terms of healthcare support for the extra demand of the expanding population in the Barking Riverside area. The response was understandably lacking in detail due to the fact
that the London Overground Extension had yet to be approved which would be a key factor in giving the go-ahead for housing developments, and that NHS England are responsible for the commissioning of primary care services such as GPs at the time. There was also mention of a project team (consisting of LBBD, CCG and NHS England and others) which would deliver in 2017/18 in which the CCG thought they would take a lead role in the development of co-commissioning.

Since my initial enquiry over a year ago, the Overground extension has been approved and has secured funding which has opened up the go-ahead for the complete development of the 10,800 homes in the masterplan and L&Q have taken a stake in the development, promising in their press statement to speed up delivery of housing. I am also led to believe that the Barking and Dagenham CCG has, since April 2015, taken on responsibility for commissioning of GP services (source: https://www.england.nhs.uk/2015/02/commissioning-of-gp/)

Barking Riverside has also been named as one of 10 “Heathy New Towns” by NHS England (source: https://www.england.nhs.uk/ourwork/innovation/healthy-new-towns/), which include pilot measures such as “accessing new GP services using digital technology” however nobody linked with this pilot we have spoken to has any clue about upcoming provision for GP services in the area.

It is also apparent to many residents that the nearest and only GP services at Thames View Medical Centre are struggling with the influx of new patients. It would be good to get views from the two lead GPs at the centre who on your governing body, Dr John and Dr Kalkat, on the local population density and capacity in the area and the impact this is having on current primary healthcare provision.

I have over the past 6 months spoken to Barking and Dagenham Council, NHS England, NHS England London, the project lead for “Heathy New Towns” and many more key stakeholders, none of which have any news on plans for the area in terms of healthcare. I even tweeted @BD_CCG in which the response was a very vague “We’re working with @lbbdcouncil to understand pop growth in the area & existing GP services to see what may be needed in future”. After trying to gain any information about the future of healthcare in the area, it is becoming clear that few people care about forward planning, hopefully today residents can get some clear answers from the governing body.

Could the CCG Governing Body please update on the plans for supporting the residents of Barking Riverside, including (but not limited to) new GP services in the local area, and any other service that the CCG has a hand in commissioning, co-commissioning or
having a hand in providing.

Has the project team (described at the January CCG governing body meeting) been set up yet, what named individuals are on it and are they still planning on “delivering” in 2017/18, and what sort of delivery of new primary care services would this entail? Planning for healthcare support to Barking Riverside is overseen by the Barking Havering & Redbridge CCG Finance and Estates Group and has been an agenda item for the past 9 months. The Finance and Estates Group is developing a Strategic Estates Plan which aligns with the commissioning plan for the area and the Barking Riverside development is recognised in the draft plan.”

Gemma Hughes provided the following response.

“Over the past six months CCG representatives have met with the developer and the London Borough of Barking & Dagenham (LBBD) regeneration team to take forward the planning for health services for Barking Riverside. The main area of work has been the review of housing projections, as they have been updated, and the phasing of the development to inform the healthcare planning process.

Outline planning permission has been granted for 10,800 homes to be completed by 2030. Phase 1 has been completed and includes 686 housing units.

A project group has been set up to take forward the planning for healthcare services. The group comprises of the CCG – Senior Locality Lead – Planning and Integration, and Health of Primary Care Transformation working with the public health, LBBD regeneration and planning and a representative from the GLA. Members of the team are also part of the team responsible for the Barking Healthy Town bid.

In relation to phase 1, the nearest GP service for residents who have moved into the borough in phase 1 is provided from Thames View health centre, although residents may choose to register with other practices in the borough. GP budgets are uplifted annually to reflect population changes and demographic growth is negotiated in contracts with other healthcare providers.

Like many other CCGs, Barking and Dagenham is facing a number of challenges particularly increased demand for services and GP shortages. With this in mind we will be looking at different ways of providing care, we will be innovating, working with stakeholders and looking for new and different opportunities to ensure we provide primary care that meets the need of the local population. This is being co-ordinated through the development of a CCG primary care strategy which is due to be presented to the Governing Body in May
The strategy will set out our vision for primary care development and how we propose to take this forward. A number of initiatives have already been introduced in the past year to improve GP access, including the opening of two GP urgent care access centres providing evening and weekend services.

The majority of housing growth is expected to take place from 2020. The project group is working with public health to understand the health needs of people who move into Barking Riverside as each phase of the development is completed so that we can plan what health provision and what infrastructure needs to be provided within the development to meet those needs. We are in the process of completing some modelling work, based on development housing trajectories. A meeting of the project group took place on Wednesday 16 March to review the outcome of that modelling. This will be supported by a wider workshop in April with commissioners, health, social care, children’s services and planners to understand what this means for services and infrastructure given also the overarching requirement to move toward increasingly integrated provision in future. Clearly additional capacity and estates should only be brought on line as people move in to each phase of development so working through a timeline for this will also be important, ensuring that appropriate NHS estate requirements are built into planning applications."

MC explained that the council were the main lead overall and had been consulting local people. He recommended that Mr Dodds links in with the council.

Mr Dodds also asked if the IAPT service which was previously available on a Saturday is now closed. It was agreed to look into this and reply to Mr Dodds in writing.

NB - A letter was sent to Mr Dodds to confirm that there were a limited number of IAPT sessions being provided in Barking & Dagenham on Saturday mornings in 2014/15. There was limited demand for sessions, which was met by some of the clinicians working in the service at the time working flexibly to provide these. As clinicians have moved on from the service and been replaced with new staff who have not been able to offer quite so much flexibility, and demand reduced, these sessions stopped. Given the limited demand for Saturday morning sessions, and the impact on the service capacity to provide these, currently the Barking and Dagenham service doesn’t offer Saturday morning sessions. It does however offer evening sessions.

10.0 Date of the next meeting

24 May 2016.
To: Meeting of the NHS Barking and Dagenham Clinical Commissioning Group Governing Body

From: Dr Waseem Mohi, Chair

Date: 24 May 2016

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.

The key focus has been the escalated approach to tackling the problem of patients waiting too long to see consultants for planned care at BHRUT - known as referral to treatment (RTT). As I have said previously, this is unacceptable, and we have increased our resources targeted at addressing the issue.

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 Referral to treatment (RTT)
2.1 As governing body colleagues, members and stakeholders will be aware, there has been considerable concern over the long delays that some patients have experienced in relation to RTT wait times at BHRUT. It’s an issue that has been flagged within our Governing Body Assurance Framework and more detailed papers at this meeting over the last year. We have however over the past few months needed to escalate the issue further.

2.2 As commissioners we agree that we need to do more and ‘step-up’ our actions in dealing with the issue, both from a contractual side and as a membership body. As a result of the escalated action, a new joint RTT programme plan and governance arrangements have been established with additional resources focussed on tacking the issue.

2.3 The report on the agenda – item 5.1 – includes further information. I also want to emphasise the degree of clinical leadership that is focussed on tackling the issue.

2.4 With my fellow BHR chairs I have joined a weekly programme group meeting, initiated a weekly communication to our GP members and changed the remit of our monthly Joint
Executive Team (JET) meeting of clinical directors. The JET meeting now convenes as a Joint Clinical Reference Group with all BHR CCGs, clinical directors and management team and BHRUT’s chief executive, medical director and relevant senior consultants. We held the first such meeting, as a summit, on 14 April 2016. We agreed a number of urgent actions to:

- Approve a revised RTT improvement plan and governance arrangements
- Agree that there be better engagement between primary and secondary care clinicians
- Agree that each CCG takes a lead for three specialities and the alternative arrangements for those on behalf of all three CCGs
- Agree clear communications to all patients affected and key stakeholders.

2.5 The CCGs’ together are focussing on tighter performance and contractual management of BHRUT, as well as leading and implementing an enhanced demand management plan. As part of this we have sourced alternative provision so that we ‘turn off the tap’ of referrals to BHRUT for some specialities so that they can recover their position and treat those already awaiting treatment.

2.6 We are also exploring pathway redesign/community options for the medium term. GP and secondary care colleagues are pairing up on three specialities per CCG to work up the options and progress plans.

2.7 We held another Joint Clinical Reference Group meeting on 12 May where we had more detailed and practical clinical discussions on plans for the nine specialities that we are prioritising across the three CCGs. It was a productive meeting with helpful input from all sides.

3.0 New clinical director

3.1 I am pleased to welcome Dr Kanika Rai to our governing body as a new member. We have previously worked with Dr Rai on a number of projects and her experience will be a welcome addition to our organisation.

4.0 New CCG offices and intranet

4.1 I am pleased that we are finally in our new offices at Maritime House and to welcome you all to our first governing body meeting here. These new offices should facilitate better flexible working too and support colleagues from across BHR to spend more time with our local team.

4.2 We have recently re-launched our GP intranet which has been a real success with more useful information for our members included. We’ve had thousands more hits and intend to develop the site further.

5.0 Diabetes

5.1 While RTT is consuming much of our time, we have not lost sight of other important work that is needed to respond to the existing and growing needs of our local population. Diabetes is one such disease area that we are prioritising. Dr Gupta is working on developing a business vase that will help improve care to existing diabetes patients, thereby reducing complications and admissions.
6.0 Locality working and primary care strategy

6.1 We will be discussing the primary care strategy later on the agenda. CDs and practices are supportive of the locality and are looking forward to working in localities to deliver care closer to home and bringing more expertise to a local patch.

7.0 Meetings

7.1 In addition to the many committee meetings that I attend, below is a summary of other meetings I’ve been to since the last governing body. The absolute priority has been a focus on RTT, and particularly our key element of the plan – demand management.

7.2 Informal CDs' meetings: I have had a number of meetings with my CDs since the last governing body meeting. We’ve focussed on QIPP and performance issues - RTT and A&E in particular. We’ve discussed our demand management plans and the three specialities that our CCG is leading on for BHR.

7.3 Health and wellbeing board: I was unable to attend the last meeting, but my colleague Dr John was able to go on my behalf. A number of items were discussed, including the primary care transformation strategy. I understand that there were some issues flagged through the discussion that have since been discussed further.

8.0 Resources/investment

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

9.0 Equalities

9.1 There are no direct equality implications from this report.

10.0 Risk

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

11.0 Managing conflicts of interest

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

14 May 2016
To: Meeting of the NHS Barking and Dagenham Clinical Commissioning Group Governing Body
From: Conor Burke, Chief Officer
Date: 24 May 2016
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 2015/16 Financial Outturn
1.1 I am pleased to confirm that the CCG has achieved planned control totals and closed our accounts on schedule. This is a significant achievement and I would like to thank all of our staff and clinical directors for their contribution. We will give more details at the special governing body meeting this month and formally to members and the public at our AGM later in the year.

2.0 2016/17 Operating Plan
2.1 Much of my time has been consumed by the 2016/17 planning process, which has been subject to a high degree of testing and scrutiny. We have worked well with our providers and have received positive feedback from NHS England. However, it is clear that this year will be the most challenging year yet for the CCG and we will need to focus all of our effort on ensuring the delivery of the operating plan targets and standards.

3.0 Transformation Programmes
3.1 In order to ensure delivery of the operating plan, we have worked closely with our partner CCGs and have established four BHR-wide transformation programmes covering planned care (including RTT), urgent and emergency care, mental health and primary care. We are currently working with clinical directors and staff to align resources to ensure delivery. There are a number of papers on the agenda that update on the progress of some of these areas.

4.0 Barking, Havering and Redbridge University Hospital Trust (BHRUT)
4.1 We are working closely with the Trust to help reduce their Referral to Treatment (RTT) waiting times and have prioritised this work across the BHR CCGs. A joint RTT summit was held in April 2016, which was attended by the Trust Chief Executive and Medical Director. A report on RTT is included later on the agenda, where more information on progress and actions is outlined.

5.0 Strategic Planning
5.1 The strategy and transformation planning process continues across the North East London footprint. Planning leads recently met with Simon Stevens, NHS England and Jim Mackay, NHS Improvement and while they received positive feedback, there is still significant work to be done to complete the plan in June. Further details are provided later in the meeting.
6.0 Health and Wellbeing Board update
6.1 I attended the Health and Wellbeing Board meeting on 26 April. Updates were received on primary care transformation, Better Care Fund, RTT and the Care City programme.

7.0 Emergency Preparedness, Resilience and Response (EPRR)
7.1 The CCG recently took part in a North East and North Central London EPRR exercise, led by NHS England. The purpose of the exercise was to test our internal arrangements for managing incidents, including the operation of an Incident Coordination Centre. The exercise was extremely useful with some learning outcomes. As soon as the exercise report is available this will be brought to the Governing Body as part of our regular EPRR update.

8.0 Meeting attendance
8.1 I was invited to attend a McKinsey and health Service Journal (HSJ) hosted event as a guest speaker on 3 May. The focus of the event was around making new models of care a reality. I gave a presentation on devolution and opportunities to enable new models of care, plus challenges to implementation.

9.0 Equalities
9.1 There are no equalities implications arising from this report.

10.0 Risk
10.1 There are no risks arising from this report.

11.0 Managing of conflicts of interest
11.1 There have been no conflicts of interest to manage.

12.0 Resources/investment
12.1 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) details the four significant risks to the organisation. These are:

1. Barking Havering and Redbridge University Hospitals Trust (BHRUT) referral to treatment times (RTT) performance
2. BHRUT emergency care performance
3. BHRUT cancer performance for the 62 days target
4. Quality, innovation, productivity and prevention (QIPP) delivery

Two risks have been de-escalated from the GBAF in April:
1. Improved access to psychological therapies (IAPT)
2. Barts Heath contract and financial risks

Risks detailed in this report are based on the April 2016 risk register and with the new financial year all risks on the register are being reviewed by individual risk owners and their teams. All risks on the risk register will have a target risk rating and a date for the target risk rating to be achieved as per the GBAF.

Recommendations
The governing body is asked to:
- Note and comment on the current risks escalated to the GBAF and 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

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 affectively 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, Havering and Redbridge CCGs.
3.0 Risks escalated to the GBAF

3.1 There are four risks on the GBAF. Please refer to appendix 1 for full details. These fall under three of the CCG’s six corporate objectives and are as follows:

**Collaborative objective 3:**
*Developing a system wide urgent care strategy and redesigning the urgent care pathway*

**Risk 3.1:** Continued concerns with urgent and emergency care at BHRUT - risks to patient care and viability of the trust.

**Mitigation:**
- BHRUT being held to account via weekly operational performance monitoring meetings, reporting to the CCG governing body, quality and safety committee and CCG executive committee
- Improvement plan agreed (with NHS Improvement (NHS I)/ Care Quality Commission (CQC) / NHS England (NHSE) and CCGs) with monthly whole system Oversight and Escalation Group (OEG) to review progress against the plan.
- System Resilience Group (SRG) is leading the work to support operational delivery
- Friends and family scores recovery plan and performance monitored through Clinical Quality Review Group (CQRM)
- Trust performance improved significantly over the past year and is most nearer to the national standard

**Corporate objective 5:**
*Ensuring that planned care is appropriate, timely and of high quality.*

**Risk 5.2:** BHRUT 18 weeks referral to treatment times (RTT) – failure to meet the national standards for RTT and data reporting.

**Mitigation:**
- Weekly RTT escalation and assurance meeting which includes NHS England, NHS Improvement and BHRUT
- Joint RTT programme director appointed across BHRUT and the CCG
- CCG RTT demand management plan has been developed
- Trust plans in place to reduce the over 52 weeks waiters with the CCGs supporting the reduction of the inflow of activity to the trust via the establishment of a re-direct scheme and the development of new clinical pathways
- Weekly operational Programme Board meeting with BHRUT and the CCGs
- The clinical harm process and outcomes reviewed through the external harm panel chaired by Angela Lennox, associate medical director NHS England with BHR CCGs’ nurse director on the panel.

**Risk 5.3:** BHRUT has failed to deliver the national 62 days cancer performance standard with potential impact on cancer diagnoses, treatment and clinical harm.

**Mitigation:**
- Revised trajectory with an associated action plan agreed to deliver recovery of the standard
- Weekly monitoring of planned activity against actual activity
- Detailed forward booking reviewed at weekly meeting to assess risk.
- Contract penalty notice issued and full contract levers applied.
- Risk managed through Performance Management Framework.
Collaborative objective 6:  
Continued focus on our development as an organisation that delivers

Risk 6.1:  
Failure to deliver identified QIPP schemes presents a risk to the achievement of planned surpluses 16/17

Mitigation:
- Review and escalation to the finance and delivery committees based on four specific trigger criteria: finance, activity, milestones and risk
- Confirm and challenge sessions implemented
- London and national horizon scanning to supplement locally developed schemes
- Linking to transformational activities and ensuring QIPP benefits trackers are applied through transformational projects governance

4.0 De-escalated risks
4.1 Two risks have been de-escalated from the GBAF on April 2016. These are

- Improved access to psychological therapies (IAPT) – the CCG is close to meeting its target and BHR are among the most improved CCGs across London in progressing towards their IAPT targets.

- Barts Heath (BH) contract and financial risks – the BH position has been closed down for 15/16. This risk will be removed from the risk register.

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
6.1 There are no equalities considerations arising from this report.

7.0 Risk
7.1 This paper relates directly to risk. This report also links to the following GB papers being presented at this meeting which provide greater detail on key risks mentioned above and how they are being mitigated by the organisation

GBAF ref. 3.1, 5.3 relates to item 3.2 - BHRUT performance risks  
GBAF ref. 5.2 relates to item 5.1 – RTT 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: 21 April 2016
Appendix 1 – NHS Barking and Dagenham CCG Governing Body Assurance Framework (GBAF)

Collaborative objective 3: Developing a system wide urgent care strategy and redesigning the urgent care pathway

<table>
<thead>
<tr>
<th>Risk Description: Failure to deliver quality improvement in urgent and emergency care at BHRUT could: a) threaten the long-term viability of the Trust and b) put patients at risk, cause reputational damage and delay the implementation of acute reconfiguration programmes.</th>
<th>Lead director: Alan Steward</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk ref: 3.1</td>
<td></td>
</tr>
</tbody>
</table>

<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 – 1/10/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Likelihood (4) x Impact (4) = Severe 16</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. System Resilience Group (SRG) focused on urgent and planned care</td>
<td>1. Minutes of the monthly System Resilience Group (E)</td>
<td>1/10/16</td>
<td>Items 4.2 and 6.1 on the agenda - Urgent and Emergency Care Plan and Contracting reports provide greater detail on the management of this risk</td>
<td>SRG leading the transformation programme to deliver Operating Plan commitments.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>2. Urgent and emergency care (UEC) programme board takes the operational lead on delivery of the UEC plan including all Operating Plan commitments</td>
<td>2. Minutes of the urgent and emergency care programme board (E)</td>
<td></td>
<td></td>
<td>The SRG has commissioned a review of urgent and emergency care and planned care system governance to reflect the heightened risk of delivery. The outcome will be reported to the Governing Body in September 2016 and the GBAF revised as necessary.</td>
<td></td>
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</tr>
<tr>
<td>5. BHRUT improvement plan monitored at monthly Oversight and Escalation Group meeting (OEG).</td>
<td>5. Minutes of the BHRUT Improvement Plan OEG (E)</td>
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</tr>
</tbody>
</table>

Likelihood (4) x Impact (3) = High 12
**Corporate objective 5:** Ensuring that planned care is appropriate, timely and of high quality.

**Risk Description:**
BHRUT 18 Week RTT – a system upgrade exposed significant issues around RTT PTL management and reporting and therefore failure to meet the national standards for RTT and reporting for 12 – 24 months.

<table>
<thead>
<tr>
<th>Initial Risk Rating</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 – 31/03/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>5/2014</td>
<td>1. Weekly RTT escalation and assurance meeting with NHSE, NHS Ia, EY, CCG and BHRUT</td>
<td>I = internal E = external</td>
<td></td>
<td>Item 5.1 and 6.1 on the agenda – BHRUT RTT report and Contracting report provides greater detail on the management of this risk</td>
<td></td>
<td>1. Return to national RTT reporting</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. Weekly Programme Board with BHRUT, CCG and EY</td>
<td></td>
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<td></td>
<td>1. Independent report on PTL and pathway management and the recs from the phase one report</td>
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<tr>
<td></td>
<td>3. Weekly CCG RTT assurance and delivery meeting including CCG Chairs</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>The RTT exception report contains details of the issues, risks and mitigating actions.</td>
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<tr>
<td></td>
<td>4. RTT clinical summit established monthly</td>
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<td>The CCG will review the independent assurance report on the systems, process and data quality necessary to return to reporting.</td>
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<tr>
<td></td>
<td>5. Weekly operational performance meeting with CCG, BHRUT and EY</td>
<td></td>
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<td></td>
<td>6. Contractual meetings – SPR / CQRM – and levers used fully</td>
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<tr>
<td></td>
<td>7. Clinical harm review framework and process including external panel in conjunction with EY</td>
<td></td>
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<td></td>
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<tr>
<td></td>
<td>8. EY support team phase two work programme agreed (E)</td>
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<td></td>
<td>9. Implementation of the approved demand management GP re-direct scheme from April 2016</td>
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</tbody>
</table>
**Risk Description:**

**BHRUT cancer standards:** failure to deliver national performance standards on cancer pathways for 62 day waits (now delivering on the 2 week standard) with potential impact on cancer diagnoses and treatment and clinical harm.

**Lead director:** Louise Mitchell  
**Risk ref:** 5.3

<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>
</tr>
</thead>
</table>
| **Likelihood (4) x Impact (4) = Severe 16** | 1. System Resilience Group (SRG) focused on urgent and planned care  
2. Contractual meetings – SPR / CQRM and Cancer CQN meeting – with levers used fully  
3. Weekly Performance Assurance Group (PAG) meeting with the Trust.  
3. Minutes of the PAG (I)  
4. Minutes of NHS England assurance meetings (E) | Items 3.2 and 6.1 on the agenda  
- BHRUT performance risks and the Contracting report provides greater detail on the management of this risk | | | **Target Risk – 31/06/16** |

**Likelihood (2) x Impact (2) = Medium 4**

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Page 3 of 8
Collaborative objective 6: Continued focus on our development as an organisation that delivers

Risk Description: **Failure to deliver the CCG QIPP could:** 1) adversely impact on the contractual activity agreements with relevant providers, 2) threaten delivery of an operating plan commitment which will impact on CCG assurance and 3) threaten the overarching year end budget delivery required for 15/16

<table>
<thead>
<tr>
<th>Initial Risk Rating 8/2015</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 – 30/9/16</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1 = internal</td>
<td></td>
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<td></td>
<td></td>
<td>2 = external</td>
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<td></td>
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<tr>
<td>1</td>
<td>Monthly review of QIPP delivery (finance and activity)</td>
<td></td>
<td></td>
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<tr>
<td>2</td>
<td>Monthly review of mitigating actions and risks per scheme where off plan</td>
<td></td>
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<tr>
<td>3</td>
<td>Formal escalation route to Finance and Delivery committee in place as due governance for all schemes that are off plan</td>
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<tr>
<td>4</td>
<td>Confirm and Challenge model in place for all new innovation / QIPP pipelines to ensure continual identification of schemes</td>
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<tr>
<td>5</td>
<td>Dedicated PMO in place as part of QIPP delivery infrastructure</td>
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<tr>
<td>6</td>
<td>Clinical Director QIPP and innovation meetings held monthly to embed clinical leadership and accountability and identification of required rectification plans</td>
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<tr>
<td>1</td>
<td>Minutes of Monthly QIPP review meetings (I)</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Risk log and mitigations for all schemes (I)</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>3</td>
<td>Minutes of Confirm and Challenge Sessions (I)</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>4</td>
<td>Minutes of Executive Committee and Governing Body (I)</td>
<td></td>
<td></td>
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<tr>
<td>5</td>
<td>Minutes of finance and Delivery Committee (I)</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Monthly QIPP delivery summary reports against year trajectory (I)</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Likelihood (4)</th>
<th>Impact (5)</th>
<th>Likelihood (3) x Impact (4) = Severe 15</th>
</tr>
</thead>
</table>

Lead director: Tom Travers
Risk ref: 6.1

- Continued liaison
- Instigate JMT level monthly deep dive on QIPP as part of overarching finance and activity review.
- Dedicated QIPP dashboard instigated to inform review
## Appendix 1

**NHS Barking and Dagenham CCG GBAF - overall summary**

<table>
<thead>
<tr>
<th>Lead / GBAF ref.</th>
<th>Risk Description</th>
<th>Initial rating (June 2013)</th>
<th>Previous risk rating</th>
<th>Current rating</th>
<th>End of year forecast</th>
<th>Target risk level</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Steward 3.1</td>
<td>Failure to deliver quality improvement in urgent and emergency care at BHRUT</td>
<td>4 x 4 = 16</td>
<td>4 x 4 = 16</td>
<td>4 x 5 = 20</td>
<td>4 x 5 = 20</td>
<td>4 x 5 = 25</td>
</tr>
<tr>
<td>L Mitchell 5.2</td>
<td>Failure to meet the 18 weeks referral to treatment times targets at BHRUT</td>
<td>5 x 5 = 25</td>
<td>5 x 5 = 25</td>
<td>4 x 4 = 16</td>
<td>4 x 4 = 16</td>
<td>4 x 4 = 20</td>
</tr>
<tr>
<td>L Mitchell 5.3</td>
<td>Failure to deliver national performance standards on cancer at BHRUT</td>
<td>3 x 4 = 12</td>
<td>3 x 3 = 9</td>
<td>3 x 3 = 9</td>
<td>3 x 3 = 9</td>
<td>4 x 4 = 16</td>
</tr>
<tr>
<td>T Travers 6.1</td>
<td>Risk of failure to deliver the CCG QIPP plans</td>
<td>4 x 5 = 20</td>
<td>4 x 5 = 20</td>
<td>3 x 5 = 15</td>
<td>3 x 5 = 15</td>
<td>3 x 5 = 15</td>
</tr>
</tbody>
</table>

### Risk Summary

<table>
<thead>
<tr>
<th>Description</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total risks last report</td>
<td>6</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>4</td>
</tr>
</tbody>
</table>
## NHS Barking and Dagenham de-escalated risks from the GBAF

<table>
<thead>
<tr>
<th>Lead / GBAF Ref.</th>
<th>Risk description</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>S Morrow 4.1</td>
<td>De-escalated in April 2016: Improving access to psychological therapies (IAPT): Failure to deliver improved access to IAPT services could: 1) restrict people who would benefit from a service in accessing it and 2) threaten delivery of an operating plan commitment for a national mental health standard which will impact on CCG assurance ratings.</td>
<td>1 x 3 = 3 Sept 2014</td>
<td>2 x 4 = 8 31 Mar 2016</td>
<td>3 x 4 = 12 April 2016</td>
</tr>
<tr>
<td>T Travers 6.2</td>
<td>De-escalated: Barts Heath contract financial risks - Acute contracts, particularly Barts 15/16 contract has been signed by the lead commissioner and the CCGs are working with the collaborative to jointly manage the contract.</td>
<td>3 x 3 = 9 May 2015</td>
<td>2 x 3 = 6 31 Mar 2016</td>
<td>3 x 4 = 12 April 2016</td>
</tr>
<tr>
<td>J Himbury 4.1a &amp; b (2 &amp; 45)</td>
<td>De-escalated in January 2015: a) A backlog of continuing health care reviews and outstanding initial assessments, inherited from the PCT, does present a clinical and financial risk to the CCG. b) Outstanding appeals and claims predating April 2014</td>
<td>5 x 5 = 25 June 2013</td>
<td>1 x 3 = 3 31 Dec 2014</td>
<td>3 x 4 = 12 Dec 2014</td>
</tr>
<tr>
<td>J Himbury 4.2 (10)</td>
<td>De-escalated in June 2014: Assurance process of care homes. The CCG has not inherited a robust system for assuring quality of all providers the risk is that there is not a culture of sound monitoring.</td>
<td>3 x 5 = 15 June 2013</td>
<td>1 x 3 = 3 1 April 2014</td>
<td>1 x 3 = 3 June 2014</td>
</tr>
<tr>
<td>M Sheldon 3.3 (22)</td>
<td>De-escalated in June 2014: 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>3 x 5 = 15 June 2013</td>
<td>1 x 3 = 3 1 April 2014</td>
<td>1 x 3 = 3 June 2014</td>
</tr>
<tr>
<td>S Morrow 3.2 (21)</td>
<td>De-escalated in June 2014: Financial and operational pressures on practices associated with the transition of GP contracts to NHSE will impact adversely on practice engagement in QIPP delivery. The key risk is that we will fail to deliver our QIPP plan as a result of the issues.</td>
<td>3 x 5 = 15 June 2013</td>
<td>1 x 3 = 3 1 April 2014</td>
<td>1 x 3 = 3 June 2014</td>
</tr>
<tr>
<td>M Sheldon 3.1 (4)</td>
<td>De-escalated in January 2014: Central allocation funding issue / specialised commissioning unexplained changes to the LSG calculations resulting in potential additional financial pressure to CCG</td>
<td>3 x 5 = 15 June 2013</td>
<td>1 x 3 = 3 1 April 2014</td>
<td>1 x 3 = 3 Sept 2013</td>
</tr>
</tbody>
</table>
## Risk grading matrix

<table>
<thead>
<tr>
<th>Rating</th>
<th>Objectives/projects</th>
<th>Severity</th>
<th>Risk Description</th>
<th>Frequency</th>
<th>Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Insignificant</td>
<td>Low</td>
<td>Insufficient cost increase/time slippage. Barely noticeable reduction in scope or quality</td>
<td>Rare</td>
<td>&lt;10%</td>
</tr>
<tr>
<td>2</td>
<td>Minor</td>
<td>Moderate</td>
<td>Less than 5% cost or time increase. Minor reduction in scope or quality</td>
<td>Unlikely</td>
<td>10%-24%</td>
</tr>
<tr>
<td>3</td>
<td>Moderate</td>
<td>Moderate</td>
<td>5-10% cost or time increase. Moderate reduction in scope or quality</td>
<td>Possible</td>
<td>25%-45%</td>
</tr>
<tr>
<td>4</td>
<td>Major</td>
<td>High</td>
<td>10-25% cost or time increase. Failure to meet secondary objectives</td>
<td>Likely</td>
<td>50%-74%</td>
</tr>
<tr>
<td>5</td>
<td>Severe</td>
<td>Extreme</td>
<td>&gt;25% cost or time increase. Failure to meet primary objective</td>
<td>Certain</td>
<td>&gt;75%</td>
</tr>
</tbody>
</table>

### Severity Levels
- **Low**: Insufficient cost increase/time slippage. Barely noticeable reduction in scope or quality.
- **Moderate**: Less than 5% cost or time increase. Minor reduction in scope or quality.
- **High**: 5-10% cost or time increase. Moderate reduction in scope or quality.
- **Extreme**: 10-25% cost or time increase. Failure to meet secondary objectives.
- **Extremely High**: >25% cost or time increase. Failure to meet primary objective.

### Risk Description
- **E1**: Inadequate cost increase/time slippage. Barely noticeable reduction in scope or quality. Incident was prevented or incident occurred and there was no harm. Locally resolved complaint with no significant media impact. Loss/interruption more than 1 hour. Short-term low staffing leading to reduction in quality (less than 1 day).
- **E2**: Raised complaint or incident, with low probability of a significant media impact. Loss of one whole working day. Ongoing low staffing levels reducing service quality. Loss of 0.1% budget, £10,000.
- **E3**: Serious complaint or incident, with high probability of a significant media impact. Loss of more than one working day. Late delivery of key service due to lack of staff. Ongoing unacceptable service levels. Small error owing to insufficient training. Loss of more than 0.25% budget, £100,000.
- **E4**: Major complaint or incident, with high probability of a significant media impact. Loss of more than one working week. Uncertain delivery of service due to lack of staff. Large error owing to insufficient training. Loss of more than 0.5% of budget, £500,000.
- **E5**: Severe complaint or incident, with high probability of a significant media impact. Loss of more than 1% of budget, £5,000,000.

### 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.

**Risk description**
For each risk note down: Who can be harmed and how can they be harmed if the risk materialises. Areas to consider are: harm/injury, objectives, claims or litigation, service disruption, staffing and competence, morale, financial, external assessment and adverse media interest.

**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</th>
<th>Proposed actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.3</td>
<td>MS</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>• 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. • Where there is no contract we will develop an alternative validation process. Until the process is developed we will not pay the invoices.</td>
<td>15</td>
<td>• A regular weekly report is being developed by the CSU to report on the process. • The audit committee will be updated on performance to only pay validated invoices.</td>
<td>15</td>
<td>• A regular report will be produced for the audit and governance committee</td>
<td>• Develop new validation process</td>
<td>1/4/14</td>
<td>3</td>
</tr>
</tbody>
</table>

**Gaps in controls**
What more can be done to control the risk and what controls could be improved?

**Gaps in assurance**
What associated documentation will demonstrate that the controls are in place?

**Controls**
What is being done to reduce the likelihood and severity of the risk. One specific risk may be mitigated by a number of controls.

**Assurance**
Assurances are inevitably ‘bits of paper’ that act as evidence the controls are in place. Examples include:
- Job descriptions / organisation charts
- Regular reports
- Contracts / service level agreements
- Policies and procedures
- Minutes / agendas / terms of reference

**Proposed actions**
Where gaps have been identified, list the actions required to put them into place. Ensure they have a named lead and target date.
To: Meeting of NHS Barking and Dagenham Clinical Commissioning Group Governing Body  

From: Conor Burke, Chief Officer  

Date: 24 May 2016  

Subject: BHRUT Performance Risks

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**Executive summary**

The CCGs are continuing to manage 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 are all included in the CCG’s Risk Register, Governing Body Framework, and there is a further report on RTT on this agenda.

This report provides a further update on the key actions that 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 support through wider system initiatives overseen by the System Resilience Group (SRG).

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

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**Recommendations**

The Governing Body is asked to:

- Note the action being taken to date to mitigate the performance risks at BHRUT
- Suggest any further actions that the CCG should consider to address the performance and quality risks for local people.

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**1.0 Purpose of the Report**

**1.1** The CCG’s Governing Body Assurance Framework and the risk register identify 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**

A&E performance at BHRUT has not achieved the national standard (95%) from August 2015 to date. Performance for March dropped to 75.6% (unvalidated) with the most recent weekly performance (18-24 April) being 83.7%. The Urgent and Emergency Care report on the agenda (Item 5.2) includes the details of the system-wide plan to address this performance. The finance and contracting report includes more detailed assessment of current performance and the contractual action being taken to address this.

**3.0 Referral to Treatment Targets (RTT)**

BHRUT is not reporting its RTT performance. The RTT report (item 5.1) includes the details of the system-wide plan to address this. The contracting report (item 6.1) provides more detailed assessment of current performance and the contractual action being taken to address this.

**4.0 Cancer**

**4.1** Cancer performance is one of the eight national priorities for delivery. While performance overall on cancer pathways has improved at the Trust over the last six months with seven of the national standards being met until December, the 62 day standard has consistently been failed.
4.2 In December the Trust reported that the 2 week wait, 2 week wait breast and 31 Day First Definitive Treatment and 31 Day Subsequent Surgery standards would not be met. Unvalidated March data has confirmed that these standards have been recovered with the exception of the 62 days standard which was not achieved.

4.3 A contract performance notice (CPN) was issued against the 62 Day Cancer standard in 2014/15, which remains open due to the lack of improvement in performance.

4.4 The Trust has failed the 62 day standard (85% target) since June 2014. The Trust developed a Cancer Action plan which has been signed off by the CCGs, TDA (now NHSI) and NHSE with a planned recovery of the standard by January 2016, with a trajectory provided showing how performance would improve month on month. The Trust did not achieve this and a revised trajectory (with associated action plan) was agreed to deliver recovery of the standard in May.

4.5 A significant increase in the number of patients waiting with or without a decision to treat (DTT) was reported in February. These patients were known and were being tracked but were not being correctly reported through weekly submissions to then TDA. The Trust has - as required - reported this as an SI. The continued failure of the 62 Day Standard has resulted in escalation to weekly monitoring of planned and actual activity and the booking of patients who have waited greater than 62 days for treatment from referral against a weekly trajectory.

4.6 Recent deliverables that the Trust and Commissioners have implemented and continue to develop include:
- Increased activity in February – May above runrate to reduce the number of patients waiting,
- Tumour site specific plans with the implementation of straight to test pathways for some specialties and a focused change programme for urology with the continued implementation of the London prostate cancer pathway,
- Improving the tracking of patients on the suspected cancer waiting list and the analysis and reporting of the trends,
- Completing pathway mapping with the support of NHS Elect – a national NHS improvement agency. Five pathways out of the nine have been completed; and
- Improving compliance on transferring tertiary cases by day 42.

4.7 Due to the issues reported in February with regard to data and the failure to recover the trajectory in January, the CCG has commissioned an independent review of the cancer pathway and process management. The review which is currently underway is being conducted by Sologic Limited. Final reporting details are currently being confirmed.

4.8 Commissioners continue to monitor the number of over 100 days' treatment breaches and have agreed with the Trust that from February patients who have waited >62 days are to be reviewed by Divisional Directors and reported to the External Harm Review Board. The Trust has issued guidance and timelines on the completion of these harm reviews. Harm reviews are expected to be complete and recorded within the second month after treatment.

4.9 The contracting report provides more detailed assessment of current performance and the contractual action being taken to address this.

5.0 Resources/investment
5.1 The CCG Chief Financial Officer and other senior leaders are working with NHSE, NHSI and other partners to secure the required resources to deliver the changes.

6.0 Equalities
6.1 The implementation of the Trust improvement plan and the associated remedial action plans identified above will improve quality and reduce health inequalities.
7.0 Risk
7.1 This report highlights the key risks around each of these issues. These risks are included in the Governing Body’s Assurance Framework and this report provides further detail to the Governing Body on the issues and action being taken to mitigate them.

Author: Alan Steward, Chief Operating Officer
Date: 6 May 2016.
Executive summary
C CGs have been required to deliver two mental health standards related to Improving Access to Psychological Services (IAPT) in 2015/16 - 15% of adults with relevant disorders will have timely access to IAPT services with a recovery rate of 50%. From 1 April 2016 CCGs are also required to meet a waiting time access standard so that 75% of people referred to IAPT are treated within six weeks of referral and 95% will be treated within 18 weeks of referral.

B&D CCG met the access standard in Q3 with 4.04% performance and has exceeded the target in Q4 with an achievement of 4.27% against the quarterly target of 3.75%. B&D CCG has seen an under-performance against the recovery standard of 50% in 15/16. The Q3 average recovery rate was 48.30% and Q4 average is 46.99%.

The report sets out plans to sustain and extend performance against access target, address underperformance of recovery standard and progress on preparation for meeting the new targets.

Recommendations
The Governing Body is asked to:

- Note the recent performance against the IAPT standards and actions planned to meet the required performance targets in 16/17.

1.0 Purpose of the Report
1.1 This report provides an update to the Governing Body on actions that are being taken to improve performance against the Improving Access to Psychological Therapies (IAPT) standards.

2.0 Background/Introduction
2.1 The Governing Body has received reports in January 2016 and March 2016 notifying it of the performance against the IAPT access and recovery targets and actions in place to recover this performance where necessary.

2.2 CCGs are required to deliver the access standard for IAPT which is that 15% of adults with relevant disorders will have timely access to IAPT services and the recovery standard of a 50% recovery rate.
2.3 From 1 April 2016 CCGs are expected to deliver (in addition to access and recovery standards) a **waiting time standard** for IAPT so that 75% of people referred to IAPT are treated within six weeks of referral and 95% will be treated within 18 weeks of referral.

2.4 Barking and Dagenham, Havering and Redbridge CCGs have contracted with NELFT to provide the IAPT service and have agreed additional investment to ensure that the capacity is in place to deliver these new targets.

2.5 Delivery of the IAPT access and recovery standards was a component of the CCG operating plan in 2015/16 and continues to be so in 2016/17 in addition to the new standards. BHR CCGs have historically been some of the few in London not attaining the required access targets.

3.0 **IAPT performance - access**

3.1 Having underperformed against the IAPT access target in the first six months of the year, Barking and Dagenham CCG exceeded the quarterly target of 3.75% in quarters 2 and 3 achieving a 4.04% access rate in Q3 and a 4.27% access rate in Q4 (Q4 provider data to be validated when HSCIC data is published). The CCG is forecasting achievement of 14.75% in Q4 against the national target of 15%. Strong performance in the last six months of the financial year provides some assurance of full delivery of the IAPT access standard in 2016/17.

Data for the neighbouring BHR CCGs is included in the table and figure below for comparative purposes. It is important to note that Q4 provider data is used as proxy due to a time lag in receiving HSCIC data.

Please see table 1 and fig 1 below.

**Table 1: Access performance report**

<table>
<thead>
<tr>
<th></th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>August</th>
<th>September</th>
<th>October</th>
<th>November</th>
<th>December</th>
<th>January</th>
<th>February</th>
<th>March</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target</td>
<td>1.25%</td>
<td>1.25%</td>
<td>1.25%</td>
<td>1.25%</td>
<td>1.25%</td>
<td>1.25%</td>
<td>1.25%</td>
<td>1.25%</td>
<td>1.25%</td>
<td>1.25%</td>
<td>1.25%</td>
<td>1.25%</td>
</tr>
<tr>
<td>B&amp;D Actual</td>
<td>0.36%</td>
<td>1.37%</td>
<td>1.32%</td>
<td>1.08%</td>
<td>1.08%</td>
<td>1.20%</td>
<td>1.37%</td>
<td>1.40%</td>
<td>1.27%</td>
<td>1.24%</td>
<td>1.23%</td>
<td>1.77%</td>
</tr>
<tr>
<td>Havering Actual</td>
<td>0.22%</td>
<td>1.14%</td>
<td>1.32%</td>
<td>0.97%</td>
<td>0.99%</td>
<td>1.12%</td>
<td>1.24%</td>
<td>1.03%</td>
<td>0.73%</td>
<td>1.06%</td>
<td>1.36%</td>
<td>1.49%</td>
</tr>
<tr>
<td>Redbridge Actual</td>
<td>0.21%</td>
<td>1.15%</td>
<td>1.25%</td>
<td>1.17%</td>
<td>0.70%</td>
<td>0.86%</td>
<td>1.01%</td>
<td>0.81%</td>
<td>0.57%</td>
<td>0.88%</td>
<td>1.08%</td>
<td>1.20%</td>
</tr>
</tbody>
</table>

**Fig 1: Graph showing CCG performance against target (Provider data)**

3.2 HSCIC Q2 data indicates a good conversion of referrals into treatment overall for BHR CCGs with a low attrition rate. The average conversion rate across London in Q2 was 74.23%. B&D
report a conversion rate of 120.93% with an assumption that some of the treatment numbers have followed from the previous quarter. Havering report a value of 92.31% and Redbridge have a rate of 89.19%. High conversion rates suggest that patients who are referred/ self-referred to the service are those that are most likely to benefit from treatment. The Graph below illustrates the results.

In Q2 the average percentage of people who did not attend for treatment in London (DNA rate) was 10.50%. Compared to the London average, more people across BHR attend services for treatment (B&D report a DNA rate of 9.58%, Havering report a value of 10.19% and Redbridge have a DNA rate of 10.61%.)

3.3 The three CCGs implemented a Recovery Action Plan to improve performance on the access target in July 2015. CCG actions since January 2016 have focused on the following:
• Completing a programme of practice visits to increase GP referrals to IAPT. 39 practice visits have been completed in B&D, supplemented by locality meetings in October and November.
• Introduced a new/simplified GP referral form to support direct referrals
• Developing a BHR marketing strategy and campaign, based on evidence and research gathered, which has resulted in rebranding of the service (Talking Therapies).
• The launch of the communications campaign (to start week commencing 18 April 2016).
• Close monitoring of activity, including requesting GPs to consistently code referrals with the same input code, and develop weekly reports of activity to drive recovery actions.
• Monitoring telephone responses from callers to the IAPT service and improvements to the telephone response to callers to the service

3.3 IAPT Performance – Communications plan
Work has been carried out by NEL CSU to research how to increase self-referrals and awareness of the psychological therapies (IAPT) programme in Barking & Dagenham, Havering and Redbridge. This is to ensure that each CCG reaches their quarterly referral targets, whilst also looking at long-term sustainable solutions to promote the service.

NEL CSU has developed a marketing and communications plan based on the research findings and recommendations.

The marketing plan for BHR CCG’s includes;
• The development of a website
• A phased door drop commencing on 16 May
• E-mail marketing using a MOSAIC socio-demographic profiling tool
• Social Media content
• Facebook adverts
• Google AdWords
• Print distribution
• A media and engagement plan which lists the stakeholder/media opportunities as well as face-to-face engagement with stakeholder groups to promote the service directly where possible.

4.0 IAPT performance – recovery
4.1 The recovery standard is for 50% of people who complete treatment to move to recovery. NELFT is currently reporting a BHR average recovery rate of 51.37% for Q4. B&D Q4 average recovery rate is 46.99%. This will need to be validated by HSCIC when the data becomes available. An analysis of underperformance is being undertaken with the provider to inform action plans for 2016/17.

5.0 IAPT Performance – waiting times
5.1 Achievement of the waiting time standard which is now required as of 1 April 2016 is;
   5.1.1 (i) the proportion of patients that wait six weeks or less for referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period
   5.1.2 (ii) the proportion of patients that wait 18 weeks or less for referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period.

5.2 Preparation for the delivery of the waiting time standard has been included in the Service Development and Improvement Plan as part of the NELFT contract. Delivery of this plan is on target.
6.0 Risk
6.1 The identified risks are included in the table below

<table>
<thead>
<tr>
<th>Risk</th>
<th>Mitigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recovery rates will not achieve national standard</td>
<td>Ongoing monitoring meetings held with provider to ensure plans in place to ensure recovery rate is delivered in year</td>
</tr>
<tr>
<td>Insufficient referrals into the service to achieve end of year trajectories</td>
<td>Ensure a robust action plan in place and regularly monitored to ensure any slippages are mitigated against. The use of additional capacity to undertake practice visits, especially for Redbridge CCG.</td>
</tr>
<tr>
<td>IAPT service commissioned is not easily accessible by patients who could benefit from it.</td>
<td>Rebranding and coms campaign to launch from April 2016.</td>
</tr>
<tr>
<td>The delivery plan for new standards doesn't deliver expected target trajectory impacting on CCG assurance levels and patient experience</td>
<td>Ongoing review through contracting meetings</td>
</tr>
</tbody>
</table>

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

Author: Tina Virdee, BHR IAPT Project Manager
Date: 26th April 2016
Executive summary

The purpose of this report is to:

- Present the updated 2016/17 Financial Plan to the CCG Governing Body for approval.
- Notify the Governing Body of the provisional 2015/16 Month 12 and provisional year-end financial position

2016/17 Financial Plan

The updated Plan assumes achievement of business rules in relation to:

- 1% surplus of £2,702k
- 0.5% Contingency
- 1.0% uncommitted non-recurrent reserve

However, since the draft Financial Plan was presented to the Governing Body in March there has been a number of developments which have considerably increased the level of risk within the Financial Plan most notably:

- A number of operating plan stocktake meetings with NHS England (NHSE), Trust Development Agency (TDA) (now NHS Improvement) and Barking, Havering and Redbridge University Hospitals Trust (BHRUT) to discuss acute activity plans for 2016/17 and alignment of assumptions with providers have taken place. This has resulted in increases in forecast emergency and elective activity based on historical and anticipated future growth.

- 2016/17 contract negotiations with BHRUT are expected to result in a full payment by results (PbR) contract rather than the block contract which has been agreed in previous years. NHSE have also made clear that contract forms that put any limits on elective activity will not be supported in 2016/17.

- There is currently a gap of £20m across the three BHR CCGs between the CCG contract offer and the proposal from BHRUT. Arbitration is currently taking place and an update will be provided at the meeting. There are also smaller gaps with other providers.

- The CCG’s ability to mitigate over performance through fines and penalties has been reduced due to the national changes in contract rules for 2016/17.
• NHSE have confirmed that the CCG’s Financial Plan cannot assume the use of the 1% non-recurrent reserve of £2.6m for clearance of the RTT backlog at BHRUT. The reserve has to be uncommitted at the beginning of the year. The estimated RTT backlog cost for the CCG is between £4.3m and £6.4m but this is subject to review by Ernst Young. This cost is therefore not currently covered and represents a significant risk if the 1% does not become available for this purpose.

• The QIPP requirement in the Plan is £7.8m (2.6%) of which £3.1m has yet to be allocated to specific schemes.

To mitigate the impact of this increased financial risk the following assumptions/actions have or are being taken:
• Assumption that the 1% non-recurrent reserve will become available in year to fund the RTT backlog. If this is not the case the full value of the RTT will become a pressure on the CCG’s ability to deliver the planned surplus.
• Creation of a pipeline of additional QIPP and Transformational Projects to address the current unallocated QIPP target.
• Agreement to a health economy wide approach to QIPP and demand management scheme development and delivery.
• Agreement to introduce a “Star Chamber” approach to assessing and approving discretionary spend.

The current level of risk within the Plan outlined in section 5 amounts to £15.5m. The only reserve mitigation to these risks is the 0.5% contingency within the plan. There is therefore a considerable risk depending on the outcome of the arbitration decision on the BHRUT contract, the 1% RTT issue and the other risks highlighted above that the CCG could move into a deficit position and thus not achieve business rules.

2015/16 Provisional Financial Position

As at the end of March (Month 12) the CCG is reporting a surplus of £3,667k. This is £315k above the revised planned year-end surplus of £3,352k. This position is reflected in the CCG’s draft annual accounts which are currently being reviewed by the External Auditors and is therefore provisional until the audit is completed.

Recommendations

The Governing Body is asked to:
• Approve the updated Financial Plan for 2016/17 noting the considerable level of financial risk to achievement of business rules. The Plan is consistent with the latest Operating Plan submission to NHSE.
• Agree the provisional financial position for 2015/16 and note that the external audit of the year-end accounts is currently in progress.

1.0 Purpose of the Report

The purpose of this report is to provide the CCG Governing Body with the 2016/17 Financial Plan for approval. The 2015/16 provisional financial position is also provided.

2.0 Background/Introduction
The CCG is expecting to deliver a 1.14% surplus in 2015/16. This was reduced in year from a 2% surplus. It faces ongoing financial challenges in order to maintain this level of surplus position in 2016/17.

The Department of Health announced a £3.8bn real terms increase for the NHS in 2016/17 in the December Spending review and the CCG has received a 3.05% increase in its Programme allocation and a 3.57% increase in Primary Care Co-Commissioning.

Despite the increased allocations, however, the CCG continues to face significant pressures on its budgets due to:

- Growth in population and the impact of non-demographic factors resulting in increases in acute activity.
- Increasing life expectancy and prevalence of long term conditions.
- Growth in prescribing and continuing care costs.
- Financial pressures at BHRUT and Barts Health including a significant RTT backlog.
- Access standards for Mental Health.
- Inflationary pressures.

The above factors mean that even with baseline funding growth, the CCG still needs to make significant Quality Innovation Productivity and Prevention (QIPP) savings and faces a considerable level of financial risk if it is to meet the financial targets outlined in this plan.

### 3.0 Report Detail

#### 3.1 The Planning Guidelines

CCGs are required to submit plans reflecting Department of Health financial rules that assume the delivery of the CCG’s commissioning objectives, including the key NHS constitution targets of:

- Maximum referral to treatment waiting times
- Access to cancer services
- Maximum wait times in A&E

For 2016/17, the CCG should set and deliver financial plans within NHS business rules. The draft plan seeks to deliver against these rules with the following targets:

<table>
<thead>
<tr>
<th>NHS Business Rules</th>
<th>%</th>
<th>£m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surplus</td>
<td>1.0%</td>
<td>2.7</td>
</tr>
<tr>
<td>Contingency</td>
<td>0.5%</td>
<td>1.5</td>
</tr>
<tr>
<td>Uncommitted Non-recurrent Investment</td>
<td>1.0%</td>
<td>2.9</td>
</tr>
</tbody>
</table>

Currently the CCG’s plan does achieve all three requirements but contains considerable financial risk. This risk includes an assumption that the uncommitted 1% non-recurrent reserve will be made available in year for the purpose of RTT backlog clearance at BHRUT.

The key financial assumptions made within the plan were provided in the March report and are included for information at Appendix A.

#### 3.2 2016/17 Resource Allocation

The CCG’s 2016/17 budget is based on a resource allocation of £384m and a breakdown of the allocation is provided at Appendix A.
3.3 **Growth**

The confirmed allocation includes a 3.06% recurrent uplift on 2015/16. This incorporates differential growth for elements of the budget:

- A programme growth of 3.05%.
- A Primary Care Co-Commissioning growth of 3.57%.
  
  Primary Care Co-Commissioning budgets for 2016/17 will be separately presented to the Primary Care Commissioning Committee for approval. It has been assumed that this budget will achieve a balanced position.
- A running cost growth of 0.29%.

The programme growth breakdown is included at Appendix A.

The increased growth allocation is due to a national policy to achieve a greater equity of access through accelerating alignment of allocations so that in 2016/17 all CCGs are no more than 5% under target for CCG commissioned services and for the total commissioning streams for their population. After taking account of the increase in funding for 2016/17 the CCG’s programme allocation is 1.8% above target and Primary Care Co-Commissioning allocation is 1.0% below target.

3.4 **Expenditure Plan**

The increased funding for the CCG has been more than offset by pressures on the CCG’s underlying financial position as highlighted in the bridge analysis in Section 3.5.

The key elements of these pressures which have changed since the draft plan presented in March are:

- The operating plan process has required additional acute activity to be included above cash envelope levels following stock take meetings with NHSE, TDA/NHSI and BHRUT.

- 2016/17 contract negotiations with BHRUT have progressed and are expected to result in a full PbR Contract with BHRUT rather than the block contract which has been agreed in previous years. NHSE have also made clear that contract forms that put any limits on elective activity levels will not be supported in 2016/17. There is a current contract gap of £20m across the three BHR CCGs between the contract offer and the proposal from BHRUT.

- There is also a contract gap of £3m with Barts Health across the three BHR CCGs and smaller gaps with LAS and a number of other providers. Contracts have been agreed with NELFT and six acute associate providers. The current NHS Provider contract status is provided in Appendix B.

- The CCG’s ability to mitigate over performance through fines and penalties has been reduced by around £2.3m due to the national changes in contract rules for 2016/17.

- NHSE have confirmed that the CCG’s Financial Plan cannot assume the use of the 1% non-recurrent reserve of £2.6m for clearance of the RTT backlog at BHRUT. The reserve has to be uncommitted at the beginning of the year. The estimated RTT backlog cost for the CCG is between £4.3m and £6.4m but this is subject to review by Ernst Young. This cost is therefore not currently covered and represents a significant risk if the 1% does not become available for this purpose.

- The QIPP requirement in the Plan is £7.8m (2.6%) of which £3.1m has yet to be allocated to specific schemes.

- To mitigate the impact of this increased financial risk the following assumptions/actions have or are being taken:
• Assumption that the 1% non-recurrent reserve will become available in year to fund the RTT backlog. If this is not the case the full value of the RTT will become a pressure on the CCG’s ability to deliver the planned surplus.
• Creation of a pipeline of additional QIPP and Transformational Projects to address the current unallocated QIPP target.
• Agreement to a health economy wide approach to QIPP and demand management scheme development and delivery.
• Agreement to introduce a “Star Chamber” approach to assessing and approving discretionary spend.

The current level of risk within the Plan outlined in section 5 amounts to £15.5m. The only reserve mitigation to these risks is the 0.5% contingency within the Plan.

3.5 Bridge Analysis
A ‘bridge’ from the 2015/16 plan (Programme spend only) to the 2016/17 Programme spend plan identifying key movements is summarised within the table below. This includes the change in baseline funding, business rules and a range of cost pressures:

<table>
<thead>
<tr>
<th></th>
<th>£000</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Programme Baseline</td>
<td>254,571</td>
<td></td>
</tr>
<tr>
<td>Programme Growth</td>
<td>7,761</td>
<td></td>
</tr>
<tr>
<td><strong>Total Growth</strong></td>
<td>7,761</td>
<td>3.0 %</td>
</tr>
<tr>
<td>Underlying Position 2015/16</td>
<td>2,996</td>
<td>1.2 %</td>
</tr>
<tr>
<td><strong>Total Funds available</strong></td>
<td>10,757</td>
<td>5.0 %</td>
</tr>
<tr>
<td>Non Recurrent Adjustments (incl ETO)</td>
<td>692</td>
<td>0.2 %</td>
</tr>
<tr>
<td>GPIT</td>
<td>542</td>
<td>0.2 %</td>
</tr>
<tr>
<td>CAMHS</td>
<td>390</td>
<td>0.1 %</td>
</tr>
<tr>
<td>Tariff Uplift 1.1%</td>
<td>2,440</td>
<td>0.8 %</td>
</tr>
<tr>
<td>CNST 0.4%</td>
<td>557</td>
<td>0.2 %</td>
</tr>
<tr>
<td>Prescribing 4%</td>
<td>1,076</td>
<td>0.3 %</td>
</tr>
<tr>
<td>Demographic Growth (ONS) 2%</td>
<td>4,150</td>
<td>1.3 %</td>
</tr>
<tr>
<td>Non-Demographic (0.5%)</td>
<td>966</td>
<td>0.3 %</td>
</tr>
<tr>
<td>0.5% Contingency</td>
<td>1,351</td>
<td>0.4 %</td>
</tr>
<tr>
<td>1% Non Recurrent Risk Reserve</td>
<td>2,623</td>
<td>0.8 %</td>
</tr>
<tr>
<td>CQUIN Change</td>
<td>725</td>
<td>0.2 %</td>
</tr>
<tr>
<td>Cost pressures</td>
<td>3,536</td>
<td>1.1 %</td>
</tr>
<tr>
<td>Change year on year in surplus</td>
<td>(651)</td>
<td>(0.2%)</td>
</tr>
<tr>
<td>QIPP</td>
<td>(7,639)</td>
<td>(2.4%)</td>
</tr>
<tr>
<td><strong>Total Increase in Expenditure</strong></td>
<td>10,758</td>
<td>4.2 %</td>
</tr>
</tbody>
</table>

2016/17 Planned Surplus        | 2,702 | 1.0 % |
3.6 Proposed Budgets

The table below summarises the proposed budgets for the CCG in 2016/17.

<table>
<thead>
<tr>
<th>Commissioner Function</th>
<th>Annual Allocation £000's</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute NHS SLA</td>
<td>130,099</td>
</tr>
<tr>
<td>Acute Other</td>
<td>12,221</td>
</tr>
<tr>
<td><strong>Acute Sub-total</strong></td>
<td><strong>142,319</strong></td>
</tr>
<tr>
<td>Mental Health</td>
<td>30,710</td>
</tr>
<tr>
<td>Community Healthcare</td>
<td>33,065</td>
</tr>
<tr>
<td>Continuing Care</td>
<td>14,398</td>
</tr>
<tr>
<td>Programme Spend</td>
<td>11,493</td>
</tr>
<tr>
<td>Services Provided in a Primary Care Setting</td>
<td>30,998</td>
</tr>
<tr>
<td><strong>Healthcare Provision Sub-total</strong></td>
<td><strong>120,663</strong></td>
</tr>
<tr>
<td>CCG Running Costs</td>
<td>4,501</td>
</tr>
<tr>
<td><strong>Running Costs</strong></td>
<td><strong>4,501</strong></td>
</tr>
<tr>
<td>Primary Care Co-Commissioning</td>
<td>28,805</td>
</tr>
<tr>
<td><strong>Primary Care Co-commissioning</strong></td>
<td><strong>28,805</strong></td>
</tr>
<tr>
<td><strong>Total Expenditure</strong></td>
<td><strong>296,288</strong></td>
</tr>
<tr>
<td><strong>Resource Limit</strong></td>
<td><strong>298,990</strong></td>
</tr>
<tr>
<td><strong>Surplus / (Deficit)</strong></td>
<td><strong>2,702</strong></td>
</tr>
</tbody>
</table>

A more detailed budget breakdown and current NHS Provider contract status is provided in Appendix B.

3.7 QIPP

To achieve business rules the CCG has a QIPP target of £7.8m of which £4.7m has been built into budgets and £3.1m remains unallocated at this stage. Detailed business cases have/are being ratified through the agreed confirm and challenge process. A breakdown of the QIPP programme by scheme is provided at Appendix C

3.8 2015/16 Provisional Financial Position

- As at the end of March 2016 (Month 12) the CCG is reporting a surplus of £3,667k. This is £315k above the revised planned year-end surplus of £3,352k. A breakdown of expenditure is provided in appendix D.
- This position is reflected in the CCG’s draft annual accounts which are currently being reviewed by the external auditors and is therefore provisional until the audit is completed.
- The CCG had a final resource limit of £293,660k. There was a change to the resource limit in Month 12 of -£1,784k.
- Reported figures reflects the statutory “Agreement of Balances” positions for NHS providers, and is based on the latest monitoring data and invoices from non-NHS providers.
- Agreement has been reached with BHRUT on 2015/16 RTT funding, improvement plans and winter resilience, constituting an agreed final outturn for the Trust. The year-end position reflects an under performance of £133k on the block payment agreed.
- The final outturn position with Barts Health is an over performance of £2,089k. The position reflects the agreement with the provider and the lead commissioner.
5.0 Risk

5.1 A high level of financial risk has been identified within the operating plan. The currently identified risks are highlighted in the table below.

<table>
<thead>
<tr>
<th>Barking &amp; Dagenham</th>
<th>Full Risk Value £'000</th>
<th>Probability of risk being realised %</th>
<th>Potential Risk Value £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute activity growth</td>
<td>15,592</td>
<td>55%</td>
<td>8,576</td>
</tr>
<tr>
<td>Continuing Care SLAs</td>
<td>520</td>
<td>50%</td>
<td>260</td>
</tr>
<tr>
<td>QIPP Under-Delivery</td>
<td>5,056</td>
<td>64%</td>
<td>3,213</td>
</tr>
<tr>
<td>Performance Issues</td>
<td>3,870</td>
<td>85%</td>
<td>3,296</td>
</tr>
<tr>
<td>Prescribing</td>
<td>279</td>
<td>50%</td>
<td>139</td>
</tr>
<tr>
<td><strong>TOTAL RISKS</strong></td>
<td><strong>25,317</strong></td>
<td><strong>61%</strong></td>
<td><strong>15,485</strong></td>
</tr>
<tr>
<td>Contingency Held</td>
<td>(1,495)</td>
<td>(100%)</td>
<td>(1,495)</td>
</tr>
<tr>
<td><strong>Net Risk/Headroom</strong></td>
<td><strong>23,822</strong></td>
<td>(39%)</td>
<td><strong>13,990</strong></td>
</tr>
</tbody>
</table>

5.2 The table shows the full risk identified and a potential risk assessed value. The risk assessed value after mitigating reserves totals £14m.

5.3 The main risk factors include:

- Acute activity growth above the planned demographic levels.
- The current significant gap between CCG and provider positions in the 16/17 contract negotiations. There is a contract gap in excess of £20m with BHRUT across all BHR CCGs plus smaller gaps with Barts Health, LAS and some other providers.
- Current business rules limiting the scope to apply contract levers.
- The risk of QIPP schemes not delivering to the expected and planned levels.
- The CCG’s plan assumes the 1% non-recurrent reserve is uncommitted at this stage but will become available during the year to fund RTT pressures. There is therefore two risks; the first that NHSE will not allow this treatment. The second risk is that the RTT clearance pressure will be in excess of the 1% reserve level.
- Other risks include potential for Prescribing and Continuing Care costs exceeding planned levels.

5.4 The only reserve mitigation to these risks is the 0.5% contingency within the plan.

5.5 The CCG will take responsibility for commissioning Bariatric Surgery in 2016/17. This transfer will be reflected in the plan once finalised. Currently it is assumed that sufficient resource will be transferred from NHSE to ensure that this does not create an additional risk. Assurance will be sought and required from NHSE on this issue.

5.6 The current budgets do not included the impacted costs of funding for the movement of property services charges to market value rents. NHSE have informed CCGs that there will be no recurrent funding to match this cost change. The CCG is awaiting further details from NHSE.

5.7 Impact upon statutory duties

The plan includes a very high level of financial risk. The materialisation of any of these key risks, including RTT treatment, PbR acute activity growth and QIPP delivery could result in the CCG posting a deficit position in 2016/17. There is a similar risk profile across all of the BHR CCG’s. Agreement would be required from NHSE to move one or more of the CCGs to a deficit plan.
6.0 Managing conflicts of interest
6.1 N/A

*Attachments:*
1. Appendix A – Planning Tables
2. Appendix B – Opening Budget Envelopes
3. Appendix C – QIPP Target
4. Appendix D – CCG Financial Position
Appendix A

Barking & Dagenham CCG Planning Tables 2016/17

The key financial assumptions made within the financial plan are as follows:

<table>
<thead>
<tr>
<th>Key Planning Assumptions</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tariff Change - Acute</td>
<td>1.10%</td>
</tr>
<tr>
<td>Tariff Change - Acute CNST</td>
<td>0.40%</td>
</tr>
<tr>
<td>Tariff Change - Non Acute</td>
<td>1.10%</td>
</tr>
<tr>
<td>Demographic Growth (Based on ONS data)</td>
<td>2.00%</td>
</tr>
<tr>
<td>Non Demographic Growth - Acute</td>
<td>0.50%</td>
</tr>
<tr>
<td>Non Demographic Growth - MH &amp; Community</td>
<td>0.50%</td>
</tr>
<tr>
<td>Prescribing</td>
<td>4.00%</td>
</tr>
</tbody>
</table>

The CCG’s resource allocation for 2016/17 is broken down as follows:

<table>
<thead>
<tr>
<th>Allocations</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barking and Dagenham</td>
<td></td>
</tr>
<tr>
<td>Baseline Allocation</td>
<td>254,571</td>
</tr>
<tr>
<td>Programme Growth</td>
<td>7,761</td>
</tr>
<tr>
<td>Primary Care Co-Commissioning</td>
<td>28,805</td>
</tr>
<tr>
<td>Return of 2015/16 Surplus</td>
<td>3,352</td>
</tr>
<tr>
<td>Running Cost Allocation</td>
<td>4,501</td>
</tr>
<tr>
<td><strong>Total Resource</strong></td>
<td><strong>298,990</strong></td>
</tr>
</tbody>
</table>

Programme Growth is further broken down as follows:

<table>
<thead>
<tr>
<th>Programme Growth</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barking and Dagenham</td>
<td></td>
</tr>
<tr>
<td>Per capita growth</td>
<td>1,559</td>
</tr>
<tr>
<td>Population growth</td>
<td>5,132</td>
</tr>
<tr>
<td>GP IT &amp; CAMHS</td>
<td>1,070</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>7,761</strong></td>
</tr>
</tbody>
</table>
## Appendix B

### Opening Budget Envelopes 2016/17 £000's

<table>
<thead>
<tr>
<th>NHS Contract Status</th>
<th>NHS Contract</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td></td>
</tr>
<tr>
<td>Barking, Havering And Redbridge University Hospitals NHS Trust</td>
<td>Offer Received</td>
</tr>
<tr>
<td>Barts Health NHS Trust</td>
<td>Offer Received</td>
</tr>
<tr>
<td>London Ambulance Service</td>
<td>8,347</td>
</tr>
<tr>
<td>Moorfields Eye Hospital NHS Foundation Trust</td>
<td>Offer Received</td>
</tr>
<tr>
<td>University College London NHS Foundation Trust</td>
<td>2,416</td>
</tr>
<tr>
<td>Guys And St Thomas NHS Foundation Trust</td>
<td>Offer Received</td>
</tr>
<tr>
<td>Homerton University Hospital NHS Foundation Trust</td>
<td>Offer Received</td>
</tr>
<tr>
<td>Mid Essex NHS Trust</td>
<td>1,757</td>
</tr>
<tr>
<td>The Royal National Orthopaedic Hospital NHS Trust</td>
<td>Offer Received</td>
</tr>
<tr>
<td>Royal Free London NHS Foundation Trust</td>
<td>Offer Received</td>
</tr>
<tr>
<td>Great Ormond Street Hospital for Children NHS Foundation Trust</td>
<td>Offer Received</td>
</tr>
<tr>
<td>Barts Health &amp; Thame NHS Foundation Trust</td>
<td>Offer Received</td>
</tr>
<tr>
<td>St Bartholomew's Hospital NHS Foundation Trust</td>
<td>Offer Received</td>
</tr>
<tr>
<td>Kings College Hospital NHS Foundation Trust</td>
<td>Offer Received</td>
</tr>
<tr>
<td>Imperial College Healthcare NHS Trust</td>
<td>Offer Received</td>
</tr>
<tr>
<td>Chelsea And Westminster Hospital NHS Foundation Trust</td>
<td>Offer Received</td>
</tr>
<tr>
<td>North Middlesex University Hospital NHS Trust</td>
<td>Offer Received</td>
</tr>
<tr>
<td>St George's Healthcare NHS Trust</td>
<td>Offer Received</td>
</tr>
<tr>
<td>North West London Hospitals NHS Trust</td>
<td>Offer Received</td>
</tr>
<tr>
<td>Royal Brompton And Harefield NHS Foundation Trust</td>
<td>Offer Received</td>
</tr>
<tr>
<td>Princess Alexandra NHS Trust</td>
<td>Offer Received</td>
</tr>
<tr>
<td>Whittington Hospital NHS Trust</td>
<td>Offer Received</td>
</tr>
<tr>
<td>The Royal Marsden Hospital NHS Foundation Trust</td>
<td>Offer Received</td>
</tr>
<tr>
<td>Imperial College Healthcare NHS Trust</td>
<td>Offer Received</td>
</tr>
<tr>
<td>Clinical Assessment &amp; Treatment Centre - Care UK</td>
<td>Offer Received</td>
</tr>
<tr>
<td>Spire Healthcare</td>
<td>Offer Received</td>
</tr>
<tr>
<td>In-Health - Independent Diagnostics</td>
<td>Offer Received</td>
</tr>
<tr>
<td>BMI</td>
<td>Offer Received</td>
</tr>
<tr>
<td>Holly House</td>
<td>Offer Received</td>
</tr>
<tr>
<td>Concordia</td>
<td>Offer Received</td>
</tr>
<tr>
<td>Other Acute</td>
<td>4,979</td>
</tr>
<tr>
<td>Total Acute</td>
<td>142,319</td>
</tr>
<tr>
<td>Non Acute</td>
<td>142,319</td>
</tr>
<tr>
<td>NELFT Mental Health Contract</td>
<td>26,238 Offer Received</td>
</tr>
<tr>
<td>NELFT - Overseas visitors</td>
<td>877</td>
</tr>
<tr>
<td>Cherry Orchards</td>
<td>1,041</td>
</tr>
<tr>
<td>Outlook Care</td>
<td>530</td>
</tr>
<tr>
<td>Other Mental Health</td>
<td>1,999</td>
</tr>
<tr>
<td>Total Mental Health</td>
<td>30,710</td>
</tr>
<tr>
<td>NELFT Community Contract</td>
<td>29,761 Offer Received</td>
</tr>
<tr>
<td>ST Francis Hospice</td>
<td>279</td>
</tr>
<tr>
<td>Marie Stopes</td>
<td>453</td>
</tr>
<tr>
<td>NELFT Non Contract</td>
<td>0</td>
</tr>
<tr>
<td>Other Community Services</td>
<td>2,141</td>
</tr>
<tr>
<td>Total Community Service</td>
<td>33,005</td>
</tr>
<tr>
<td>Physical Disabilities</td>
<td>6,249</td>
</tr>
<tr>
<td>Mental Health Continuing Care</td>
<td>2,248</td>
</tr>
<tr>
<td>Palliative</td>
<td>2,966</td>
</tr>
<tr>
<td>Learning Disabilities</td>
<td>2,066</td>
</tr>
<tr>
<td>Funded Nursing Care</td>
<td>1,126</td>
</tr>
<tr>
<td>Children's Continuing Care</td>
<td>987</td>
</tr>
<tr>
<td>Other Continuing Care</td>
<td>1,733</td>
</tr>
<tr>
<td>Total Continuing Care</td>
<td>14,398</td>
</tr>
<tr>
<td>Programme Spend</td>
<td>6,709</td>
</tr>
<tr>
<td>Better Care Fund</td>
<td>4,784</td>
</tr>
<tr>
<td>Total Non Acute</td>
<td>89,665</td>
</tr>
<tr>
<td>Primary Care</td>
<td>28,805</td>
</tr>
<tr>
<td>Prescribing</td>
<td>26,259</td>
</tr>
<tr>
<td>Oxygen</td>
<td>375</td>
</tr>
<tr>
<td>Central Drugs</td>
<td>748</td>
</tr>
<tr>
<td>Out of Hours Service</td>
<td>1,292</td>
</tr>
<tr>
<td>EVERYBODY COUNTS</td>
<td>1,091</td>
</tr>
<tr>
<td>Other Primary Care</td>
<td>1,237</td>
</tr>
<tr>
<td>Total Primary Care</td>
<td>30,999</td>
</tr>
<tr>
<td>Primary Care Co-Commissioning</td>
<td>28,805</td>
</tr>
<tr>
<td>Total Primary Care Co-Commissioning</td>
<td>28,805</td>
</tr>
<tr>
<td>Running Cost Allowance</td>
<td>4,501</td>
</tr>
<tr>
<td>Total Running Costs</td>
<td>4,501</td>
</tr>
<tr>
<td>Total Expenditure</td>
<td>296,288</td>
</tr>
<tr>
<td>Resource</td>
<td>298,990</td>
</tr>
<tr>
<td>Surplus</td>
<td>2,702</td>
</tr>
</tbody>
</table>
Appendix C

Development of QIPP plans for 2016/17

Current plans in development total £4.6m which is 60% of the £7.8m target.

Work is continuing on closing the gap and the process has resulted in the development of the following QIPP projects.

<table>
<thead>
<tr>
<th>QIPP Initiative</th>
<th>PID Status</th>
<th>Gross Saving £000</th>
<th>Investment £000</th>
<th>Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barking &amp; Dagemham</td>
<td>Draft</td>
<td>661</td>
<td>661</td>
<td></td>
</tr>
<tr>
<td>Vanguard</td>
<td>Draft</td>
<td>430</td>
<td>430</td>
<td></td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>Draft</td>
<td>416</td>
<td>416</td>
<td></td>
</tr>
<tr>
<td>MSK</td>
<td>Draft</td>
<td>208</td>
<td>(125)</td>
<td>83</td>
</tr>
<tr>
<td>Dermatology</td>
<td>Draft</td>
<td>900</td>
<td>900</td>
<td></td>
</tr>
<tr>
<td>Medicines Management</td>
<td>Draft</td>
<td>456</td>
<td>(72)</td>
<td>384</td>
</tr>
<tr>
<td>Estates</td>
<td>Draft</td>
<td>133</td>
<td>133</td>
<td></td>
</tr>
<tr>
<td>Chronic Kidney Disease</td>
<td>Draft</td>
<td>247</td>
<td>247</td>
<td></td>
</tr>
<tr>
<td>BCF</td>
<td>Draft</td>
<td>615</td>
<td>615</td>
<td></td>
</tr>
<tr>
<td>RTT demand management</td>
<td>Draft</td>
<td>54</td>
<td>54</td>
<td></td>
</tr>
<tr>
<td>Right Care</td>
<td>Draft</td>
<td>581</td>
<td>581</td>
<td></td>
</tr>
<tr>
<td>Primary Care Co-Comm</td>
<td>Draft</td>
<td>143</td>
<td>143</td>
<td></td>
</tr>
<tr>
<td><strong>Current Total</strong></td>
<td></td>
<td><strong>4,844</strong></td>
<td><strong>(197)</strong></td>
<td><strong>4,647</strong></td>
</tr>
<tr>
<td><strong>Current Total as % of target</strong></td>
<td></td>
<td></td>
<td></td>
<td>60%</td>
</tr>
<tr>
<td><strong>QIPP Gap</strong></td>
<td></td>
<td></td>
<td></td>
<td>3,135</td>
</tr>
<tr>
<td><strong>Gap as % of target</strong></td>
<td></td>
<td></td>
<td></td>
<td>40%</td>
</tr>
</tbody>
</table>

The projects listed above are being progressed through the QIPP PMO review sessions. Additional QIPP projects will need to be developed in the first quarter of 2016/17. To close the QIPP gap, there is continued effort to identify and work up new opportunities.

Failure to identify the £3.1m QIPP gap will present the CCG with a significant financial pressure in 2016/17. However steps are being taken to mitigate this risk through the additional opportunities identified, including:

- Review of current contracts and spend
- Scrutiny of other BHR CCG project implementation documents (PIDs) for implementation by Barking and Dagenham CCG
- Review of other CCG QIPP ideas, web based or through contact with other CCGs.
### Appendix D

#### Barking and Dagenham CCG Financial Position 2015/16

**Month 12 - 31st Mar 2016**

<table>
<thead>
<tr>
<th>Commissioner Function</th>
<th>Annual Allocation £000's</th>
<th>YTD Budget £000's</th>
<th>YTD Actual £000's</th>
<th>YTD Variance £000's</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute Healthcare</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Commissioning</td>
<td>121,963</td>
<td>121,963</td>
<td>124,333</td>
<td>(2,370)</td>
</tr>
<tr>
<td>Acute Commissioning Other</td>
<td>3,123</td>
<td>3,123</td>
<td>2,719</td>
<td>403</td>
</tr>
<tr>
<td>Winter Resilience</td>
<td>883</td>
<td>883</td>
<td>1,309</td>
<td>(426)</td>
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<tr>
<td>High Cost Drugs</td>
<td>10</td>
<td>10</td>
<td>12</td>
<td>(2)</td>
</tr>
<tr>
<td>Ambulance Services</td>
<td>7,375</td>
<td>7,375</td>
<td>7,374</td>
<td>1</td>
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<tr>
<td>Clinical Assessment and Treatment Centres</td>
<td>4,029</td>
<td>4,029</td>
<td>4,469</td>
<td>(440)</td>
</tr>
<tr>
<td>NCA</td>
<td>2,943</td>
<td>2,943</td>
<td>3,066</td>
<td>(123)</td>
</tr>
<tr>
<td><strong>Acute sub-tot Acute sub-total</strong></td>
<td><strong>140,326</strong></td>
<td><strong>140,326</strong></td>
<td><strong>143,282</strong></td>
<td><strong>(2,956)</strong></td>
</tr>
<tr>
<td><strong>Mental Health &amp; LD</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health Contracts</td>
<td>25,009</td>
<td>25,009</td>
<td>25,001</td>
<td>9</td>
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<tr>
<td>Mental Health Services - Adult</td>
<td>996</td>
<td>996</td>
<td>931</td>
<td>64</td>
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<tr>
<td>Non Acute NCA</td>
<td>333</td>
<td>333</td>
<td>422</td>
<td>(89)</td>
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<tr>
<td>Mental Health Services Other</td>
<td>3,283</td>
<td>3,283</td>
<td>3,265</td>
<td>18</td>
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<tr>
<td><strong>Mental Health &amp; LD sub-total</strong></td>
<td><strong>29,622</strong></td>
<td><strong>29,622</strong></td>
<td><strong>29,619</strong></td>
<td><strong>3</strong></td>
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<tr>
<td><strong>Community Healthcare</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Community Services</td>
<td>30,970</td>
<td>30,970</td>
<td>30,481</td>
<td>489</td>
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<tr>
<td>Palliative Care</td>
<td>88</td>
<td>88</td>
<td>57</td>
<td>31</td>
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<td>Hospices</td>
<td>882</td>
<td>882</td>
<td>785</td>
<td>97</td>
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<td>Long Term Conditions</td>
<td>205</td>
<td>205</td>
<td>201</td>
<td>(57)</td>
</tr>
<tr>
<td>Wheel chair service</td>
<td>36</td>
<td>36</td>
<td>28</td>
<td>8</td>
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<tr>
<td><strong>Community Sub-total</strong></td>
<td><strong>32,181</strong></td>
<td><strong>32,181</strong></td>
<td><strong>31,612</strong></td>
<td><strong>569</strong></td>
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<tr>
<td><strong>Continuing Care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHC Adult</td>
<td>11,438</td>
<td>11,438</td>
<td>12,012</td>
<td>(574)</td>
</tr>
<tr>
<td>CHC Adult Full Fund Pers Hlth Bud</td>
<td>46</td>
<td>46</td>
<td>75</td>
<td>(29)</td>
</tr>
<tr>
<td>CHC Assessment and Support</td>
<td>350</td>
<td>350</td>
<td>721</td>
<td>(371)</td>
</tr>
<tr>
<td>CHC Children</td>
<td>946</td>
<td>946</td>
<td>1,457</td>
<td>(511)</td>
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<tr>
<td>Funded Nursing Care</td>
<td>1,035</td>
<td>1,035</td>
<td>1,113</td>
<td>(78)</td>
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<tr>
<td><strong>Continuing Care Sub-total</strong></td>
<td><strong>13,814</strong></td>
<td><strong>13,814</strong></td>
<td><strong>15,378</strong></td>
<td><strong>(1,564)</strong></td>
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<tr>
<td><strong>Programme Spend</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Commissioning - Non Acute</td>
<td>587</td>
<td>587</td>
<td>564</td>
<td>23</td>
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<tr>
<td>Better Care Fund</td>
<td>4,185</td>
<td>4,185</td>
<td>4,182</td>
<td>3</td>
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<tr>
<td>Health Analytics</td>
<td>147</td>
<td>147</td>
<td>143</td>
<td>4</td>
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<tr>
<td>Counselling services</td>
<td>122</td>
<td>122</td>
<td>(120)</td>
<td>242</td>
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<tr>
<td>Safeguarding</td>
<td>135</td>
<td>135</td>
<td>149</td>
<td>(15)</td>
</tr>
<tr>
<td>Non Recurrent Programmes</td>
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<td>1,320</td>
<td>1,295</td>
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<td>Programmes Projects</td>
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<td>2,329</td>
<td>(750)</td>
<td>3,079</td>
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<td>Reablement</td>
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<td>661</td>
<td>661</td>
<td>(0)</td>
</tr>
<tr>
<td>NHS 111</td>
<td>454</td>
<td>454</td>
<td>453</td>
<td>1</td>
</tr>
<tr>
<td>NHS Prop.Co</td>
<td>841</td>
<td>841</td>
<td>1,237</td>
<td>(396)</td>
</tr>
<tr>
<td><strong>Programme Spend Sub total</strong></td>
<td><strong>10,780</strong></td>
<td><strong>10,780</strong></td>
<td><strong>7,816</strong></td>
<td><strong>2,964</strong></td>
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<tr>
<td><strong>Services Provided in a Primary Care Setting</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Out of Hours</td>
<td>1,059</td>
<td>1,059</td>
<td>1,059</td>
<td>0</td>
</tr>
<tr>
<td>Everybody Counts</td>
<td>1,427</td>
<td>1,427</td>
<td>1,427</td>
<td>1,414</td>
</tr>
<tr>
<td>Commissioner Schemes</td>
<td>133</td>
<td>133</td>
<td>1,566</td>
<td>(1,433)</td>
</tr>
<tr>
<td>Primary Care Co-Commissioning / LES</td>
<td>27,893</td>
<td>27,893</td>
<td>27,827</td>
<td>67</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>203</td>
<td>203</td>
<td>177</td>
<td>26</td>
</tr>
<tr>
<td>Primary Care IT</td>
<td>680</td>
<td>680</td>
<td>577</td>
<td>103</td>
</tr>
<tr>
<td>GP Prescribing</td>
<td>24,622</td>
<td>24,622</td>
<td>25,343</td>
<td>(61)</td>
</tr>
<tr>
<td>Oxygen</td>
<td>380</td>
<td>380</td>
<td>348</td>
<td>32</td>
</tr>
<tr>
<td>Central Drugs</td>
<td>691</td>
<td>691</td>
<td>739</td>
<td>(48)</td>
</tr>
<tr>
<td><strong>Services Provided in a Primary Care Setting Sub-total</strong></td>
<td><strong>57,149</strong></td>
<td><strong>57,149</strong></td>
<td><strong>57,650</strong></td>
<td><strong>(501)</strong></td>
</tr>
<tr>
<td><strong>Sub-total Healthcare provision</strong></td>
<td><strong>283,872</strong></td>
<td><strong>283,872</strong></td>
<td><strong>285,356</strong></td>
<td><strong>(1,485)</strong></td>
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<tr>
<td><strong>Running Costs</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CCG Running Costs</td>
<td>4,488</td>
<td>4,488</td>
<td>4,487</td>
<td>1</td>
</tr>
<tr>
<td>Quality Premium Admin</td>
<td>0</td>
<td>0</td>
<td>149</td>
<td>(149)</td>
</tr>
<tr>
<td><strong>Running Costs Sub-total</strong></td>
<td><strong>4,488</strong></td>
<td><strong>4,488</strong></td>
<td><strong>4,636</strong></td>
<td><strong>(148)</strong></td>
</tr>
<tr>
<td><strong>Gross Expenditure</strong></td>
<td>288,360</td>
<td>288,360</td>
<td>289,993</td>
<td>(1,633)</td>
</tr>
<tr>
<td><strong>Resource Limit</strong></td>
<td>293,660</td>
<td>293,660</td>
<td>293,660</td>
<td>0</td>
</tr>
<tr>
<td><strong>Surplus/Deficit</strong></td>
<td>5,300</td>
<td>5,300</td>
<td>3,667</td>
<td>(1,633)</td>
</tr>
</tbody>
</table>
To: Meeting of the NHS Barking and Dagenham Governing Body

From: Conor Burke, Chief Officer

Date: 24 May 2016

Subject: Sustainability and Transformation Plan

Executive summary
Planning guidance was published on 22 December which set out the requirement for the NHS to produce two separate but connected plans:
- A five-year Sustainability and Transformation Plan (STP), place based and driving the Five Year Forward View; and
- A one year operational plan for 2016/17, organisation based but consistent with the emerging STP

North East London, as the agreed STP footprint, is required to deliver the following with respect to the STP:
- Delivery of an STP Base Case Submission by 15 April 2016 (complete)
- Delivery of the full STP by the end of June 2016

This paper will outline the above and propose arrangements for sign off of the June submission.

Recommendations
The Governing Body are requested to note the contents of this report and agree the proposed sign off approach for the June submission as flows:
- the NEL STP is submitted in draft on 30 of June, subject to sign off.
- delegated authority be made to the following individuals on behalf of the Governing Body to sign off the draft NEL STP week commencing 20th of June.

- Chair: Dr Waseem Mohi
- Chief Officer: Conor Burke
- Chief Operating Officer: Sharon Morrow
- Chief Finance Director: Tom Travers
- Lay member: to be nominated
- Clinical Director: to be nominated

In agreeing the delegation above, the Governing Body are requested to nominate a lay member and Clinical Director.

To note, that subject to the above, the final NEL STP brought to this Governing Body in September 16 for agreement.
1.0 **Purpose of the Report**
To update the governing body regarding the North East London (NEL) Sustainability and Transformation Plan (STP) arrangements and agree processes for sign off of the June submission.

2.0 **Background/Introduction**

2.1 Planning guidance was published on 22 December which set out the requirement for the NHS to produce two separate but connected plans:
- A five-year Sustainability and Transformation Plan (STP), place based and driving the Five Year Forward View; and
- A one year operational plan for 2016/17, organisation based but consistent with the emerging STP

2.2 Further guidance on the STP was published 16 March 2016 and set out the following deliverables required for the STP.

1. Delivery of an STP Base Case Submission by 15 April 2016 (complete)
Consisting of a 10 a page slide deck which set out emerging arrangements and high level initial hypotheses regarding potential areas of focus for the STP, as follows:
- Leadership, governance and engagement
- Health and wellbeing
- Care and quality
- Efficiency and finance
- Emerging priorities
- Support requirements and risks

2. Delivery of the full STP by the end of June. It is worth noting the specific requirements of the full STP currently remain unclear.

2.3 The constituent footprint across commissioners and providers of the NEL STP is:
- City and Hackney - Barking & Dagenham
- Waltham Forest - Havering
- Tower Hamlets - Redbridge
- Newham

Providers are as follows:
- Barking, Havering and Redbridge University Hospitals Trust,
- Barts Health NHS Trust,
- East London NHS Foundation Trust,
- Homerton University Hospitals NHS Foundation Trust,
- NELFT NHS Foundation Trust.

Local authorities: Barking and Dagenham, City of London, Hackney, Havering, Newham, Redbridge, Tower Hamlets and Waltham Forest.

Whilst local authorities are not signatories to the STP there is an acknowledgement that for an STP to be robust, local authorities must be engaged. See section 3.6 for arrangements regarding local authority engagement.

2.4 The NEL STP will focus on scaling/building up of local area accountable care system plans these being:
- the Accountable Care Organisation for BHR
- Transforming Services Together for WEL
- the Devolution pilot for Hackney

The NEL STP is intended to add value and identify areas from the above which would benefit from consideration of approaches at scale.

2.5 A successful STP at a NEL level will:
- Show a whole system approach to health and social care planning
- Require systems to work together to produce a sustainable plan that both meets quality and performance standards and ensures financial sustainability
- Require conjoined commissioner and provider plans which align activity and finance
- Crucially, the NEL STP will be the single application and approval process for transformation funding for 2017/18 onwards

3.0 Governance

3.1 Correspondence from NHS England dated 16 February 2016 specified a requirement to identify a chief officer lead, provider lead and local authority lead for delivery of the STP, with one of these representatives to be confirmed as overall lead. For NEL, the following leads have been proposed:

Jane Milligan, Chief Officer, Tower Hamlets CCG: STP Executive Lead
Terry Huff, Chief Officer, Waltham Forest CCG: CCG Lead
Matthew Hopkins, Chief Executive, BHRUT: Provider Lead
Cheryl Coppell, Chief Executive, London Borough of Havering: Local Authority Lead

3.2 The proposed governance structure for the development of STP can be referred to in Appendix 1 and builds upon arrangements which were already in place in NEL such as the North East London Advisory Group. The governance structure also recognises the interface between accountable care system plans and the STP development.

3.3 Each member of the Sustainability and Transformation Board will be responsible for internal briefing regarding the STP arrangements and progress.

3.4 An independent facilitator has been recruited short term for the purpose of providing external challenge and facilitation to ensure that the overall STP is successful from its initiation through to final completion and collective sign off.

3.5 Robust programme governance arrangements have been established including: a NEL PMO to oversee programme delivery, programme initiation document, risk management processes, assurance framework (in train), and communications and engagement plan.

3.6 A resource specifically committed to local authority engagement has been secured to ensure the NEL STP fully engages with local authority partners including via Health and Wellbeing Boards, and in particular workstreams where relevant. Local authorities are also represented on the Steering Group and Sustainability and Transformation Board.

4.0 Proposals for sign off of the full STP for submission 30 June

4.1 It is recognised that to achieve the 30 June milestone for the submission of the NEL STP to NHS England a robust decision making and approvals process that respects the
sovereignty, governance and assurance requirements of the respective CCGs and Providers is required.

4.2 The programme team has mapped all Trust Boards and Governing Bodies between now and June, and as a result have identified that full Board/Governing Body sign off across NEL is currently unfeasible with a submission deadline of 30 June, as this would require the full STP to be developed by 11 May.

4.3 It is therefore proposed that:
- the NEL STP is submitted in draft on 30 of June, subject to sign off.
- delegated authority be made to the following individuals on behalf of the Governing Body to sign off the draft NEL STP week commencing 20th of June.

Chair: Dr Waseem Mohi
Chief Officer: Conor Burke
Chief Operating Officer: Sharon Morrow
Chief Finance Director: Tom Travers
Lay member: to be nominated
Clinical Director: to be nominated

4.4 The Governing Body are requested to nominate lay member and clinical director representatives in line with the above.

4.5 Following submission, NHS England will undertake an assurance process July/August (tbc). With the NEL STP then finalised to reflect feedback from NHS England assurance process, and signed off in public through the CCG Governing Body meetings September 16.

5.0 Resources/investment

5.1 Each CCG (x 7) and each major acute and community/MH provider (x5) has agreed to commit an initial investment ask of £35K to support the STP development with a view to securing transformation funding from 2017/18 onwards. However, there is recognition across system leaders that required ask is likely to be greater than this to ensure successful delivery of the programme.
Crucially, the NEL STP will be the single application and approval process for transformation funding for 2017/18 onwards

6.0 Equalities

6.1 There are no equalities considerations at this point.

7.0 Risk

7.1 Failure to agree the above with respect to the June submission will result in the system failing to meet the requirements for delivery of the STP.

7.2 There is a risk that now all partners will sign off the draft STP meaning the system will not submit a plan endorsed by all partners and in turn impacting on the ability of the system to secure sustainability and transformation funding.
7.3 There is a risk that lack of guidance from NHS England regarding the expected structure and content of the final STP may result in NEL developing a plan which does not meet NHSE assurance.

8.0 Managing conflicts of interest

8.1 There are no conflicts of interest to consider.

Attachments:
1. Appendix 1 NEL STP Governance Structure
2. Appendix 2 Proposed sign off process for NEL STP

Author: Tara-Lee Baohm on behalf of the NEL PMO
Date: 22 April 2016
Programme governance: STP governance structure and leadership

**North East London Sustainability & Transformation Board**

**Purpose:** Oversee delivery NEL STP in line with NHS E requirements. Senior cross organization group for collaborative decision making.

**Chair:** Independent Facilitator

**Members:** CCG Chief Officers (x5), Provider Chief Execs (x5), CCG Chairs (x2), NEL PH Lead, CCG CFOs (x3), DASS lead, NHSE, NHS TDA, LA Lead, NHSI

**STP Leadership Group**

**Purpose:** Set strategic direction for STP and resolve emerging risks / issues

**Chair:** STP Executive Lead

**Members:** BHRUT CE, WF CCG Chief Officer, TH CCG Chair, LBH CE, Independent Facilitator

**NEL Partnership Steering Group**

**Purpose:** Shape and define NEL STP

**Chair:** STP Executive Lead

**Members:** CCG leads (x3), Provider Leads (x6), STP CFO, PH Lead, NHS E Spec. Comm, HLP, Comms Lead

**NEL Finance and Activity Group**

**Purpose:** Coordinate development and assurance of financial base case

**Chair:** STP Executive Lead

**Members:** CCG CFOs (x3), Provider CFO Lead(s)

**NEL Clinical Senate**

**Purpose:** Provide clinical assurance of STP development

**Chair:** GP Chair of C&H CCG

**Members:** GP Clinical Directors CCG Chairs Trust Medical Directors

**STP Signatories**

- Provider Trust Boards
- CCG Governing Bodies

**Organisation governance**

- Local Authority Cabinets
- HWBBs
- HealthWatch
- OSCs

**STP leadership and governance**

- TST Programme Board
- BHR Devolution Vanguard
- Hackney Health & Social Care Transformation Board

**New Models of Care**

- TH MCP Vanguard
- WEL Transforming Services Together
- BHR ACO (Devolution Pilot)
- Hackney Devolution
- BHR UEC Vanguard

**Enablers**

- Technology
- Finance
- Workforce
- Assets & Infrastructure
- Estates
- Comms & Engagement

**Service Improvement and Quality**

- Prevention
- Wider Determinants of Health
- Personalisation & Self Care
- Primary Care
- Urgent Care
- Mental Health
- Acute Reconfiguration
- Specialised Commissioning
- Maternity
- Cancer

**Five Year Forward View**

#futureNHS
STP submission sign off timelines:
Barking & Dagenham CCG – sign off by delegation

**RAG Status:**

**w/c 25th April**
GB receive information on proposed sign off timelines

**Inputs:**
- NEL STP team to pre engage on sign off process with GB members

**Outputs:**
- NEL STP team to ensure board members are informed on upcoming timeline for STP sign off and engagement
- GB have considered appropriate delegated authority, e.g. Chair, CO, FD, Lay member, +1CD for each CCG

**Actions:**
- GB to provide NEL STP team with comments/ concerns on the sign off process going forward

**24th May**
Proposal to GB for delegated sign off

**Inputs:**
- NEL STP team to provide GB with progression on STP draft submission for review
- NEL STP team to present a formal proposal to GB members for STP sign off by a delegated authority

**Outputs:**
- GB to agree on delegation process and authority
- GB to provide comments to NEL STP team on STP draft submission that enable fine tuning of the submission

**Actions:**
- NEL STP team to address any sticking points highlighted by the GB on the STP draft submission

**w/c 20th June**
Delegated authority to sign off final STP draft submission

**Inputs:**
- NEL STP team to present final STP draft submission to delegated authority for sign off

**Outputs:**
- Delegated authority commit to adding their signature to the final STP draft submission as formal sign off of the document.
- Delegated authority consists of:
  - Chair: Dr Waseem Mohi
  - AO: Conor Burke
  - CO: Sharon Morrow
  - FD: Tom Travers
  - Lay member: to be nominated
  - CD: to be nominated

**Actions:**
- After the STP submission has been through the NHSE assurance process it will be sent to the 27th September GB
Executive summary
We have worked in partnership with our fellow BHR CCGs and engaged stakeholders from within our borough and more widely to produce this strategy.

We think that it will help us move to the next level in terms of our engagement with patients, carers and the public.

The strategy sets out our legal obligations and how we intend to meet these, but it goes further in terms of setting out how we can fully embed engagement in all that we do.

We’ve had lots of input in its production through interviews, group discussions, an event, survey and comments invited on the draft, so feel that it’s something that we and our fellow stakeholders can own.

The challenge now is to put it into practice, so included at the end of the strategy is a draft action plan for making it real and a handy guide to help colleagues deliver.

Recommendations
The governing body is asked to:
• Review, comment on and approve the attached strategy

1.0 Purpose of the report

2.0 Introduction
2.1 Patient engagement helps us to develop better services. It enables us to understand what services should be in place, where things need to be improved and how commissioning and provider staff should interact with patients.

2.2 As a CCG we have done reasonably well in meeting our requirements, but we want and need to go further. That’s why we have developed this strategy, using independent experts, and through engaging local stakeholders. We think it will help us move to the next level and be an organisation where the patient voice is fully embedded in all that we do.

3.0 Background
3.1 All NHS organisations have a responsibility to meet legal obligations with regard to engaging patients. Each year we are assessed by NHS England (NHSE) as to how well we have done in
meeting these. We produce an annual report on engagement, and once reviewed by NHSE, we publish it on our website. We currently have a ‘good’ rating for our arrangements.

3.2 We developed an initial strategy as part of the authorisation process and it was a useful start. But that strategy expired and we wanted to co-produce something locally that we felt could really have impact.

4.0 Development of strategy

4.1 PPI Solutions were commissioned as independent experts to develop the strategy in partnership with the CCG. The process of initial engagement across BHR involved:

- 30+ interviews
- 10+ small group discussions
- A paper and online survey seeking views on the principles which should underpin our strategy which received approx. 100 responses
- A stakeholder event with over 60 attendees

4.2 A draft was then produced and was shared with all the stakeholders involved in the above activities for their views. The strategy was then refined based on their feedback and this draft is attached for agreement by the governing body. The PEF Chair has provided helpful comment and suggestions, some of which are reflected in this draft. A further discussion is taking place at the May PEF meeting which may result in some edits to the final version – and which will be reported to this meeting.

5.0 Next steps

5.1 An initial draft action plan is attached to the strategy and will be shared with colleagues before being finalised. A helpful guide to accompany the strategy has also been produced and will be circulated and included with the final approved strategy.

5.2 Once agreed the strategy will be designed and formatted. It will then be shared with staff, members and stakeholders.

6.0 Resources/investment

6.1 The strategy will be implemented within the current resources available.

6.2 Sustainability - the CCG is including more opportunities for electronic and online engagement with the CCG, through the creation of an online group and increased usage of social media.

7.0 Equalities

7.1 In developing the strategy we engaged with a wide cross-section of groups. We anticipate that implementation of the strategy will support the CCG in meeting our equalities obligations and this is referred to within the document itself.

8.0 Risk

8.1 There are no specific risks in relation to this report.

9.0 Managing conflicts of interest

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

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Date: 25 April 2016
Patient, Carer and Public Engagement

A strategy and guide for Barking and Dagenham Clinical Commissioning Group 2016 - 2019

Front cover – pictures + logo to be added

Inside front cover

‘The NHS Belongs to us all. Patients come first in everything we do. We fully involve patients, staff, families, carers, communities, and professionals inside and outside the NHS. We put the needs of patients and communities before organisational boundaries. We speak up when things go wrong.’ The NHS Constitution

Publication date to be added.
Welcome

Here at Barking and Dagenham Clinical Commissioning Group (CCG) we plan, design, buy and improve the health services for the local population. Our aim is to ensure that all the services provided have people firmly at their heart. This means we need to involve local people every step of the way so that the services people receive are tailored to their needs. To ensure we are able to do this effectively we are very pleased to present this strategy and guide for patient, carer and public engagement.

Patient and public engagement is a legal requirement for the NHS but we believe it is also a better way to make sure local people get the services they need. The CCG is responsible for choosing and buying services on behalf of local people. To help us to write this strategy we undertook a process of co-design that involved a series of meetings with patients, carers, members of the public, representatives of the voluntary and community sector and staff. We know from talking to people about how we should engage patients, carers and the public that honesty is one of the most important things to get right and that this is particularly important when there is an increasing demand for services and less money available to spend.

We hope this strategy and guide will help us to use the experience, knowledge and creativity of local people to enable us to make the best decisions possible with and for local people. We would also like to thank everyone for their input in helping us to bring this strategy together.

Signatures to be added here.
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1 Introduction

This strategy and guide is set out in two parts.

In Part 1 ‘The Strategy’ you will find information about our approach including:

- Who we are and what we do
- Our commitment to patient, carer and public engagement
- The ways we make sure we can be held to account for our decisions and actions
- The ways we involve and engage local people
- Knowing what good looks like and being able to check whether we are engaging patients, carers and the public to a high standard

We will produce and share an action plan outlining the actions that we intend to take for the coming year in May 2016.

In Part 2 ‘The Guide’ you will find practical information including:

- Patient, carer and public engagement in commissioning, a step by step guide
- A plan on a page
- Methods and approaches
- Resources and contacts

NHS England has produced a framework for patient and public participation in primary care. You can view the document by [clicking here](#). Our strategy and guide is aligned to this framework and should be read alongside it.
2 The Strategy

2.1 Our Aim

A strategy is a plan for how to achieve a long term or overall aim. The aim of this strategy is to set out a plan that will enable us to ensure patients, carers and the public are engaged in our work in a meaningful and effective way over the next three years. Using the action plan included at the end we will check ourselves against our strategy as we go.

2.2 Our Objectives

There are lots of reasons why we want to engage patients, carers and the public, including that we are required in law, but more importantly we want to do this because our job is to plan and organise health and care on behalf of local people. We don’t believe we can do that effectively if we don’t understand what it is like to be on the receiving end or to be the person needing to use the service. Whilst this strategy is primarily to guide the Clinical Commissioning Group and staff employed within it, we also hope it will be useful and interesting for local people and others interested in our work.

2.3 The NHS Constitution

The NHS Constitution sets out rights for patients, public and staff. It outlines NHS commitments to patients and staff, and the responsibilities that the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively. All NHS bodies and private and third sector providers supplying NHS services are required by law to take account of the Constitution in their decisions and actions.
There are three specific rights that relate to people being involved in their healthcare and in the NHS.

1. You have the right to be involved in planning and making decisions about your health and care with your care provider or providers, including your end of life care, and to be given information and support to enable you to do this.

2. You have the right to an open and transparent relationship with the organisation providing your care.

3. You have the right to be involved, directly or through representatives, in the planning of healthcare services commissioned by NHS bodies, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services.

In our role as ‘commissioner’, we are charged with planning, organising, buying and monitoring the services that people ultimately use. To that end, it is the third one of these rights that this strategy and guide is particularly focusing on.

You can see the NHS Constitution by clicking here or you can telephone Tel: 0300 123 1002 to order a copy. There is also an accompanying handbook that you might find useful that can be accessed by clicking here.
3 What is important to us about patient, carer and public engagement

3.1 At a co-design event in February to help us put this strategy together, we asked people to tell us why patient, carer and public engagement was important. People told us, and we agree, that it is important to make sure services are planned and delivered in a way that puts people first, that is informed by different perspectives and that decisions are clear for all to see. A partnership between professionals, patients, carers and the public is the right approach and will help us to care, ensuring the right services are shaped to the needs of the people who need to use them.

3.2 Patient, carer and public engagement is important to:

- Make sure services are consistent, equal and unbiased
- Make improvements based on learning from patient and carer experiences
- Learn about expectations – getting a balance between wanting the best/better and being realistic
- Value people and their individual role in good health and care
- Empowering people, to harness their passion and understand their needs
- Identify and work with communities and populations whose health needs are not being met

3.3 Through the delivery of this strategy patients, carers and the public will become equal partners alongside clinicians and managers. This will help us to make sure everyone has access to all the services they need, at the right time and in the right place.
4 About Barking and Dagenham

4.1 Barking and Dagenham CCG is responsible, along with other health and social care professionals and patients, for deciding how most of the local NHS budget is spent.

4.2 GPs have always had a say in developing local health services, but since 2013 have taken on much greater responsibility to plan, buy and monitor NHS services. To do this, they joined together as Clinical Commissioning Groups.

4.3 All GP practices in the borough are part of the CCG. We have a governing body, which meets regularly, and is chaired by Dr Waseem Mohi, a local GP.

4.4 We have developed a set of values and behaviours that describe how we conduct our business and how our staff conduct themselves. These values are the building blocks of our organisation.

4.5 They are: honesty, responsibility, being caring, respect, professionalism, responsiveness, courage, collaboration and integrity. These values are embedded in the NHS Constitution and in the CCG’s commitment to promote equality and human rights.

4.6 We work very closely with our neighbouring CCGs in Havering and Redbridge with our local services providers and with our local Council to join up our services as much as possible and to help improve the health and care of local people.
5 Guiding Principles for Patient, Carer and Public Engagement

5.1 To help us make sure we approach the way we do patient, carer and public engagement in the right way, we undertook some work to find out what principles people thought were important to guide us.

5.2 We started with a list of 20 principles and asked people to tell us the ones they thought were most important. Whilst all of the principles were seen as important there were some that stood out from the crowd. With additional help from those who attended the event, the following list are set out as a way to help us make sure we do a good, high quality job of engaging our patients, carers and the public.

- Be open and honest about what is possible and what is not possible
- Involve people as early as possible, listen and act on patients and carer feedback every step of the way and tell people how their involvement made a difference throughout the process and at the end
- Be accessible, the way you engage people should be tailored to the people you are trying to engage, ask people what will work best for them
- Communicate clearly in easy to understand, plain English
- Allocate appropriate resources and support so that engagement can be effective
- Work hard to seek the views of people and communities who experience the highest health inequalities and the poorest health outcomes
- Base relationships on equality and respect, patients, carers and the public have an equal voice to professionals
- Work with relevant partner organisations

5.3 It is not our intention that this is a definitive or ‘tokenistic’ list for us to follow but a set of principles to guide us on our way.
5.4 We expect all of our staff and Governing Body members to use these principles to guide them in their work, we will include them within staff induction and appraisal procedures and we will require all business cases presented for approval to include a patient, carer and public engagement plan that sets out how the commissioning of services will meet the expectations set out in this strategy and within these guiding principles.

6 Our Legal Responsibilities

6.1 The NHS Act 2006 and the Health and Social Care Act 2012 introduced two complementary duties for clinical commissioning groups with respect to patient, carer and public engagement.

6.2 They relate to a duty for Individual Participation, which means involving patients and carers in decisions that effect their care or treatment and a duty for Public Participation which is to ensure public involvement and consultation in commissioning processes and decisions. The part that relates to specifically engaging people in the process of commissioning is called Section 13Q – you can read more information by clicking here.

6.3 We are also required in law through this Act to report to NHS England on how we are discharging our duties.

6.4 The Health and Social Care Act 2012 also amends the Local Government and Public Involvement in Health Act 2007 and places a duty on us through our membership of the Health and Wellbeing Board to work closely with Local Healthwatch the independent consumer champion for health and care. In particular, “Health and wellbeing boards must involve the local Healthwatch organisation and the local community, and this should be continuous. When involving the local community, boards should consider inclusive ways to involve people from different parts of the community including people with particular communication needs to ensure that differing health and social care needs are understood, reflected, and can be addressed by commissioners. This should recognise the need to engage with
parts of the community that are socially excluded and vulnerable. Involvement should aim to allow active participation of the community throughout the process” NHS Act 2006 (as amended).

6.5 We are also required to meet expectations in law that relate to reducing inequalities of a person’s ability to access health services and the health outcomes achieved through receiving a service. This is reinforced and further strengthened for us in the Equalities Act 2010 and the Mental Capacity Act 2005.

6.6 Further information is available from NHS England within the guidance available by clicking here.

6.7 Whilst these important duties are set out in law and we are keen for them to be visible in this strategy, we believe doing them for the right reason is as much if not more important than doing them because we are required in law.

7 The Compact

7.1 The Compact is a joint agreement between voluntary groups and public bodies and exists to help the partners improve their relationship for mutual advantage and community gain.

7.2 This strategy complements the Compact and we hope it will strengthen the agreements set out.

7.3 You can search and view a copy of all the local Compacts at the following link: by clicking here.
8 Governance and Accountability for Patient, Carer and Public Engagement

8.1 As a public organisation ‘Governance’ is the way we ensure the CCG is run and managed effectively and within the law. ‘Accountability’ is the way we take responsibility for the way we do this on behalf of the people we are set up to serve, and how we demonstrate that the decisions we make and take are in the best interests of the people of Barking and Dagenham.

8.2 We govern the CCG and make sure it is accountable to local people in a number of ways and central to the way we do this are the roles that local people play within our organisation, our structures and the day to day work that we do.

8.3 We don’t want to rely on one single way of doing this and aim to provide a full range of opportunities and approaches to patient, carer and public engagement that enable people to engage with us in whatever way suits them and in ways that support us to be effective in our role as the commissioner of services on behalf of our local population.

8.4 Set out here are ways that people can get involved with the CCG. It is not an exhaustive list and we will always aim to ensure the way we do this supports a meaningful contribution from all sections of our community.
8.5 Lay Members of the Governing Body

The Governing Body is the group of people who are charged with taking overall responsibility for how the CCG is run and managed and the decisions it takes. The Governing Body is largely made up of GPs who have been elected to take up positions of responsibility including areas of special interest and expertise. One GP on the Governing Body takes particular interest in patient, carer and public engagement. To ensure the public has a voice at the heart of the organisation we have local members of the community who sit as ‘Lay Members’ alongside the GPs and other nurses and managers on the Governing Body. Lay Members are appointed by a selection process following an open advert and application that invites any local interested member of the community to put themselves forward. There is always a minimum of two Lay Members on the governing body, one of which takes a particular interest in patient, carer and public engagement. The Lay Member in Barking and Dagenham is Sahdia Warraich. The Governing Body is responsible for signing this strategy off and is ultimately responsible for making sure it is implemented.

8.6 Public Access to Board Meetings

As a public body, all of our Governing Body meetings are held in public. We welcome members of the public to attend and there is allocated time for questions to be asked. The times, dates and venues of meetings are available in advance and the papers for the meetings can be accessed on our website http://www.Barking and Dagenhamccg.nhs.uk/. Papers are available a minimum of five working days in advance.
8.7 The Barking and Dagenham, Havering and Redbridge Patient and Public Engagement Seminar Series.

The three CCGs, Barking and Dagenham, Havering and Redbridge work closely together, sharing some management and back office functions. When talking to people about this strategy and how it should be developed we learned that it can be difficult for patient, carer and public feedback to be heard at the highest levels within the CCGs and for patient, carer and public feedback to influence strategic developments.

To address this gap, we plan to set up a series of seminars to support good practice and innovation in engagement on projects and initiatives that span the three CCGs. We envisage 2 - 4 seminars a year taking place around the three Boroughs or more frequently as required. We will be keen to work closely with our voluntary and community sector partners drawing on examples of good practice in engagement. This year we will specifically explore how we can work together across agencies to ensure local people are engaged in a seamless way and are able to influence new models of care for example the Vanguard Programme on Urgent and Emergency Care and the Sustainability and Transformation Plans.

Attendance at the Seminar Series might include but will not be limited to;

- CCG Lay members
- CCG Directors
- CCG PPE Clinical leads
- Patient Engagement (Reference) Forum Members
- Healthwatch
- Representatives of the Voluntary and Community Sector
- Representatives of Communities of Interest
- Representatives from the Local Authority
- Representatives from service provider organisations
- Regulators (CQC)
- CCG engagement advisor/staff
A terms of reference will be developed to include the Seminar Series remit and purpose.

8.8 Co-Production and Co-Design

Co-production and co-design describe a way of working that means working together in an equal and shared way between professionals, people using services, their families and their neighbours. This approach is particularly useful in helping to shape and design services every step of the way from beginning to end. In line with the Guiding Principles developed in discussion with local interested people and organisations we have recently used co-production and co-design as part of the Vanguard Programme (as a vanguard we are taking a lead on the development of a new care model for urgent and emergency care that will act as a blueprint for the NHS moving forward). Our co-design work has been cited as good practice and we are looking to build on it in the Urgent and Emergency Care transformation work in 16/17 and beyond. You can view a video that describes co-production in an accessible and fun way by clicking here.

8.9 The Patient Engagement Forum

The Patient Engagement Forum was set up when the CCG was formed in 2013. The purpose of the forum is to provide patients and the public the opportunity to give and receive feedback on the work of the Clinical Commissioning Group. The forum also gives local people the opportunity to influence commissioning decisions and to give GPs and their supporting teams the opportunity to receive direct feedback about peoples’ experiences of using local health services.

With the support of a committed group of local members the Forum has provided an important way for the CCG to seek feedback and a patient, carer and public perspective on its work.
We see the Forum taking a lead role in ensuring this strategy is implemented in the local area and that the CCG delivers its commitment and duties of patient, carer and public engagement fully and meaningfully.

Membership is open to patients, carers and the public who are registered with a GP in the area and meetings are held regularly throughout the year. We are keen for the local community to be reflected in the membership of the Forum as far as possible. We also recognise it is impossible for all people and groups to be directly involved in this way. If you have any questions about the work of the Patient Engagement Forum or are interested to get involved with the group please contact Boba Rangelov on 020 8926 5048 or email: boba.rangelov@onel.nhs.uk

We will work with existing Forum members to review the membership of the group and to develop a clear membership structure with clarity about roles, expectations, responsibilities and support.

We will support the Patient Engagement Forum to ensure it is able to support an active voice for all people across the Borough.

8.10 Working with Healthwatch

Healthwatch Barking and Dagenham was set up in April 2013 and is the independent consumer champion for health and social care. Through its statutory remit and its specific powers such as having a seat on the Health and Wellbeing Board and its right to Enter, View and Observe services as they are being provided Healthwatch provides an essential opportunity for local people to influence the priorities and work of the CCG.

Healthwatch plays a unique and important role within health and social care locally. We see Healthwatch as an independent critical friend and will look to engage Healthwatch appropriately throughout our work as we do now.

We see Healthwatch as an early warning system. By spotting trends and themes in the issues they pick up from their conversations with local people. We will respond
to their requests in a timely way and will provide information on any actions we take based on their recommendations and reports.

We will work with Healthwatch to agree an information sharing protocol so that we can share relevant information that will enable us to work effectively together across the Borough to develop a big picture of the issues that are affecting local people.

For more information, you can get in touch with Healthwatch in the following ways.

**Healthwatch Barking and Dagenham**

[http://www.healthwatchbarkinganddagenham.co.uk/](http://www.healthwatchbarkinganddagenham.co.uk/) Harmony House Dagenham CIC, Baden Powell Close, Dagenham, Essex RM9 6XN. Tel: 020 8526 8200

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### 8.11 Working with GP Patient Participation Groups

From 1 April 2015 it is a contractual requirement for all English GP Practices to establish and maintain a Patient Participation Group. The Practice must make reasonable efforts during each year for this to be representative of the practice population. The Practice must engage with the group throughout the year to review feedback about services. The purpose of the engagement is to identify improvements that can be made. Where the practice and PPG agree, the practice must act on suggestions for improvement. The purpose of the Patient Participation Group (PPG) is to ensure that patients and carers are involved in decisions about the range, shape and quality of services provided by their practice.

In our role to support continuous improvement and to monitor the effective delivery of contracts we will continue to undertake a programme of development and support for Patient Participation Groups across all practices in the Borough.

The support we provide will enable each Patient Participation Group to consider and agree its remit and purpose and using good practice guidance we will support the implementation of any actions required.
We will specifically support groups to look at ways to reach out to all patients within the practice population including those who would find it hard to engage in traditional ways such as at meetings.

8.12 Working with the Voluntary and Community Sector

The voluntary sector in Barking and Dagenham is rich and diverse, providing representation for a wide range of interests and groups.

In line with the Compact we would like to work increasingly closely with the voluntary and community sector as a way to reach out to the people of the Borough. We would like to build on existing initiatives including the the Voluntary and Community Sector Forum we host in partnership with the London Borough of Barking and Dagenham. The voluntary and community sector can be described in a number of ways: by geography, with organisations ranging from the very local (a walking club) to the national (e.g. Disability Rights UK) and international (e.g. Save the Children); by type - for example ‘provider’ organisations which offer a service (e.g. meals on wheels offered by local branches of Age UK), umbrella organisations which support or represent a range of organisations (e.g. the Neurological Alliance), or research focused organisations (e.g. Cancer Research UK); according to whether they are generalist or specialist (focusing on a particular health condition); by beneficiary – e.g. those focusing on young people, those which target the elderly; or by size and income – from a local volunteer-led peer support groups, to a multi-million pound organisation on multiple sites with paid staff, a management team and a board of governors.

We see value in working with the full range of voluntary and community sector organisations and agencies, we will:

- Invite representatives of the sector to attend the Patient, Carer and Public Engagement Seminar Series.
• Support the Patient Engagement Forum to reach out to voluntary and community sector groups to ensure the interests of diverse local communities are reflected.

• Look to work more closely with the voluntary and community sector to enable communities of interest to feed into all stages of the commissioning process.

• Recognise that the involvement of the voluntary and community sector is not necessarily free

9 Widening Participation

9.1 There are groups who face specific barriers to participation in commissioning, and whose specific needs must be taken into account. Examples of these groups are children and young people, carers, and patients and service users with disabilities and long-term conditions. There are also groups that experience poorer access to primary care and poorer health outcomes, for example insecurely housed people, Gypsy Traveller groups, refugees, asylum-seekers, migrants, sex workers, and people with mental health problems, learning disabilities, low health literacy, and drug and alcohol problems. This includes people who may not be registered with GP practices or ‘visible’ in the primary care system. Barking and Dagenham CCG recognise the importance of taking into account all of these groups.

9.2 Our population

The overall population of Barking and Dagenham is currently 190,560 people (based on 2012 ONS figures).

Since 2001, Barking and Dagenham has seen rapid population growth, linked to both to new housing development and birth rate changes. The population structure has changed significantly with particularly large increases in the numbers of younger people living in the borough. The main component of population change across the
London boroughs over the last decade has been and remains natural increase which is the result of having more births than deaths.

There has also been a rapid shift in the proportions of various communities, with a large decrease in the white British community and a large increase in the black African community. Our population faces a range of major health challenges and health outcomes are poor for many local people because of a combination of poverty, deprivation and lifestyle. We have higher numbers of deaths from the major diseases (heart disease, stroke, cancer, diabetes and chronic lung disease) compared with the London average. Our residents also experience more ill health and disability during their lifetimes.

There is a strong correlation between poverty/deprivation and poor health, for many reasons that include poor diet/nutrition and unhealthy living and working conditions. The index of multiple deprivations (IMD 2010) is a measure of multiple deprivations at a small area level. In general, those who live in areas of high deprivation suffer the most from poor health and wellbeing. Barking and Dagenham was ranked at 22 out of 326 local authorities for deprivation in the Indices of Deprivation 2010 (1st being most deprived, 326th being least deprived), which places it in the top 7% most deprived boroughs in England.

9.3 We are keen to ensure that as far as possible the diversity of our community is reflected in our engagement activity and that no person or group is excluded from becoming involved due to their age, disability, race, religion and beliefs, gender identity or sexual preference. This is in line with the Equality Act 2010 and the Equality Delivery System https://www.england.nhs.uk/about/gov/equality-hub/eds/.

9.4 We will undertake the following actions to make sure all people who want to can become involved in our work:

- Include a specific section on Engagement in our revised Equality and Diversity Policy
• Ensure any communication whether written or face to face is made available in alternative formats and languages where required and that meetings and events are held in accessible venues
• Work with Healthwatch and the Voluntary and Community Sector to ensure specific communities can be engaged in our work in appropriate ways

9.5 We are also keen to ensure as many people from across our community can get involved in our work. However, we recognise that for many people, getting involved by attending meetings or groups is not convenient, appropriate or accessible. As one way to address this, we will look to establish an e-network that will provide an alternative way for local people to be engaged in our work. People will be invited to join the e-network by providing their email address and expressing interest in specific areas of interest. We will build on the information and offers made by people at the co-design event held to help bring this strategy together. The e-network will provide a platform for people to receive updates about the CCG, information about specific projects that are taking place and an opportunity to get more involved if they wish. For example, by attending a focus group, event or by responding to an on-line survey.

9.6 We also see the value of social media as a cost effective way to connect further with people across the Borough.

We will increase our use of Twitter and other forms of social media as a communication tool and to alert people to projects that are taking place and to seek feedback when appropriate.

9.7 At our co-design event held to get input to this strategy we were very pleased to receive a significant number of offers to help provide support in accessing different communities across our Borough.

We will develop a database of the offers and look at how we can co-design this over time to create a way to share and swap ways to engage with our patients, carers and the public. We will follow up on these offers to explore how we can take them up.
10  Reward and Recognition

10.1 We sincerely value the contribution that patients, carers and the public make towards improving health and care services. We do not think anyone should be financially out of pocket when they get involved in our work.

We will work with the Patient Engagement Forum and the Patient, Carer and Public Engagement Seminar Series to develop and adopt a policy that is appropriate and clearly sets out when and what support is available to patients, carers and the public who become involved in our work. We will draw on existing work completed by NHS England available to view by clicking here.

11  Service Improvement and Commissioning

11.1 Every year the Clinical Commissioning Group (CCG) receives funds from Government and undertakes a range of activities to ensure local people have access to and receive the right health care, at the right time in the right place. This includes arrangements with large services providers such as hospitals, the London Ambulance Service and mental health trusts as well as smaller local service providers such community pharmacies and community health services. By co-commissioning with HS England the CCG also takes some responsibility for commissioning GP services. Commissioning can involve setting up new services or new ways of providing services as well as improving existing services.
11.2 To make sure we set up new services or improve existing services in a way that meets the needs of those who use them, we will:

- Require each commissioning business case that goes to our Governing Body for approval to include a statement of Patient, Carer and Public Engagement that sets out how patients, carers and the public have been or will be engaged in service planning, service designing, procurement and service monitoring
- We will expect each contract we let with a service provider to demonstrate through key performance indicators how the views of service users will be gathered and how this insight will be used to ensure continuous improvement in the way the service is delivered
- As commissioners we will monitor this aspect of performance to ensure service user feedback is embedded in all services for which we are responsible as commissioner
As commissioners we will ensure the insight gathered through patient experience is used to inform and improve the services we plan going forward and any future business cases we may propose.

11.3 A template to support the above actions is available in Part 2 - ‘The Guide’. Commissioners will take responsibility for developing and carrying out and documenting clear plans for patient, carer and public engagement.

The Patient and Public Engagement Seminars and the Patient Engagement Forum will also be available as a resource for commissioners to seek advice and or guidance in developing and implementing their plans and business cases.

12 Formal Consultations

12.1 If a service is likely to change significantly in the way it is provided, in addition to undertaking on-going engagement in line with our Guiding Principles and this strategy, we would expect to undertake a formal process of consultation with those who will be effected by the change.

12.2 In line with the Compact agreement with the voluntary and community sector we will:

- Consult voluntary sector groups on issues of interest to them using mechanisms that support and enable as many responses as possible
- Invite relevant groups to work with us from the start of planning consultations and give early notice of forthcoming consultations
- Conduct 12-week formal consultation exercises, with clear explanations and rationales for shorter time-frames or less formal approaches where these are necessary or more appropriate (and longer, where possible, particularly when the 12 weeks covers a holiday period)
- Have a cross-agency consultation calendar to facilitate co-ordination, avoid overload, and make key information accessible
- Seek to ensure fair access and engagement opportunities for all, including
consideration of all Equalities categories

- Seek to ensure that people feel that their views will count and that they are valued by decision makers
- Present consultation choices clearly and realistically, including where there is a preferred option. Alternatives should be invited, whilst making clear what can and cannot be changed as a result of consultation and engagement
- Give feedback to respondents on what has been heard and what will be happening. Consultation results should be made publically available

12.3 In following the strategy as set out here, we would not envisage needing to consult on a significant service change in this way without there having been substantial prior patient, carer and public engagement activity.

13 Complaints, comments and compliments

13.1 As an organisation we value the opportunity to learn from the experiences of those who come into contact with us. To that end we see complaints, comments and compliments as a positive way to learn from others to improve the way we carry out our work.

- We will improve the information available on our website and in our literature so that the ways that people can easily know how to make a complaint, comment or compliment about our work
- We will regularly review complaints, comments and compliments and look to make changes to the way we do things based on the feedback we receive. We will report this to our Governing Body.

13.2 Whilst we don’t directly provide health and care services, we do commission others who do. We will therefore ensure each contract we commission includes key performance indicators that set out how complaints, comments and compliments
will be gathered and analysed and will seek evidence of how services are improved as a result through our contract monitoring role.

14 Reporting Back

14.1 We believe it is essential for those who we engage in our work to know how their contribution has made a difference. We will feedback to people about any changes that are made and any reasons for why changes are not made. We hope this will nurture a culture that values the contributions of patients, carers and the public throughout our work. We will use a range of different ways to feedback to people including:

- The website
- The Patient Engagement Forum
- The Patient and Public Engagement Seminar Series
- Face to face meetings and events
- The e-network
- Social media
- Newsletters including those of voluntary and community sector partners
- Network meetings, forum and events
- Personal contact
- Letters of thanks

We will support commissioners to ensure they go back to people who they have engaged and to develop an on-going relationship with patients, carers and the public throughout the process of service planning, design, procurement and monitoring.

We will keep good records of our approaches to patient and public engagement with a particular emphasis on the impact or difference made as a result of patient and public engagement and use these to report to NHS England against Section 13Q of the Health and Social Care Act 2006.
15  Evaluating Progress

15.1 It is important that we aim for continuous improvement in the way we undertake patient, carer and public engagement.

The Patient Engagement Forum will be invited to oversee the implementation of this strategy and resulting action plan.

15.2 In addition we will look to undertake an independent peer review within the three year period of the strategy. To achieve this we will look for a peer review partner and aim to do a review mid-term and one at the end of three years.

15.3 Annually in line with our reporting requirements to NHS England we will produce and publish an annual report on patient, carer and public engagement. This report will demonstrate how we are doing against our action plan and what actions we need to take to make improvements. We will work with our local partners to co-produce our annual report and plan and work with the Patient, Carer and Public Engagement Seminar Series to co-design a series of ‘test questions’ that we can apply. We will also invite Healthwatch to make an independent statement.

15.4 We will draw on existing work in this area developed by NHS England and available at [https://www.england.nhs.uk/ourwork/patients/participation/](https://www.england.nhs.uk/ourwork/patients/participation/)

16  Further Resources and Support


NHS England: Framework for Patient and Public Participation in Primary Care Commissioning. [click here](https://www.england.nhs.uk/ourwork/patients/participation/).

NAVCA – find your local Council for Voluntary Service Searchable Directory [click here](https://www.england.nhs.uk/ourwork/patients/participation/).

NHS England – Transforming Participation [click here](https://www.england.nhs.uk/ourwork/patients/participation/).
The Consultation Institute: training on consultation and engagement methods [click here].

Scottish Government Community Engagement Pages – more detail on engagement methods and techniques [click here].

Participation Compass – practical advice and guidance on planning community engagement [click here].

Acronym Buster NHS Confederation - [click here].

Other patient, carer and public engagement related documents and articles - [click here].

### 17 Thanks and Acknowledgements

We would like to thank everyone who has participated in helping to bring this strategy and guide together. We are committed to making sure patients, carers and the public are equal partners in the way services are planned, designed, procured and monitored. We would like to receive any feedback you might have on the strategy and guide and invite you to send your comments through to marie.price@onel.nhs.uk

### 18 Other Formats

*This document is available in other formats – table to be included with contact details on published document.*
19 Words and phrases used

**Clinical Commissioning Group** - is the term given to a form of commissioning that is clinically led by a group of GPs. Each GO in the area is a member of the Clinical Commissioning Group.

**Commissioning**: the process of planning, specifying, buying and monitoring services to meet peoples needs.

**Commissioners**: in this document this refers to people who work for Barking and Dagenham, Redbridge and Havering CCGs on planning, specifying, buying and monitoring services.

**Co-production**: The design and delivery of services by citizens and professionals in equal partnership.

**Governing Body**: this is the group who are responsible for leading and managing the Clinical Commissioning Group on behalf of its members.

**Health and Wellbeing Board (HWB)**: Local authorities have established a Board that lead on improving the strategic co-ordination of commissioning across NHS, social care and related children’s and public health services.

**Healthwatch**: an independent organisation that is the local consumer champion for health and social care

**Local Authority (LA)**: refers to the local council

**Patient**: Someone who is receiving medical care or treatment, whether in a health or care setting (such as a hospital, GP practice or care home) or at home.

**Public**: for the purposes of the strategy, this means the residents of Barking and Dagenham, Redbridge and Havering.

**Voluntary and community sector (VCS)**: VCS is a common umbrella term for organisations known variously as charities, third sector organisations, not for profit organisations, community groups, social enterprises, civil society organisations and non-governmental organisations.
## Appendix 1 - Action Plan

NB: dates and actions to be added by end of May 2016 and circulated to relevant parties.

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<td>1</td>
<td>We will produce and share an action plan each year in May</td>
<td>1.1 Create an action plan and present it to the Governing Body along with the Strategy.</td>
<td>MP</td>
<td>May 2016</td>
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| 2  | We expect all of our staff and Governing Body members to use the principles to guide them in their work: | 2.1 Place principles on the website  
2.2 Include principles within staff induction  
2.3 Include principles within staff appraisal procedures  
2.4 Develop a patient, carer and public engagement statement template for use when presenting business cases to the Governing Body |      |          |
<p>| 3  | To ensure local people are engaged in a seamless way and are able to influence new | 3.1 Set up a series of seminars to (2 – 4 a year) support good practice and innovation in engagement on |      |          |</p>
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<td>models of care for example the Vanguard Programme on Urgent and Emergency Care and the Sustainability and Transformation Plans.</td>
<td>projects and initiatives that span the three CCGs. Taking place around the three Boroughs or more frequently as required. This year we will specifically explore how we can work together across agencies on transformation programmes.</td>
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<td>4</td>
<td>Ensure the Seminar Series have a clear purpose and remit.</td>
<td>4.1 Develop a terms of reference for the seminar series.</td>
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<td>5</td>
<td>Ensure the membership of the Patient Engagement Forums is reflective of the local community and that they have clear roles, expectations, responsibilities and support.</td>
<td>5.1 Work with existing Forum members to develop a clear membership structure.</td>
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<td>6</td>
<td>Ensure we are able to work effectively together with Healthwatch across the</td>
<td>6.1 We will work with Healthwatch to agree an information sharing protocol so that we can share</td>
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<td>Borough to develop a big picture of the issues that are affecting local people.</td>
<td>relevant information.</td>
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<td>7</td>
<td>Ensure continuous improvement and to monitor the effective delivery of contracts.</td>
<td>7.1 Continue our programme of development and support for Patient Participation Groups across all practices in the Borough.</td>
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<td>7.2 We will specifically support groups to look at ways to reach out to all patients within the practice population including those who would find it hard to engage in traditional ways such as at meetings.</td>
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<td>8</td>
<td>Ensure we build strong and effective partnership with the voluntary and community sector.</td>
<td>8.1 Invite representatives of the sector to attend the Patient, Carer and Public Engagement Seminar Series.</td>
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<td>8.2 Support the Patient Engagement Forum to reach out to voluntary and community sector groups to ensure the interests of diverse local communities can</td>
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<td>8.3 Look to work more closely with the voluntary and community sector to enable communities of interest to feed into all stages of the commissioning process.</td>
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<td>8.4 Recognise that the involvement of the voluntary and community sector is not necessarily free</td>
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<td>9</td>
<td>Ensure our engagement activity is inclusive and reaches all parts of our community.</td>
<td>9.1 Include a specific section on Engagement in our revised Equality and Diversity Policy</td>
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<td>9.2 Ensure any communication whether written or face to face is made available in alternative formats and languages where required and that meetings and events are held in accessible venues</td>
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<td>9.3 Work with Healthwatch and the Voluntary and Community Sector to ensure specific communities can</td>
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<td>be engaged in our work in appropriate ways.</td>
<td>10.1 We will look to establish an e-network that will provide an alternative way for local people to be engaged in our work.</td>
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<td>10</td>
<td>Widen our participation to engage with people through on-line networks.</td>
<td>11.1 We will build on the information and offers made by people at the event held to help bring this strategy together. 11.2 We will develop a database of the offers and look at how we can co-design this over time to create a way to share and swap ways to engage with our patients, carers and the public. We will follow up on these offers made to explore how we can take them up.</td>
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<td>11</td>
<td>Work closely with our community partners to reach people in new and creative ways.</td>
<td>12.1 We will increase our use of Twitter and other forms of social media as a communication tool and to alert people to projects that are taking place and to</td>
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<td>seek feedback when appropriate.</td>
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<td>13 Ensure all people who participate are recognised appropriately for</td>
<td>13.1 We will work with the Patient Engagement Forum and the Patient, Carer and Public Engagement Seminar Series to develop and adopt a policy that is appropriate and clearly sets out when and what support is available to patients, carers and the public who become involved in our work.</td>
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<td>their contribution and that no one is left out of pocket.</td>
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<td>14</td>
<td>Ensure commissioning plans always consider how the patient, carer</td>
<td>14.1 Require each commissioning business case that goes to our Governing Body for approval to include a statement of Patient, Carer and Public Engagement that sets out how patients, carers and the public have been or will be engaged in service planning, service designing, procurement and service monitoring</td>
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<td>and public voice will be included throughout the commissioning</td>
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<td>process.</td>
<td>14.2 Each contract to demonstrate through key</td>
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<td>performance indicators how the views of service users will be gathered and how this insight will be used to ensure continuous improvement in the way the service is delivered</td>
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<td>14.3 Monitor patient experience and engagement performance to ensure service user feedback is embedded in all services for which we are responsible as commissioner</td>
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<td>14.4 Ensure the insight gathered through patient experience is used to inform and improve the services we plan going forward and any future business cases we may propose.</td>
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<td>15</td>
<td>Ensure the ways that people can make a complaint, comment or compliment is easy to find out and that we systematically</td>
<td>15.1 We will improve the information available on our website and in our literature</td>
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<td>consider these and use them to inform our commissioning work.</td>
<td>15.2 We will regularly review complaints, comments and compliments and look to make changes to the way we do things based on the feedback we receive.</td>
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<td>15.3 We will report this to our Governing Body</td>
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<td>15.4 We will ensure the contracts we let include key performance indicators about complaints, comments and compliments will be gathered and analysed and will seek evidence of how services are improved as a result through our contract monitoring processes.</td>
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<td>15.5 We will feedback to people about any changes that are made and any reasons for why changes are not made</td>
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<td>16</td>
<td>Ensure people know how their contribution has made a difference</td>
<td>16.1 We will use a range of different ways to feedback to people including</td>
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<td>• Letters of thanks</td>
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16.2 We will support commissioners to ensure they go back to people who they have engaged and to develop an on-going relationship with patients, carers and the public throughout the process of service planning, design, procurement and monitoring.

16.3 We will keep good records of our approaches to and impact of patient and public engagement and use these to report to NHS England against our legal requirements under Section 13Q (the legal requirement to engage patients and the public in commissioning).
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| 17 | Ensure we evaluate our progress in patient, carer and public engagement including delivery against this plan. | 17.1 The Patient Engagement Forum will be invited to oversee the implementation of this strategy and resulting action plan.  
17.2 Identify a peer review partner  
17.3 Undertake an independent peer review at least once in the three year period of the strategy.  
17.4 Make an annual report to our Governing Body and NHS England  
17.5 Work with our partners to develop a set of ‘test’ questions to help us measure progress.  
17.6 Invite Healthwatch to make an independent statement |      |          |
To: Meeting of the NHS Havering Clinical Commissioning Group Governing Body

From: Louise Mitchell, Chief Operating Officer, Redbridge CCG

Date: 24 May 2016

Subject: BHRUT Referral to Treatment Times

Executive summary
The NHS Constitution gives patients the right to access services within 18 weeks following a GP referral. Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT) which runs King George and Queen’s Hospitals, suspended formal reporting of its Referral to Treatment (RTT) performance in February 2014 due to a lack of confidence in the ability of the Trust to reliably report the numbers of patients waiting.

BHR CCGs and BHRUT were subsequently tasked by NHS England (NHSE) and the Trust Development Agency (TDA), now NHS Improvement (NHSI), to develop and deliver an RTT recovery and improvement plan. The full extent of the RTT challenge has evolved more recently through the development of the recovery plan which has a parallel focused requirement of limiting inflowing planned care demand to the Trust.

Despite BHRUT data quality not being assured, its March 2016 Board papers stated that it had 1,015 patients waiting more than 52 weeks on the elective RTT pathway. This led to considerable national publicity. Clearly this is a major issue for us as commissioners and we have made it very clear to BHRUT that it is unacceptable for patients to wait this long for the treatment that they need.

Ernst & Young (EY) have been commissioned to support the RTT turnaround work and the first phase of their work has specifically focused on system governance, clinical harm review, data validation and demand and capacity planning.

This report sets out the specific actions that BHR CCGs are taking from both an assurance and support perspective to achieve system stability which will return the Trust to a NHS constitutional compliance status of delivering patients’ rights to timely treatment times.

Recommendations
Members of the Governing Body are asked to:

- Note the delivery of immediate priority improvement actions in train whilst the delivery of the final improvement plan is developed with the support of Ernst & Young (EY) following the recent independent review undertaken by both EY and MBI Health Group.
- Advise of any further actions that the CCG should consider taking to address the performance and quality risks for local people.

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

2.0 Background/Introduction

2.1 The NHS Constitution gives patients the right to access services within maximum waiting times, or for the NHS to take all reasonable steps to offer patients a range of suitable alternative providers if this is not possible. Even if a patient requires a range of tests and appointments this should take no longer than 18 weeks.

2.2 The number of patients waiting beyond the 18 weeks limit is formally reported by Trusts to NHS England and monitored as a key performance standard.

2.3 BHRUT, which runs King George and Queen’s Hospitals, suspended formal reporting of its Referral to Treatment (RTT) performance in February 2014. This was due to a lack of confidence in the ability of the Trust to reliably report both the numbers of patients waiting, and the length of wait for elective care and treatment. A number of other trusts across England have also suspended reporting due to data issues during this time.

2.4 The Trust identified issues with the accuracy of waiting times data since upgrading their Patient Administration System (PAS) which led to a backlog of patients waiting longer than the 18 week referral to treatment time standard.

2.5 This information was shared with stakeholders in RTT briefings from the Trust available on its website.

2.6 GPs have reported awareness of the long waits for some of their patients and some have escalated these with BHRUT, but the Trust have been unable to track patient level activity due to on-going data issues. GPs in Barking and Dagenham have also raised concerns with the CCG about availability of Dermatology appointment slots.

3.0 Scale of the issue

3.1 Despite BHRUT data quality not being assured, BHRUT revealed in its March 2016 Board papers that it had 1,015 patients waiting more than 52 weeks on the elective RTT pathway. In addition to the existing local concerns, the release of the data led to national publicity about the length of the waiting time for BHRUT patients and additional scrutiny on the local system.

3.2 We are starting to see some reduction in this figure but naturally there are week to week variances as the waiting list will be impacted by continuation of referral activity in real time. NHSE (London) has written to commissioners outlining its on-going concerns.

3.3 The commissioners and Trust response to date is as follows.

3.4. BHRUT does not have sufficient capacity to address all of the issues currently, so commissioners and the Trust have agreed a response that includes;

- Redirection of waiting patients to alternative providers
- Demand management including use of alternative providers, (including additional community provider clinics)
- Improving patients pathways to reduce delays and duplication
- Trust looking to increase capacity by recruiting 17 additional staff
- Trust looking to increase activity through its operating theatres
Commissioners and the Trust have increased resources to address the issue and put a series of additional actions in place, forming project groups to deliver a number of urgent work streams and setting up a dedicated Project Management Office (PMO) to enable partners to effectively tackle this issue together.

A Joint Programme Board has been established between the Trust and CCGs to implement the recovery plan and ensure issues and risks are mitigated. A system director for RTT came into post in January 2016. She reports directly to the Trust Chief Executive and CCG Chief Officer.

Patient safety is of paramount importance and the Trust has agreed a clinical harm process drawing on good practice developed elsewhere. This is being implemented with both an internal and external harm review panel meeting to review progress and outcomes. Arrangements are being reviewed as part of the EY process highlighted above.

It is anticipated that the earliest recovery of the standard will be March 2017; however there remains substantial risk to achieving this due to the volume of patients who have already breached their 18 week wait. Priority is given to any patient that has waited over 52 weeks to make sure that they are treated as soon as possible.

Further details of the governance/programme structure in place to oversee the plan is included in appendix 1.

An RTT ‘summit’ took place on Thursday 14 April with CCG Chairs, Clinical Directors and BHRUT clinicians and agreed:
- To meet on a regular basis to develop clinically led pathway reviews for specialist areas identified as key clinical priorities.
- That there be better engagement between primary and secondary care clinicians
- That each CCG take a lead for three specialities and alternative arrangements on behalf of all three CCGs.
- Clear communications to all affected and key stakeholders.
- To receive the full RTT recovery plan at a future date.

There is significant cost pressure across the system to resolve the current RTT status and the impact of this is in the process of being considered. We will report back to members reflecting the detail of this when we have the final improvement plan.

There are no equalities implications arising from this report.

Potential quality risks may emerge as a result of the delay to treatment experienced by individuals. These are the most critical risks to mitigate. As addressed within this report there is a clinical harm process in place to determine and manage this risk, and this is being further reviewed.

There is a reputational risk as a result of the RTT delays experienced by the public. Both the development of a system wide recovery plan as referenced within this report and the implementation of a system wide stakeholder communication and engagement programme have been agreed.

There are no conflict of interest issues in relation to this paper.
Attachments:
1. System Governance Structure for the RTT programme

Author: Louise Mitchell, Chief Operating Officer, NHS Redbridge CCG
Date: 6th May 2016
Programme structure – governance and reporting view

- **Weekly RTT Steering group** (NHSE, NHSI, BHR CCG and BHRUT)
- **Weekly RTT Programme Board** (BHR CCG and BHRUT selected exec members)
- **Weekly Access / PMO Meeting** (Programme Director and workstream leads)
- **Outsourcing meeting**
- **RTT Clinical leadership meeting**
- **Demand management meeting**

**Individual workstream meetings**
- Theatre group: Weekly
- Outsourcing meeting: Weekly
- Demand management meeting: Weekly
- RTT Clinical leadership meeting: Monthly
Executive summary

The Barking and Dagenham, Havering and Redbridge (BHR) urgent and emergency care (UEC) vision seeks to create a simplified, streamlined urgent care system delivering intelligent, responsive urgent care for the 750,000 residents across the BHR health. The System Resilience Group (SRG) believes there is a need to do things differently and evidence suggests that patients are confused by the many and various urgent and emergency care services available to them - A&E, walk-in centre, urgent care centre (UCC), GPs, pharmacists, out of hours services etc.

The UEC programme has been re-structured with our system partners working together to create a programme which will deliver improvement to all areas of the UEC pathway and our Operating Plan commitments (performance and activity) for 2016/17. This aligns and builds on the better care fund, QIPP plans and the vanguard programme.

Recommendations

The governing body is asked to:
- Note the progress of the urgent and emergency care transformation programme

1.0 Purpose of the Report
1.1 This report provides the governing body with an overview of the Barking and Dagenham, Havering and Redbridge (BHR) urgent and emergency care programme (UEC).

2.0 Background and context
2.1 Urgent and emergency care has been a key challenge for our health economy for many years with a background that includes:
- A complex urgent care system with duplication and fragmentation across services
- Challenged health economies and challenged acute trusts
- Key national standards and targets, particularly in accident and emergency, not being met

2.2 A BHR urgent care conference was held on 1 July 2015. The purpose was to gather views on how we can transform urgent care services over the next 2-5 years. Soon after the BHR urgent care conference an opportunity to bid to become an urgent and
emergency care “Vanguard” site was announced. The BHR SRG was successful in its application to become a national urgent and emergency care Vanguard. The outcome of the Keogh Review led to a nationally agreed model for UEC. Therefore the priority was to accelerate the implementation of those measures.

These are:
- Delivery of the eight key elements of Integrated Urgent Care (IUC) – the national enhancements to NHS 111
- New payment models
- Testing of new system measures
- The economic evaluation of channel shifts
- Setting up effective urgent and emergency care networks
- Designation of UEC services
- Ambulance response times

3.0 Developing our Urgent and Emergency Care Programme for 16/17
3.1 The UEC programme builds on and aligns with the vanguard programme, better care fund plans and planned activity reductions into a single programme that will deliver improvement to all areas of the UEC pathway and deliver our Operating Plan commitments. It is a system programme involving BHRUT, NELFT, PELC and local authority colleagues.

3.2 Our Operating Plan commitments are:
- To deliver 93% on the national 4 hour A&E wait standard by March 2016.
- Activity reductions of 4,296 A&E attendances and 2,150 non-elective admissions

3.3 The UEC service model is organised into five service delivery workstreams:
- Integrated urgent care (IUC)
- Out of hospital
- Hospital front door
- In hospital
- Hospital back door

3.4 These are supported by five enabling workstreams
- Communication and engagement
- Technology
- Finance and activity
- Workforce
- Governance and project management

3.5 Each of the service delivery workstreams oversee a number of projects aimed at reducing attendances and admissions: The workstreams each have a CCG and provider management lead, with clinical leads for each being identified.

3.5 Each project within the UEC programme will deliver improvements to performance. The planned activity reductions are as follows:
<table>
<thead>
<tr>
<th>Scheme</th>
<th>A&amp;E (atts)</th>
<th>NEL (adm)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enhanced mental health (MH) liaison for children and young people</td>
<td>30</td>
<td>2</td>
</tr>
<tr>
<td>(24/7 Interact)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enhanced UCC (Queens)</td>
<td>1,165</td>
<td>93</td>
</tr>
<tr>
<td>Professional hub &amp; expansion of call centre capacity for 111</td>
<td>784</td>
<td>78</td>
</tr>
<tr>
<td>Acute Care Improvements (Ambulatory Care &amp; Hot Clinics)</td>
<td>469</td>
<td>487</td>
</tr>
<tr>
<td>Care in the community enhancements: Rapid response, in-reach and social care</td>
<td>119</td>
<td>10</td>
</tr>
<tr>
<td>Software and configuration</td>
<td>231</td>
<td>159</td>
</tr>
<tr>
<td>Integrated Case Management (ICM)</td>
<td>565</td>
<td>565</td>
</tr>
<tr>
<td>Falls (includes Falls with and without Fracture)</td>
<td>118</td>
<td>94</td>
</tr>
<tr>
<td>End of Life Care (EOLC)</td>
<td>52</td>
<td>52</td>
</tr>
<tr>
<td>Care Homes</td>
<td>390</td>
<td>312</td>
</tr>
<tr>
<td>Chronic Kidney Disease/ Acute Kidney Injury (CKD/AKI)</td>
<td>373</td>
<td>298</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4,296</strong></td>
<td><strong>2,150</strong></td>
</tr>
</tbody>
</table>

3.6 The key national service delivery priority is integrated urgent care. Under this scheme our plans will increase the level of professionals available via NHS 111 so professionals in the community (e.g. GPs, care home staff, paramedics) can seek additional advice to resolve more cases or divert patients to more appropriate healthcare settings than A&E. This will also be available to people calling 111. This is important because high levels of people seek advice from healthcare professionals before attending A&E. This has been demonstrated in two recent surveys undertaken in BHR - audits undertaken at Queen’s hospital as part of the Healthy London Partnership UEC behavioural insights survey (50%) and a research survey undertaken as part of the vanguard programme (61% of those seeking advice before attending A&E).

4.0 Consultation and Engagement

4.1 BHR has a commitment to co-design throughout the UEC programme, building on the work started at the UEC conference in July 2015.

4.2 The UEC co-design stakeholder group agreed that first step to the UEC programme should be significant local research to provide sound evidence of local understanding, awareness and drivers for UEC services.

4.3 A significant research study (co-designed with Healthwatch) was conducted in March 2016 to survey the local population on our urgent and emergency care services. This involved telephone interviews with 3000 people, and 900+ face to face interviews and 10 focus groups.

4.4 This culminated in a successful stakeholder co-design workshop to discuss the findings, identify gaps and propose next steps.
4.5 Research findings are being used to inform care model co-design and will inform co-design and engagement programme for 16/17. Key findings from the research are:

- overall the highest UEC usage is of primary care, then pharmacy followed by A&E
- there is a high awareness of current UEC services
- of those attending A&E
  - 39% sought no advice before attending ED
  - 37% had seen their GP with the same issue
  - 26% had been to A&E before with same issue
- 41% of parents surveyed had attended A&E at least once in the last six months, non-parents 27% and of those aged over 65 this was 21%

4.6 We are aligning the outcomes of the research with our detailed analysis of current attendances and admissions to refine the delivery plans within the programme. This will include a workshop with all stakeholders to consider the latest data and the implications for our delivery plans.

5.0 Improving Current Performance

5.1 A&E performance at BHRUT has not achieved the national standard (95%) since August 2015 and for March it dropped to 75.6%. In April weekly performance has averaged 81.38% (unvalidated). More details of the performance and contractual measures taken are contained within the finance and contracting report.

5.2 This fragile and below standard performance is driven by the following key issues:
- Surge in A&E attendances compared to prior year both “walk-in” and ambulance conveyance
- ED staffing shortages, in particular low proportion of medical rotas that are filled
- Poor performance during night shifts, related to access to access to senior decision making and surges of patients during the evening and night
- Reduced throughput in the Queens’ UCC
- Multiple services at the front door of A&E that can be confusing to patients

5.3 Following a detailed review of attendance and admission data at its April meeting, the Systems Resilience Group agreed to hold a summit to address these issues and stabilise performance with the aim of ensuring that any actions have an impact on performance by the start of July.

5.4 The summit was chaired by the SRG Chair (Conor Burke) and agreed the following actions:

<table>
<thead>
<tr>
<th>Service delivery workstream</th>
<th>Quarter one actions</th>
<th>Lead</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS111</td>
<td>Implement / extend the planned pilot to re-triage NHS 111 ED dispositions</td>
<td>Yemisi Osho (PELC)</td>
</tr>
<tr>
<td>Front door</td>
<td>Move streaming and triage to the UCC front door and extend the capacity (with GPs and ENPs) to allow more time with individual people and extend to midnight / 1am. Enhance UCC staffing and integrate UCC – integrate UCC with Majors Light to provide an integrated non-admitted service</td>
<td>Sheraiz Younas (GP Federation) and Mairead McCormick (BHRUT) and Sheraiz Younas and Mairead McCormick</td>
</tr>
</tbody>
</table>

This plan was signed off at the SRG on 4 May 2016

6.0 Resources/investment

6.1 As a Vanguard site, in addition to practical support offered by the national teams, Vanguards also have access to the national Transformation Fund. We are awaiting
confirmation of our national resource bid for 2016/17 and any conditions attached. An update will be provided at the governing body. As part of the Vanguard programme we are also required to adopt and test a new contracting / pathway payment mechanism as supported by NHSI. This will be aligned to the developing work around the Accountable Care Organisation (ACO).

7.0 **Equalities**

7.1 An equalities impact assessment has not been undertaken but this will be a key element of the testing of the new service model. The brief for the research survey required BMG Research and Healthwatch to ensure the participants were statistically representative of the communities living within each of the boroughs in line with the latest demographic information.

8.0 **Risk**

8.1 We will be developing full risk logs and assessments as part of the programme governance. This will include risks around finance, clinical and resident engagement and programme delivery. It is worth noting that some key risks on the CCG risk registers and Governing Body Assurance Framework – such as that for A&E – will be mitigated by the successful implementation of the Urgent and Emergency Care Programme.

9.0 **Managing conflicts of interest**

9.1 There are no identified conflicts of interest to manage in relation to the decision requested/issues raised in this paper

Author: Alan Steward
Date: May 2016
To: Meeting of the NHS Barking and Dagenham CCG Governing Body

From: Sarah See, Director, Primary Care Transformation

Date: 24 May 2016

Subject: Primary Care Transformation Strategy – a strategy for the development of general practice and place based care 2016-21

Executive summary

The CCG has developed a strategy for the transformation of primary care over the next five years. The work is framed by national and London policy and the Barking & Dagenham, Havering and Redbridge (BHR) system challenges, taking account of input gathered from local GPs and wider local stakeholders.

The vision is of primary care at the forefront of joined-up health and social care in localities, with sustainable and productive practices at its foundation. This builds on the King’s Funds concept of place-based care and wider evidence from places where this approach has been implemented.

In developing this strategy, we have engaged with stakeholders with a role in the Barking & Dagenham health and care economy: patient representatives, patient groups, general practitioners, practice managers, pharmacists, nurses, community and mental health services provided by NELFT, acute services provided by Barking, Havering and Redbridge University Hospitals Trust (BHRUT), the Partnership of East London Co-operatives (PELC), the Local Medical Council, the local authority, NHS commissioners and Care City. We have also consulted with workforce leads at the NHS England London level. Discussions have taken place with and between local clinical leaders about how this model will facilitate the development of local schemes to deliver better care for local people and what the implications and opportunities will be for individual GP practices, their autonomy and sustainability.

The transformation programme for 2016/17 will be primarily about provider development – strengthening individual practices, progressing collaborative working amongst GP practices in localities and developing extended locality teams, bringing together GPs with all local health and social care professionals to provide care for patients. The delivery focus will be on:

- Reducing elective hospital referrals for three specialities through the development of pathways for locality-based care, in conjunction with the Planned Care Programme
- Improving the quality of general practice care for patients with long term conditions.

This focus can be used to inform development of collaborative governance and working arrangements in localities and as a proving ground in localities, ensuring they are wholly grounded in the business of local providers and the care needs of local people.

Recommendation:

The governing body is asked to:

- Review and approve the Primary Care Transformation Strategy, prior to its implementation, and development of the clinical operating model.
1.0 Purpose of the Report

1.1 The purpose of this report is to allow the governing body to formally review and approve the Primary Care Transformation Strategy to allow its implementation to proceed with the developments of the clinical operating model and detailed scoping of 2016/17 projects and workstreams.

2.0 Introduction

2.1 The CCG has developed a strategy for the transformation of primary care in Barking and Dagenham over the next five years. The work is framed by national and London policy and the Barking & Dagenham, Havering and Redbridge (BHR) system commissioning challenges and takes account of substantial input gathered from local stakeholders.

2.2 In March the Governing Body reviewed a high-level draft of this strategy and agreed a programme of stakeholder engagement to review and refine the strategy proposals so that the strategy could be finalised.

2.3 The Governing Body is requested to review the completed strategy attached and approve it subject to further feedback prior to implementation.

3.0 The Vision for Primary Care

3.1 The strategy proposes step-by-step migration to a place-based delivery model for care out of hospital in each Barking and Dagenham locality. The model has at its foundation stronger GP practices and involves effective collaborative working across groups of practices and an extended team of community, social care, pharmacy, dental and opticians and the voluntary sector.

3.2 General practice along with the wider health and care teams, strengthened and extended, will have the collective capacity and appropriate funding to take on the majority of patient care, as well as prevention services.

3.3 Evidence advanced by the King’s Fund, drawing on examples from New Zealand, Chenn Med and elsewhere, is that place-based care works best with a population of 50-70,000 people, and clinical leaders in the borough are assessing the suitability of existing commissioning clusters as the starting point for deciding on the geographic footprints for localities.

3.4 Practice productivity and collaborative provision and administration will be enhanced through better exploitation of available information, IT and digital solutions.

3.5 A BHR-wide approach to the development of the primary care, community and social-care workforce will create the right staff mix for locality-based working, and localities will be empowered to co-design and deliver locally appropriate solutions for the recruitment and retention of staff.

4.0 Benefits for Patients and Implications for Practices

4.1 The benefits envisaged for patients from the strategy are:
- Personalised, responsive, timely and accessible primary care, provided in a way that is both patient-centred and coordinated
An integrated service that supports and improves their health and wellbeing, enhances their ability to self-care, increases health literacy, and keeps them healthy.
More treatment closer to home where previously provided in secondary care.
Involvement in the co-design of services with professionals in their locality.

4.2 The key implications for practices of the strategy are envisaged to be:
- Retention of practice autonomy, with GPs playing leading roles in locality-based care.
- Improved financial sustainability through the pooling of resources to reduce costs and the creation of new opportunities to generate income.
- Better practice productivity through improved team working and better use of IT, reducing administration and freeing up GP time for patient care.
- The potential to develop more attractive career offers to recruit and retain primary care clinicians.

5.0 Implementation Approach

5.1 The King’s Fund’s framework for implementing place-based models of care will be used as the starting point from the implementation of locality-based care in Barking and Dagenham.

5.2 It is proposed to work with a single locality within the borough as a pilot to design collaborative governance and working arrangements while working on selected prevention, planned care, mental health and/or urgent and emergency care schemes. This will enable initial lessons from locality-based working to be properly understood and the learning to be reflected in the designs and planning for the other localities.

5.3 A parallel programme of work will be put in place to help practices improve their productivity, make better use of information and IT systems and better understand their financial sustainability.

5.4 There is a 12-18 month target timescale for all localities to be operational and effective.

6.0 Resources/investment

6.1 Resources will be needed to help GP leaders in localities establish organisational and governance arrangements for collaborative working and operate these effectively and to assist with specific initiatives to strengthen practice productivity and enable wider use of information, IT and digital solutions. Resource will also be needed to run the transformation programme at the BHR level. Following a review of CCG organisational arrangements individuals with the right skills and experience have been identified to support the programme.

6.2 The strategy will improve the productivity and financial sustainability of GP practices through better management of workload and use of IT, freeing up GP time for patient care. It will also enhance the financial and social sustainability of the wider system through enabling:
- Reduction in unnecessary duplicate assessments and diagnostic tests.
- Enhanced outcomes at individual patient and locality population levels.
- Better targeting of local resource to locality health needs.
- Increased support for individuals’ self-management.
- Better access to the right urgent care services.
• Reduced unplanned A&E attendances and emergency admissions
• Reduced re-admissions to hospital
• Quality and financial benefits realised from investment in digital, IT and business intelligence solutions

7.0 Equalities
7.1 An Equality Impact Assessment is underway and no negative impacts have been identified so far; by delivering common standards of prevention, planned care, mental health and urgency and emergency care across the BHR system and organising delivery in localities, the CCG’s overall approach aims to both reduce health inequalities and optimise services to meet the needs of local populations in Barking and Dagenham.

8.0 Risk
8.1 A detailed risk analysis is being undertaken across the four transformation programmes (Urgent & Emergency Care; Planned Care; Mental Health and Primary Care) to ensure a joined up approach to delivery and managing risks and dependencies across all programmes.

8.2 The Primary Care Transformation Programme has developed its own risk register, identifying investment and workforce capacity as the two highest risks.

9.0 Managing conflicts of interest
9.1 None.

Attachments:
1. Barking & Dagenham Primary Care Transformation Strategy

Author: Sarah See, Director, Primary Care Transformation
Date: 12/05/16
Transforming Primary Care in Barking and Dagenham - a strategy for the development of general practice and place based care

Our strategy 2016 – 2021

May 2016
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1 Executive summary

For patients, primary care and their relationship with their local GP form the foundation of the NHS service they expect and receive. If the NHS is to be clinically and financially sustainable in the years ahead, primary care and the rest of the system need to be transformed. If this can be done right, primary care can be a rewarding place to work for the professionals working in it, now and in future.

Nationally, the NHS faces significant future challenge in the form of the increasing health needs and expectations of the population, changes in treatments and technologies, and increasing pressures on finances – both from reduced spending growth in the NHS and cuts to social care budgets. Current projections from Monitor and NHS England (NHSE) estimate that the NHS will face a £30 billion funding gap by 2020/21. To tackle these challenges within Government funding limits, the Five Year Forward View sets out a transformational change agenda for the NHS that involves:

- Reducing variation in care quality and patient outcomes
- Increasing the emphasis on preventative care
- A shift towards more care being delivered in primary care
- Breaking down the barriers in how care is provided through the introduction of new models of care spanning current organisational boundaries
- Action on demand, efficiency and funding mechanisms to improve financial sustainability.

Recently published, the General Practice Forward View offers funding opportunities and practical steps to stabilise and transform general practice through addressing workforce, workload, infrastructure and care design issues.

Locally, Barking and Dagenham, along with the wider Barking and Dagenham, Havering and Redbridge (BHR) system, has a greater commissioning challenge than the national average in the form of a system-wide budget gap of over £400m. The BHR system needs to be transformed to:

- Meet the health needs of the diverse, growing young population in one of the most deprived areas in England where an increasing number of people are living with one or more long-term conditions in its local communities
- Improve health outcomes for these populations and reduce health inequalities overall
- Meet national and regional quality standards and access targets
- Close a £400m budget gap.

To achieve this, local commissioners agree that acute hospital care should be reserved for acutely ill patients with the majority of care delivered nearer home. Key themes for the development of general practice and the wider primary care family are that it should be accessible, coordinated and proactive (with a focus on prevention).

So what is the current state of primary care, and general practice in particular in Barking and Dagenham and how does it need to be transformed to meet commissioners’ requirements and the needs of local people?

Significant progress has been made in improving access to general practice, with the establishment of hub-based urgent evening and weekend GP appointment service. However, local GPs and stakeholders have told us that the current model in primary care is
unsustainable. The workforce is stretched, with recruitment and retention of staff challenging. Workload is increasing, and will do further with an ageing population, and practices cannot deliver the quality of care their patients need without becoming financially unsustainable. While national funds are available for clear, coherent transformation strategies, there is no additional ongoing funding available in the system beyond funding potentially released through a proportional reduction in acute hospital care. Primary care needs to change to better meet demand and be a rewarding place to work and attractive to future potential recruits.

This strategy puts forward a multi-layer definition of primary care, which incorporates not just general practice, now commissioned under delegated arrangements by the CCG, but also the community pharmacy, community optician and dentistry services currently commissioned by NHS England, as well also the portfolio of services that can be provided by general practices working in collaboration with each other and other community-based providers.

The CCG’s vision for primary care is to combine general practice care with other community-based health and social care into a place-based care model with productive general practice at its foundation and GPs overseeing care for their patients. Each of the localities in Barking and Dagenham where neighbouring GP practices work together will be a ‘place’, and the vision is therefore to establish locality-based care across all health and social care services for the populations within those geographical localities.

Locality-based care will be proactive, with a focus on prevention, support for self-care, active management of long-term conditions and the avoidance of unnecessary hospital admissions. Patients will have a more joined-up care experience, be enabled to take more control of their care, and more of their treatment will be closer to home.

The locality-based care model has at its foundation highly productive GP practices working individually and collaboratively to deliver care, improve care quality systematically and optimise the use of GP time and collective resources, reducing administrative costs and making best use of available IT solutions. General practice will be integral to the formation of a highly effective extended locality team of community, social care, pharmacy, dental and ophthalmology professionals and the voluntary sector providing local people with the majority of their care. With input from local patients, this team will decide local pathways, how the care workload is shared, and where care delivered from, in line with standards set and common assets managed at the BHR system level.

In configuration terms, locality teams will initially be virtual teams. General practice will have the opportunity to shape the way locality provision develops, learning from the experience of joint working. In 2021, provision may continue in the form of an alliance of individual GP practices who operate autonomously. Alternatively, by then, general practices may consolidate into a larger scale provider, or join with community and other providers into a multi-speciality community provider.

This aligns with the London Borough Barking & Dagenham vision of improved access and self-sufficiency.

“Our vision is that many 21st century services will be delivered through a range of digital channels which will improve access and speed response coupled with a move towards developing a population that is more self-sufficient and resilient. Where care is needed we would expect it to be personalised and delivered as close to home as possible. Therefore for some/most services a locality approach would be an appropriate model of deliver.”
A system-wide programme will be established to refresh the roles and mix of professionals needed for locality-based care and to develop the career packages needed to sustainably attract and retain GPs, nurses and healthcare assistants and care professionals needed.

With the balance of care delivery shifting away from hospital care, a commensurate share of the existing funding envelope will fall to general practice and fellow locality team providers, that is, the funding will follow the patient to the provider of the service within the locality. In some situations an ‘invest to save’ approach may be appropriate by accessing future transformation funds.

In time, it is likely that contractual arrangements will change to incentivise population-level outcomes rather than reward provider activity.

The CCG aims to have locality-based care fully operational within two years. Key changes will be:

1. GP practices will work more productively and free up GP time to provide and oversee patient care.
2. Collaborative working between GP practices in localities and with the extended team of care professional will become established, raising quality and increasing capacity for locality care services and helping reduce the cost of administration.
3. Clear boundaries between primary care and acute hospitals, with good handovers between teams.
4. A programme will be put in place to recruit, develop and retain a primary care workforce suited to delivery in a place-based model in Barking and Dagenham.
5. Increasingly, reliable IT solutions will enable joined-up patient care and the automation of administrative tasks, and locality-based providers will adopt and use them with confidence.

This strategy will be a working document, implemented by a range of projects across the system, which will continue to evolve as locality working is developed into a place based care model.
2 Introduction

This strategy sets out a future vision for general practice in Barking and Dagenham in the context of wider change in Barking and Dagenham and the Barking and Dagenham Havering and Redbridge (BHR) health and care system, defines the overall scope and approach for the associated transformation programme and implementation of place based care and provides a detailed plan for 2016/17.

The strategy addresses the future roles, form and sustainability of general practice specifically, given the role of the CCG in commissioning primary medical services. It also considers the future role of other primary care services such as community pharmacy, dentistry and community opticians as participants – along with community health, social care and voluntary sector providers – in integrated local care services.

Section 3 describes the drivers for change, summarising the commissioning agenda at national, London and local levels and the presenting a thematic analysis of the issues and opportunities raised at grass roots level by local stakeholders.

Section 4 assesses the strategic options for a future model, making the case for change, and Section 5 describes the future vision and how it addresses the drivers for change.

Section 6 describes what will change over the first two years of the programme and Section 7 presents the detailed 2016/17 plan.

In developing this strategy, we have engaged extensively with stakeholders with a role in the Barking and Dagenham health and care economy: patient representatives, patient groups, the Health and Wellbeing Board, general practitioners, practice managers, pharmacists, nurses, community and mental health services provided by North East London NHS Foundation Trust (NELFT), acute services provided by Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT), the Partnership of East London Co-operatives (PELC), the Local Medical Council (LMC), the London Borough of Barking and Dagenham (LBBD), NHS commissioners and Care City. We have also consulted with general practice, primary care and workforce leads at NHS England London level. Thanks are due to individuals who have provided their time and perspectives.

In formulating the vision, programme and plan we have worked closely with the BHR primary care transformation programme board. Many of the issues that have been identified in the development of this strategy are local and specific to Barking and Dagenham. Others we share with our neighbouring boroughs in Redbridge and Havering and where we believe that a collaborative approach can be taken to addressing them, we will.

We have also consulted LBBD and BHR commissioning colleagues responsible for parallel strategic work on commissioning for population health, planned care, mental health and urgent and emergency care to ensure alignment of vision and clarity on programme scope where proposals overlap.
3 Drivers for change

3.1 The commissioning context

3.1.1 National

Nationally, the NHS faces significant future challenge in the form of the increasing health needs and expectations of the population; changes in treatments and technologies; and increasing pressures on finances, both from reduced spending growth in the NHS and cuts to social care budgets. Current projections from Monitor and NHS England estimate that the NHS will face a £30 billion funding gap by 2020/21. To tackle these challenges within Government funding limits, NHS England’s *Five Year Forward View*\(^2\) sets out transformational change for the NHS to be driven by commissioners and realised by providers. This involves:

- Reducing variation in care quality and patient outcomes
- Increasing the emphasis on preventative care
- A shift towards more care being delivered in primary care
- Breaking down the barriers in how care is provided through the introduction of new models of care spanning current organisational boundaries
- Action on demand, efficiency and funding mechanisms to improve financial sustainability.

The *Five Year Forward View* recognised that primary care has been underfunded compared to secondary care and general practice faces problems with workforce, workload, infrastructure and care design. In response to this, the *General Practice Forward View*\(^3\) offers funding opportunities (further detail from NHS England expected in Spring 2016) and practical steps to stabilise and transform general practice through a plan focusing on:

- Growth and development of the workforce within general practice
- Driving efficiencies in workload and relieving demand
- Modernisation of infrastructure and technology
- Support for local practices to redesign the way primary care is offered to patients

3.1.2 Regional

At a London level, the *Better Health for London*\(^4\) report from the Mayor’s Office contained a range of recommendations that related to general practice. In particular, it called for significant investment in premises,
developing at scale models of general practice and the need for ambitious quality standards. This vision for primary care was further articulated by the publication of the Strategic Commissioning Framework for Primary care in London\textsuperscript{5} which outlines a key set of specifications (service offers) aligned to the areas that patients and clinicians feel to be most important:

- **Accessible care** – better access to primary care professionals, at a time and through a method that’s convenient and based on choice.
- **Coordinated care** – greater continuity of care between the NHS and other health services, including named clinicians and more time with patients as and when needed.
- **Proactive care** – more health prevention by working in partnerships to improve health outcomes, reduce health inequalities, and move towards a model of health that treats causes and not just symptoms.

The 17 indicators under these themes will be used across London to ensure a consistent, high quality service offer is available across the city.

### 3.1.3 Local

Barking and Dagenham, along with the wider BHR health system, has a greater commissioning challenge than the national and London average. The system-wide budget gap for BHR is over £400m, and the key challenges are set out in figure 1, below.

\textsuperscript{5} Transforming Primary Care in London, NHS England
The BHR system needs to be transformed to:

- Meet the health needs of the diverse, growing and ageing populations in its various local communities
- Improve health outcomes for these populations and reduce health inequalities overall
- Meet national quality standards for care
- Close a £400m gap.

To achieve this, commissioners and local providers agree that acute hospital care should be reserved for acutely ill patients and deliver the majority of care nearer home, and that more emphasis is needed on prevention to improve outcomes and contain demand for care.

**Local strategies**

Within BHR, strategies are in development that will have major implications for the transformation of general practice and primary care providers, in terms of future service configuration and contracts, supporting infrastructure, and work that must be coordinated to achieve maximum benefit across the local health system (e.g. workforce development). These include:

- A strategy for planned care, which includes a programme to reduce significantly elective referrals to secondary care and put in place alternative pathways and community-based provision
- A new model of urgent and emergency care, which will radically transform local urgent and emergency services, removing barriers between health and social care and between organisations. Urgent care will be simple for people to use and services will be consistent, no matter where people use them (i.e. by phone, online or in person). This will be enabled by the use of the latest technology to make care records accessible to patients and clinicians.
- A mental health strategy, which is currently in the early stages of development.

LBBD’s Ambition 2020 programme, together with actions and opportunities arising from the Barking and Dagenham Growth Commission, will set an agenda for prevention and building resourceful communities, to be achieved through transformation and partnership working. This and the Five Year Forward View will provide the context within which LBBD commissioners look to improve the health and wellbeing of the local population, with implications for primary care service provision.

The BHR partnership is currently drawing up a business case to explore opportunities through an Accountable Care Organisation (ACO) pilot. If implemented, it would deliver structural changes in the local health economy that align incentives and payment mechanisms to enable common goals and integrated working. The creation of an ACO locally would be a further demonstration of local ambition and see a large part of the budget currently controlled by NHS England and Health Education England devolved to the new body to spend on local needs. No decision to form an ACO has yet been taken by BHR partners.
Services within the scope of primary care include:

<table>
<thead>
<tr>
<th>Preventative care</th>
<th>Health and wellbeing advice: healthy eating, physical activity, mental health, kicking bad habits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Screening</td>
</tr>
<tr>
<td></td>
<td>Immunisations</td>
</tr>
<tr>
<td>Planned care</td>
<td>Self-care, self-management with coaching, education and support from primary care to manage their condition and to have a plan for escalation/emergency</td>
</tr>
<tr>
<td></td>
<td>Planned and preventative case management</td>
</tr>
<tr>
<td></td>
<td>Pharmacy services: Dispensing, medicine reviews, prescribing</td>
</tr>
<tr>
<td></td>
<td>Enhanced services</td>
</tr>
<tr>
<td></td>
<td>Specialist input</td>
</tr>
<tr>
<td></td>
<td>Transitions between secondary care/reablement</td>
</tr>
<tr>
<td>Urgent and emergency care</td>
<td>Urgent care - holistic assessment, streaming, booking</td>
</tr>
<tr>
<td></td>
<td>Minor ailments advice and treatment</td>
</tr>
<tr>
<td></td>
<td>Planned GP appointment</td>
</tr>
</tbody>
</table>

3.2 Performance and future sustainability of the current primary care model

Our analysis shows that current performance is mixed and the current model will not be able to cope with higher demand and meet care quality expectation. The headlines are:

- Our primary care workforce is already stretched
- Demand is growing due to a growing and younger population, with high levels of migration in and out of the borough, and more patients having more than one long-term condition
- A high proportion of GPs are nearing retirement, and recruitment and retention is challenging
- There is too much variation in quality
- There has been substantial progress in improving the accessibility of general practice, but there remains more to do
- There is too much variation in patient satisfaction, particularly around access
- Sharing of patient/client information between providers of health and care can be improved
- Some of our premises are poor quality
- Patients are being seen in a hospital setting for conditions that could be better managed in primary care.

3.2.1 Workforce

Our workforce is stretched and recruitment and retention is challenging

Barking and Dagenham has some of the lowest rates of GPs per 1,000 population in London, with 0.44 GPs for every 1,000 registered patients, compared to a London average of 0.55. The number of Practice Nurses only just meets the London average (0.22 Nurses per 1,000 population compared to a London average of 0.2). See figure 2, below.
Traditionally, outer London has found it harder to attract newly qualified GPs than inner London. It is difficult both to recruit and retain salaried GPs and to attract GP partners in Barking and Dagenham, as well as other members of the primary care workforce. The reasons identified by stakeholders are set out in the following table.

<table>
<thead>
<tr>
<th>Category</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>Isolated GPs</td>
<td>Salaried GPs and long-term locums feel disenfranchised and isolated.</td>
</tr>
<tr>
<td></td>
<td>High numbers of single handed GPs.</td>
</tr>
<tr>
<td>Older GPs</td>
<td>High proportion GPs reaching retirement age</td>
</tr>
<tr>
<td>Older nurses</td>
<td>High proportion nurses reaching retirement age</td>
</tr>
<tr>
<td>Overworked GPs</td>
<td>Lowest quartile of GPs per head of population in the country</td>
</tr>
<tr>
<td>Nationwide shortage of GPs</td>
<td>Shortage of medical students going into general practice despite Health Education England mandate. Training posts remain unfilled</td>
</tr>
<tr>
<td>Cost of living in London</td>
<td>Inner London posts attract inner London weighting pay whereas outer London posts attract lower band outer London weighting</td>
</tr>
<tr>
<td>Brand and reputation</td>
<td>Other parts of London are further ahead in marketing themselves and adjacent opportunities e.g. career development, research opportunities, honorary positions</td>
</tr>
</tbody>
</table>

High proportion of GPs nearing retirement

In addition to the current challenges faced by the shortage of GPs working in Barking and Dagenham, the age profile of the GP workforce signals that this challenge will be greater in future years. Barking and Dagenham has more than twice as many GPs over the age of 60 than the national average: 30% of GPs are over 60, compared to 15% in London and 9% nationally (figure 3). With potential retirements in this already stretched workforce, this is clearly a local priority.
Local stakeholder interviews provided us with a consistent narrative of increased demand, increased workload and, especially, increased time spent on bureaucracy and administrative tasks. Barking and Dagenham’s GPs find their current workload unsustainable. Many are overworked, and feel they are spending too much time on administrative tasks and chasing information, with not enough time for patient care. This work can be from external sources (e.g. patients who are discharged from secondary care with increased demands from primary care) as well as work generated within their practices (e.g. time spent on repeat prescriptions). Delegating care to other healthcare professionals/services can be difficult, with uncertainty over resources and capacity elsewhere in the system. Lack of information sharing between services makes it difficult for all members of the primary care team to know what other professionals are doing. This means work may be duplicated and confidence in the whole system working in an integrated way is reduced.

Patient behaviour also contributes to GP workload. Many patients find the primary care offer around urgent care confusing and will seek an appointment with their own GP, on top of contact with GPs/other professionals in urgent care, to ‘check’ their treatment is correct. Others still feel they need to see their GP for minor illnesses such as coughs and colds when another professional such as a community pharmacist could provide that care.

**Population growth and demographic change - growing population and a rise in the number of patients suffering from one or more long-term conditions**

The population of Barking and Dagenham is growing and the local healthcare needs are changing.

- Barking and Dagenham has seen a significant overall population increase of 13.4% to 185,911 (2011 Census). This is 22,000 more people since 2001, including a 50% increase in 0-4 year-olds. Within Greater London, Barking and Dagenham had the fourth...
biggest percentage population increase (2%) of all London boroughs between 2012 and 2013.
- 30% of the population are children, placing a huge pressure on school places, housing and social care including on workloads across key agencies working with the borough’s families.
- The population is projected to rise from 190,600 in 2012 to 229,300 in 2022. This is a 20.3% increase and is the second largest in England after Tower Hamlets.
- Barking and Dagenham has a population churn of 189 per 1000 or 19% which is significantly higher than the London rate of 9%.

The Barking and Dagenham Independent Growth Commission report 6 sets out a 20-year vision for the London Borough of Barking and Dagenham to deliver Barking and Dagenham’s growth opportunity. The Commission proposes at least 35,000 new homes and 10,000 new jobs will be created over the next 20 years, the most high profile development being at Barking Riverside. The council will publish its detailed response to the Commission’s report and strategy for transforming the borough and transforming the way in which the council is organised in April 2016.

Barking and Dagenham has also seen a rapid shift in the proportions of various ethnic groups across the borough, with a large decrease in the white British ethnic group and a large increase in the black African ethnic group. The most recent ethnic breakdown is shown in figure 5. By 2020, the expectation is that black and minority ethnic community will make up approximately 50% of the population.

The borough is the seventh most deprived in London and 22nd most deprived nationally which is also reflected in the relatively poor standard of health - life expectancy for both men and women is lower than the England average. Over half of the borough’s population live in the 20% most deprived areas in England and around one third of children in the borough are living in poverty.

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Long-term conditions

In addition to the growth in our population, we are seeing a growth in the number of people living with one or more long-term conditions.

- Diabetes prevalence is higher in Barking and Dagenham than the London and England average and the burden of disease from long-term conditions is likely to increase in primary care. The number of people recorded with diabetes in Barking and Dagenham increased from 10,625 in 2013 (6.4%) to 11,418 (6.8%) 2014 and is projected to increase further.
- About 10% of the population has caring responsibilities for someone who is ill, frail or disabled.
- Of the over 75 year olds living alone in the borough, almost 4,100 (41%) are living with a long-term condition and 1,317 have dementia.
- A population such as Barking and Dagenham is likely to have particularly high mental health needs and it is known that the rate of mental health disorders in children and adolescents in Barking and Dagenham is significantly higher than the national averages.

General Practice has a key role in the identification, treatment and management of long-term conditions and mental health. These trends impact on the demand on GPs and their teams.

Improved care coordination is central to the model of care provided to patients with long-term conditions. It has been shown to deliver better health outcomes, improve patient experience and is vital for people living with multiple conditions. Better care coordination is key to delivering an integrated health service. However, care coordination is complex and requires a shared approach across the healthcare system.

3.2.3 Quality

There is variation in the patient outcomes across Barking and Dagenham. General practice makes a significant contribution to improving the health of the population and influencing patient health outcomes. Across Barking and Dagenham there are examples of excellence in practice. We need to learn from these examples of excellence to reduce the variation that currently exists.

Quality Outcome Framework (QOF) achievement in Barking and Dagenham is an indicator GP practices will be familiar with that highlights the needs for reducing variation in the quality of care between Practices in the borough. The variance in QOF achievement in 2014/15 ranged from 458 to 559 (maximum). Lower QOF scores affect both the care of patients with long-term conditions and practice income.

<table>
<thead>
<tr>
<th>CCG</th>
<th>Average achievement (559 maximum)</th>
<th>Lowest score</th>
<th>Highest score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barking and Dagenham</td>
<td>530</td>
<td>458</td>
<td>559</td>
</tr>
<tr>
<td>Havering</td>
<td>516</td>
<td>282</td>
<td>559</td>
</tr>
<tr>
<td>Redbridge</td>
<td>522</td>
<td>443</td>
<td>559</td>
</tr>
<tr>
<td>London</td>
<td>521</td>
<td>139</td>
<td>559</td>
</tr>
<tr>
<td>England</td>
<td>530</td>
<td>139</td>
<td>559</td>
</tr>
</tbody>
</table>
Achievement against the general practice outcome standards (GPOS) allow us to see how GP practices perform against a set of 26 indicators for quality improvement agreed with GP leaders, clinicians, the London-wide LMCs, commissioners and other health care professionals, think tanks and patient groups. Barking and Dagenham CCG has a slightly lower proportion of GP practices rated as ‘achieving’ or ‘higher achieving’ against GPOS as London as a whole, see figure 6. The proportion of practices in the lowest performing category of ‘review identified’ is 45% (18 practices), similar to average of 46% in London. Practices in this category have nine or more triggers in total, or three or more level two triggers (where they are well below target/England average). For more detail on individual indicators where comparison to the England average is possible see figure 7, below.

Some of our premises are of poor quality and need further investment

To ensure that patients receive high quality, accessible and safe care it is fundamental that general practice is able to deliver care from buildings that are fit for purpose and have the relevant facilities. Investment in primary care estates and IT has lagged behind investment in secondary care. Some general practices are working from inadequate buildings with limited facilities. This creates a poor environment for patients and staff. Much of the general practice estate is out-of-date, under-developed and cannot provide the facilities needed to deliver high quality care.
In Barking and Dagenham there has recently been significant investment in the health estate over the last decade, with one new community hospital and seven large LIFT centres but there is still a very mixed picture across primary care. Much of the general practice estate is in poor condition, with a large number of single-handed practices operating out of old houses.

Barking and Dagenham have invested in a DDA and infection control compliance programme for a portion of their primary care estate in 2010 and continuing this improvement in primary care premises must continue to remain a focus. This improvement needs to be coupled with opportunities presented through the new modern estate, which now needs to be fully utilised with extended opening hours. Most is generic space that would benefit from sessional booking and use. This will allow for rationalisation of the remaining NHS Property Services sites, a lot of which is in poor condition and not fit for purpose.

An additional consideration for the primary care estate in Barking and Dagenham is the number of regeneration schemes planned in the borough. The council’s local housing strategy for Barking and Dagenham identified dense areas of regeneration such as Barking town centre and Barking Riverside. The borough is situated in the Thames Gateway growth area and has the potential to develop 15,000 new homes over the next ten years. Barking Riverside will be the most significant of these developments, leading to the creation of a major new community in the borough, with approximately 10,800 new homes. There is an opportunity to improve our primary care estate through the funding available through London Borough of Barking and Dagenham and housing developers to support public infrastructure as a result of these developments.

There are variable levels of patient satisfaction, particularly in terms of access

Improving access to primary care professionals, at a time and through a method that's convenient and based on choice is outlined as a key priority for the delivery of primary care services in London. General practice core hours of operation are 8.30am to 6.30pm, Monday to Friday. The direct

The Enhanced Service for access incentivises practices to open additional hours outside of this core offer. Across Barking and Dagenham there are eight GP practices, one in five, that are not open during core hours - this impacts on the amount of access available to their patients

As part of the engagement on the development of this strategy a survey was circulated to patients, carers and their representative groups to seek their views on local GP services. Access to services was highlighted as an issue for some respondents and highlighted as an area where things could be improved. The boxes on the right show a selection of the comments received about access.

Access has been a key priority for general practice development over recent years and work has begun to develop the strong foundations for opening up
access to patients across Barking and Dagenham. In collaboration with Redbridge and Havering CCGs integrated GP services through access hubs during evenings and weekends are being offered across the network. This new model of extending access has so far achieved a 90% patient satisfaction rate and has opened up an additional 4,800 urgent care slots a month.

**Patients are being seen in a hospital setting for conditions that could be better managed in primary care**

As the usual first point of contact for patients when accessing the healthcare system, primary care plays a crucial role in preventing unnecessary hospital attendances and admissions.

Across Barking and Dagenham a high proportion of patients attend A&E. It may have been appropriate to treat some of these patients in primary care. Figure 8 reflects the attendance rate per thousand registered patient at each practice in Barking and Dagenham in 2013-14:

- In Barking and Dagenham the average attendance rate is 426 per 1,000 registered patients, one of the highest rates in London;
- The London average in 2012-13 was 312 per 1,000 population which itself was the highest in the country;
- Variation locally in A&E attendance rate by Practice range from approximately 320 to 680 per 1,000 and is unlikely to be as a result of population factors alone.

This suggests that more can be done to treat patients in primary care, ensuring they have access to the care closer to home.

![Figure 8: A&E attendance by practice per 1,000 population](image)

Outpatient referrals show a similar trend with variation in referral rates varying across practices, see figure 9.
3.3 GP and stakeholder perspectives

We have consulted with patient representatives, general practitioners, practice managers, community pharmacists, nurses, community and mental health services (NELFT), acute services (BHRUT), the London Borough of Barking and Dagenham, NHS commissioners and Care City. We have also had conversations with GP, primary care and workforce leads at NHS England London level. Local stakeholders have identified issues with primary care as it is now, and potential solutions. There is wide recognition that transformation in primary care is both necessary and desirable.

A full thematic analysis of feedback is available from the primary care transformation team. The key themes are shown below.

<table>
<thead>
<tr>
<th>Challenge</th>
<th>Aspiration</th>
<th>Solutions offered</th>
<th>Examples</th>
</tr>
</thead>
</table>
| The system is fractured – we work in silos and there is a lot of inefficiency and duplication | We want integrated health and wellbeing services that meet our populations’ physical, mental and social care needs (Five Year Forward View – Action on demand, efficiency and funding mechanisms/emphasis on preventative care/reducing variation in care quality and patient outcomes) | • We want more focus on prevention  
• We need to help patients to self-care  
• Care should be close to home  
• Links and handovers between primary, community, secondary and social care should be seamless  
• To improve quality and reduce costs we should align incentives across providers – ie resource in terms of new roles and funding | • Developing social prescribing, parenting skills classes, working with schools and nurseries  
• Locality focussed care to meet the needs of the population eg services for older people/younger people – delivered through pathway redesign in localities  
• Working with patient participation groups to develop services – improve uptake on vaccination/immunisation |
<table>
<thead>
<tr>
<th>Challenge</th>
<th>Aspiration</th>
<th>Solutions offered</th>
<th>Examples</th>
</tr>
</thead>
</table>
| Demands and expectations of GPs are too high                             | We need to re-define the role of the GP in relation to the rest of the primary care team (Five Year Forward View – Action on breaking down the barriers in how care is provided through new models of care spanning organisational boundaries) | • GPs want to retain overall responsibility for their patients but not feel like they have to do everything  
• We want GPs to be able to delegate work/decisions to other members of the primary care team where appropriate  
• We want GPs to have more time for complex, planned and preventative work  
• We want the benefits of collective working but also need to balance that against the desire for GP autonomy. | • Can be achieved by developing new roles with primary and community services  
• Working with primary care at scale providers eg GP federations to provide services within a locality  
• Exploring different ways of working with community pharmacy |
| Our workforce is stretched and the workload is getting bigger            | There are ways we could tackle our workload and workforce challenges (Five Year Forward View – Action on breaking down the barriers in how care is provided through new models of care spanning organisational boundaries) | • We could share staff  
• We could pilot new care pathways and ways of working  
• By enhancing peoples’ skills we could enable more sharing of the workload  
• Shared education and training would help team working and build relationships between professionals  
• We could train hybrid health and social care workers  
• Building communities of practice and support across professions would reduce feelings of isolation and allow us to share knowledge  
• Sharing back office functions would cut | • Focus on areas to support the planned care programme – more care support provided in a locality setting eg rheumatology services, diabetes services (more patient education programmes and nurse specialists working at a locality level)  
• Develop the shared care model across a range of specialties with both acute care and social services eg London Borough of Havering’s Vulnerable Family Scheme |
<table>
<thead>
<tr>
<th>Challenge</th>
<th>Aspiration</th>
<th>Solutions offered</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>We are committed to our patients and do some things really well</td>
<td>We want to build on what already works (Five Year Forward view – Action on more care being delivered in primary care)</td>
<td>• We want to roll out the successful pilots we already have</td>
<td>• Data sharing scheme being trialled in GP Access Hubs</td>
</tr>
<tr>
<td>Poor use of technology and low quality facilities makes our work harder</td>
<td>To do our jobs well we need fit for purpose buildings and good IT (Five Year Forward View – Action on more care being delivered in primary care/demand, efficiency and funding mechanisms)</td>
<td>• We need good IT and digital platforms to improve self-care and access for patients</td>
<td>• Develop a GP User Group to identify needs of general practice/localities</td>
</tr>
</tbody>
</table>
4 Primary care strategic options

4.1 Requirements
In summary, the drivers for change described in the previous section give us a set of requirements a new primary care model must aim to meet. These are:

<table>
<thead>
<tr>
<th>Delivery</th>
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<tbody>
<tr>
<td>• Meet the health needs of the diverse, growing and ageing populations in its various local communities</td>
</tr>
<tr>
<td>• Contribute substantially to the improvement of health outcomes for these populations and the reduction of health inequalities overall</td>
</tr>
<tr>
<td>• Meet national and regional quality standards for primary care, ensuring care is accessible, coordinated and proactive</td>
</tr>
<tr>
<td>• Strengthen the system's capability/capacity to deliver the majority of patient care – planned, mental health and urgent – out of hospital with a focus on prevention and early intervention, reducing demand for acute care and enabling savings of £400m across BHR.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Patients can continue to benefit from a relationship with their local GP</td>
</tr>
<tr>
<td>• Patients receive a joined-up, cost-effective care service with unnecessary duplicate assessment and treatment avoided.</td>
</tr>
<tr>
<td>• Patients find it easier to access appropriate primary care</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>General practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The quality of care provided in general practice is systematically improved and variation between practices reduced</td>
</tr>
<tr>
<td>• Productive GP practices can retain their autonomy and have a financially sustainable future</td>
</tr>
<tr>
<td>• GPs have the time they need to provide quality patient care</td>
</tr>
<tr>
<td>• The time and effort spent by GPs and practice colleagues on administrative tasks is minimised</td>
</tr>
<tr>
<td>• The respective roles and responsibilities of GP practices and all local care providers in delivering care are clearly defined and consistently applied day-to-day by all parties</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Workforce</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The career offer and working environment for GPs in Barking and Dagenham are sufficiently compelling to retain existing GPs and attract new enough recruits.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Infrastructure</th>
</tr>
</thead>
<tbody>
<tr>
<td>• GPs and their fellow professionals can rely on IT to present the information about their patients that they need at the point of care to make the best decisions for patients</td>
</tr>
<tr>
<td>• Care is delivered in premises that are fit for purpose in a way that makes the best use of existing assets.</td>
</tr>
</tbody>
</table>

4.2 Strategic options
We have identified five possible options for the transformation of primary care in Barking and Dagenham over the coming five years:

1. “Do nothing” – retain the existing model at current levels of funding
2. Retain the existing model and increase funding
3. Invest in improving care quality and productivity in general practice and make it sustainable
4. Extend general practice incrementally to become a place-based model of care, whereby general practice and other primary and community-based providers collaborate to deliver proactive, joined-up care out-of-hospital for a local population
5. Building on the Five Year Forward View, move directly to merging the provision of general practice and community-based care and create a new form of provider, such as a multi-speciality community provider.

Our analysis in Section 3 demonstrates that option one is not sustainable.

Option two is neither clinically sustainable nor financially viable. BHR has a system wide budget gap of over £400m, and there is no additional funding available in the system beyond funding potentially released through a proportional reduction in acute hospital care.

The current primary care model therefore needs to change. A focus on improving general practice (option three) meets a number of the requirements above, but is not sufficient to create the capability and capacity needed to deliver the majority of patient care, or to transform care so it is joined-up and cost-effective with unnecessary duplicate assessment and treatment avoided. This would require closer integration of general practice with other primary and community-based care (option four).

Our recommendation is a vision which combines the strengthening of general practice (option three), maintenance of the patient-GP relationship and the continued autonomy of practices, with the extension of general practice to become place-based care (option four).

Experience of collaborative working in a virtual team may, in time, build a case to move to new forms of provider configuration (option five), but change should be made incrementally by local care professionals with a focus on what will improve services for patients.

5 The vision for general practice in Barking and Dagenham

5.1 Vision for general practice

The CCG’s vision is to combine general practice with other community-based health and social care into a place-based care model with productive general practice at its foundation and GPs overseeing care for their patients. Each of the three existing localities in Barking and Dagenham where neighbouring GP practices work together will be a ‘place’, and the vision is therefore to establish locality-based care across all health and social care services for the populations within those geographical localities.

Locality-based care will be proactive, with a focus on prevention, support for self-care, active management of long-term conditions, the avoidance of unnecessary hospital admissions and the reduction of unnecessary elective hospital referrals. Patients will have a more joined-up care experience, be enabled to take more control of their care, and more of their treatment will be closer to home.

The locality-based care model has at its foundation highly productive GP practices working individually and collaboratively to deliver care, improve care quality systematically and optimise the use of GP time and collective resources, reducing administrative costs and making best use of available IT solutions. General practice will be integral to a highly effective extended locality team of community, social care, pharmacy, dental and community opticians and the voluntary sector providing local people with the majority of their care. With input from local patients, this team will decide local pathways, how the care workload is shared, and where care is delivered from, in line with standards set and common assets managed at the BHR health system level.

Collaborative working will involve GPs working together on quality improvement and deciding how practices should work collectively across localities to offer services to patients, both within
routine and extended opening hours, as defined by the strategic commissioning framework standards, and how collective working to manage workload will create more time for extended appointments. Localities will also decide what blend of services best meet local need and standards, for example the number of appointments available with GPs and other health professionals, and where those appointments will be offered (e.g. GP practices, hubs). To see how locality-based care will meet each strategic commissioning framework standard, see Appendix A: Strategic Commissioning Framework delivery plan.

In configuration terms, locality teams will initially be virtual teams. General practice will have the opportunity to shape the way locality provision develops, learning from the experience of joint working. In 2021, provision may continue in the form of an alliance of individual GP practices who operate autonomously. Alternatively, by then, general practices may consolidate into a larger scale provider, or join with community and other providers into a multi-speciality community provider.

A system-wide programme will be established to refresh the roles and mix of professionals needed for locality-based care and to develop the career packages needed to sustainably attract and retain the GPs, nurses and healthcare assistants needed.

With the balance of care delivery shifting away from hospital care, a greater share of the existing funding envelope will fall to general practice and fellow locality team providers. In time, it is likely that contractual arrangements will change to incentivise population-level outcomes rather than reward provider activity.

<table>
<thead>
<tr>
<th>2016</th>
<th>2017/8, a stepping stone to...</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reactive care: unplanned hospital admissions, duplicate care activity, disjoined patient experience, a financially unsustainable system</td>
<td>BHR System-level standards and assets driving proactive care, developed for planned care, mental health and urgent &amp; emergency care</td>
<td>Proactive care: prevention, self-care and managed LTCs, avoiding unnecessary hospital admissions, joined-up and cost-effective</td>
</tr>
<tr>
<td>Practices and GPs overloaded</td>
<td>Productive GP practices working collaboratively to deliver care, improve quality, free up GP time and reduce administrative costs, making best use of available IT solutions</td>
<td>Future primary care provider configuration decided locally, based on experience of locality teams, to best meet population needs</td>
</tr>
<tr>
<td>Autonomous GP Practices operating as standalone SME businesses with challenged financial outlook</td>
<td>Highly effective virtual Locality Teams in place to provide the majority of care and decide local pathways and how work is shared, and where care delivered from, with GP overseeing a patient’s care</td>
<td>Locality alliance, with retained provider autonomy</td>
</tr>
<tr>
<td>Multiple local providers operating independently: General Practices Community Pharmacies Dentists/Ophthalmologist Community Care Social Care</td>
<td>Future locality-based primary care workforce defined and system-wide programme in place to define, recruit and retain talented professionals</td>
<td>General practice provider working at scale</td>
</tr>
<tr>
<td>Major recruitment and retention issues in general practice and community nursing</td>
<td>Piloting accountable care arrangements</td>
<td>Multi-specialty community provider</td>
</tr>
<tr>
<td>Contracts and funding based on separate provider activity</td>
<td></td>
<td>Talented professionals attracted to the area, pursuing fulfilling careers in providing care that meets local needs</td>
</tr>
</tbody>
</table>

Figure 10. Milestones in journey towards achieving the vision
What is place-based care?
The King’s Fund proposes place-based care as a way to create an environment where health care organisations can effectively work together towards improving health outcomes for the populations they serve. By pooling their resources, providers are freed from the pressure to focus on their own services and organisational survival to the potential detriment of other organisations within the health economy. In place-based care, providers collaborate to manage pooled resources, enabling them to consider the whole health economy when making decisions and to better use resources to meet their local populations’ needs. Place-based care is not about top-down change, it’s about enabling local systems of care to develop ways of working that effectively meet population need. The King’s Fund’s framework for developing place-based models of care will be used to develop the model in Barking and Dagenham.

Evidence advanced by the King’s Fund, drawing on examples from New Zealand, Chenn Med, is that place-based care works best with a population of 50-70,000 people. Barking and Dagenham has a history of working in localities, and partnership working is fundamental to the effective working of the localities as a transformed system. Geographical boundaries must align with ward boundaries (super output areas) in order that data can be effectively used to inform place-based commissioning. Additionally the boundaries of localities are a function of current locality-based services - children and adult social care, community health services. In the future localities will also be the focus for residents of Barking and Dagenham who access Community Solutions (LBBD). See Appendix B: Current localities, it is proposed that place-based care be established after a joint review of the configuration of existing boundaries/localities – and will be agreed through a consensus approach between health and social care partners.

How will place-based care in a Barking and Dagenham locality work?
The vision for locality-based care is summarised in figure 11, below. As now, it is founded on GP practices.

Providers and professionals working collaboratively
The locality-based care model comprises multiple layers, operating in parallel:

- Individual GPs, supporting, treating and referring patients on their list, taking, where appropriate, oversight of their care across the system, equipped with the information they need to do so
- Productive GP practices, effective at improving care quality, managing and prioritising their workload, using the full resources of the practice and making best use of IT solutions to free up GP time for patient care
- GP practices working within collaborative arrangements to deliver primary medical and additional services, improve care quality and manage administrative activity more cost-effectively; existing federation arrangements may offer a starting point for this
- General practice shaping and integral to an extended multi-professional team of community, social care, pharmacy, dental, ophthalmology and voluntary sector services.
The team in a locality will be sufficiently small (averaging circa 100 team members) to allow the formation of trusted working relationships between clinicians and care workers from different organisations and professional backgrounds, which will be important in improving care quality, patient experience and productivity. The inclusion of patients in that team of 100 will be key for the co-design of services with the population they serve.

It is assumed, initially, that general practice and fellow providers will come together in a virtual team, with the option to evolve into more formal organisational structures for collaborative working based on experience from delivering care collaboratively.

Whilst there may be similar services provided in localities, there may be differences too – that is this will not be a one-size fits all approach as the locality will need to be able to flex to the needs of its patients/residents. For example, localities with a high number of children aged 16 or under will need to consider services to reduce attendances at A&E (children being one of the highest users) – this could be achieved by a paediatric service being available at an out of hours hub within the locality. Prevention work could be achieved by outreach work in nurseries, schools and colleges – with a focus on healthy lifestyles, dental hygiene, self care education programmes etc.

**Figure 11. General practice-led locality-based care**
Building a locality strategy and plan

To ensure equity and quality of care, localities will need to provide services which meet NHS England’s strategic commissioning framework quality standards, and with BHR ambitions set within a formal quality improvement framework with evaluation via the system’s agreed primary care transformation dashboard (Appendix C). Within this framework, locality teams will develop a shared strategy and plan to meet the needs, priorities and preferences of the population they serve. They will decide what resources will best meet local health needs, and the specific health outcomes they want to target and track.

Localised pathway design

Pathway design within each locality will be informed by BHR standards for pathways for preventative, planned, urgent and mental health care. Within these standards, localities will be supported to design the pathways that work best for their population. Pathway design at locality level will include:

- Designing and developing services commissioners determine may be provided by locality-based providers as a better quality and value-for-money alternative to secondary care
- Deciding the division of responsibility for delivery of primary care services across GP practices individually, GP practices collectively and the extended team
- Thresholds and protocols for referral to, and discharge from local hospital services
- The relative proportion of GP practice appointment time to be made available for prevention, planned and unplanned care.
- How the locality will utilise the planned urgent and emergency care ‘click, call, come in’ capacity as part of their urgent care offer
- How care across providers is joined up around the patient
- How providers all play to their strengths
- How quality is assured.
Figure 12. Example of how the mix of services might be distributed across the locality team

Wider community of primary care providers

- Consultant diabetologists and diabetes specialist nurses (DSPNs) working in the community to support GPs in the delivery of services, support ongoing management of patients and play a key role in multidisciplinary team meetings, delivering education and increasing the local skill base.
- Upskilled workforce providing health coaching to people with diabetes and pre-diabetes to self-care and facilitating access to lifestyle interventions (healthy eating courses, smoking cessation, exercise on prescription).
- Rapid response team – specialist emergency response team to help care for people in a crisis outside hospital and close to home.

Collectives of GP Practices

- Employing additional specialist diabetes nurse to allow smaller practices to split cost of new additional weekly diabetes clinics between them.
- Jointly providing training to patients in how to use mobile devices to monitor their diabetes.
- Collective monitoring of patient data for both correct use of technology and changes in their health status.
- Shared back office staff communicating with people with diabetes and pre-diabetes for the total combined registered list for the locality.

GP Practice team

- Admin team - Helping patients access services across locality. E.g. specialist diabetes nurse clinics, health eating courses, healthy eating on a budget courses.
- Practice nurse - health coaching patients to self-care.

GP

- Overseeing care for people with diabetes.
- Delegating work as appropriate to others (e.g. prescribing for stable patients to pharmacists, admin for all patients to admin team).
- Sealing people in emergencies and on periodic reviews of holistic care plan.

Patients

- Those who are able to are taking ownership of their care.
- Know how to access services they need.
- Ability to self-care enhanced by innovative use of technology (e.g. mobile apps to monitor HbA1c).
- Have management and crisis plans that they have made with their GP or diabetes nurse.
- Confident what to do if diabetes worsens or in an emergency (diabetes-related and other emergencies).
Enablers and Support

The CCG will provide investment and support in the enablers of this vision for locality working. BHR will:

- Provide each locality with dedicated resources to support the development of locality working
- Provide quality improvement methodologies and training to enable general practice to improve care quality systematically and reduce variation in practice
- Identify solutions for the recruitment, retention and development of the GP workforce, as well as nursing, pharmacists and practice management. Other roles, including primary care healthcare assistants any physician assistants etc may need to be developed (details below)
- Develop funding and contractual arrangements for primary care and the wider system to incentivise joined-up care, prevention and avoidance of avoidable hospital admissions.
- Enable GPs and the extended primary care team to operate from fit-for-purpose premises, making best collective use of local public service estates.
- Support both patients and their care providers to be confident users of information and IT solutions that enable self-care, care scheduling, joined-up care planning and management, and safe clinical decision-making.

At the same time, the financial sustainability of the system will be enhanced through the de-duplication and appropriate automation of administrative functions, releasing more patient-facing time.

Local Authority Partnership Working

The development of localities will be undertaken in partnership with LBBD to ensure strategic alignment and the smart combination of delivery resources. Specific inputs anticipated are that:

- Social care services will make up a core part of locality-based teams
- Public health will contribute in a number of ways:
  - input into needs assessments for each locality
  - map the current social capital available within each locality
  - commission services that focus on prevention of ill health
  - evaluate the impact of prevention on care capacity.

Evolution of the way providers are organised and work together

In configuration terms, locality teams will initially be virtual teams. General practice will have the opportunity to lead and shape the way locality provision develops, learning from the experience of joint working. Provision may continue in the form of an alliance of autonomous health and social care providers. Alternatively, by 2021, general practices may consolidate into a larger scale provider, or join with community and other providers into a multi-speciality community provider. Local authorities will have joint oversight of the evolution of the system so it continues to meet population need.

5.4 What is the vision for workforce in general practice and the locality?

Throughout our stakeholder interviews, there was a shared vision of integrated primary, community and social care working at a locality level with the patient and GP in the centre.

This strategy, therefore, makes recommendations for the general practice workforce for the first two years whilst the landscape becomes clearer with other strategies and initiatives. These recommendations will create the framework for a more engaged, mature and agile locality-
based general practice team empowered to ‘sense and respond’ in a fast-changing world. This will allow benefits from working as part of the CCG but also be locally driven.

As the vision is very much about empowering localities to co-design and deliver locally appropriate solutions, we have set out a range of potential options proposed by stakeholders for workforce development within locality settings. Localities can choose to adopt solutions that suit their population’s and workforce’s needs. These are set out in Appendix D: Workforce development in primary care.

5.5 What would locality-based care mean for a GP practice in 2018?

Different ways of working will develop within each locality, but GPs will see key changes in their day to day working across Barking and Dagenham take place over the next two years.

1. GP practices will work more productively and free up GP time to provide and oversee patient care

I’m a Practice Manager for quite a big practice (9 FTE GPs). I did a bit of work with one of our partners looking at the activity in our practice using a tool developed by the RCGP, which we found out about at one of the locality support sessions. I found the tool really helpful, not least because while everyone at our practice feels stretched and that things could be more efficient, they all have different opinions about what the problem is! Having the information about how we were spending our time in black and white made it a lot easier to agree what we should focus on, and ways we could change it.

We realised that a lot of GP time was spent on patients that could be seen by someone else in the practice. For example, GPs were doing routine blood pressure checks that could have been done by the nurse; hospital referral chasing that could have been done by reception; repeat prescriptions could have been done by our admin team. We talked through a couple of options that we’d gone through at a locality workshop and decided we would try ‘process triage’ at our practice. That means getting reception to ask what appointments were for and directing the routine checks, repeat prescriptions, coughs etc to alternative members of staff or the pharmacy. Of course, if a patient doesn’t want to say why they want a GP appointment, we don’t push them to say, it’s just where they are happy to give that information. It’s also not infallible; sometimes patients do reveal they have another problem which needs GP attention during their nurse appointment. Even taking all that into account, we managed to move about 10-15% of our GPs’ workload onto other members of the practice team. That frees up about a day a week of GP time that can be spent on more valuable work.

2. Collaborative working between GP practices in localities and with the extended team of care professional will become established, raising quality and increasing capacity for locality care services and helping reduce the cost of administration

I'm a partner in a small practice and, like many practices, we have a lot of patients with diabetes. A specialist nurse helping to care for these patients would really improve these peoples’ care, but we don’t have the resources to employ a full-time specialist nurse, and have never been able to recruit one on a part-time basis. Because the practices in our locality have all outsourced our payroll and HR through the same company, it’s been easy to join up with two other small practices to create a full-time role for a specialist diabetes nurse that we share between us. We share the cost of her salary, and all our patients get the benefit of specialist nursing. Our nurse likes the variety and was attracted by the full time job close to home. Our practices are close together so it's similar for her in terms of travel, and she’s never working too far away from her son’s nursery either.

We don’t just outsource as a locality though; we also share work between our existing staff. We realised there are a lot of tasks that we didn’t want to outsource, but that didn’t make sense for every practice to do its own. Our practice managers have divided up this work we all do between them and now focus each team on doing one thing (e.g. call-recall) really well for the whole locality.

3. Clear boundaries between general practice and acute hospitals, with good handovers between teams

I used to spend hours chasing up information about my patients that had been discharged from hospital, making sure I knew what care needed to be in place and that it was happening. It was very often reactive, non-medical work, that was draining and frustrating. Having better information flows with our local hospital has improved things a lot. Joined-up IT means I have much more of the information I need to manage patients post-discharge. Reducing the administrative burden associated with discharged patients means I have more time to focus on planned care. For example, working on emergency plans with those patients who are likely to require acute care when their condition deteriorates. By having those plans in place with patients, and other services they will need, we can make the transition between primary and secondary care much better for those patients.
4. A programme will be put in place to recruit, develop and retain a primary care workforce suited to delivery in a place-based model in Barking and Dagenham

After years of trying, six months ago I finally recruited a new salaried GP to my practice and it’s made a huge difference. Before she started I’d been reliant on locums and working myself into the ground. I used to regularly think to myself ‘I’m a GP in my prime, I’m highly skilled, do I really want to do this for another 20 years when I could have a much, much nicer life in Australia?!’. Having another full time GP that’s committed to the practice and the patients has really helped take some of that pressure off.

I think the recent changes have helped make our borough an attractive option for newly qualified GPs, when they wouldn’t have considered it a few years ago. Now we’re getting a reputation as the top place in London for innovation, what with the Vanguard and work on integration. She wanted to work somewhere where she would definitely be developed, on top of getting experience in all the multiprofessional working. It also helps that the CCG have got a bit slicker at marketing the area - good house prices compared to the rest of London and so on – as well as the work we do.

5. Increasingly, reliable IT solutions will enable joined-up patient care and the automation of administrative tasks, and locality-based providers will adopt and use them with confidence

I knew that joined-up IT would release a significant amount of time that my receptionists used to spend printing and scanning paper documents. What I hadn’t really expected was the difference it’s made in terms of building trust in my colleagues outside my practice, and the benefits that has brought me in my job as a GP. It’s not just that I started to build relationships with them in joint IT training sessions, or during Skype MDT meetings. Having shared records where we can access the information we need means I can easily see what community nursing, pharmacies, social care etc are doing to care for my patients. For example, if a patient needs a home visit after coming out of hospital, I can see when it’s happened, what the outcome was and who is doing what. I don’t have to hunt for that information, or call to double-check. It’s just there. It means that I can really focus on what I need to do as a doctor for my patients, keep an overview of their care, but not feel like I have to do everything myself to be sure it will get done.

5.6 What would be the benefits of locality-based care for patients?
Across primary care there will be an overall improvement in quality of primary care in Barking and Dagenham, and a reduction in the variation of quality between GP practices. Patients will benefit from care that is more proactive (the prevention agenda), accessible and coordinated, as out outlined in the patient offer of London’s strategic commissioning framework. Their experience will be of an integrated service that supports and improves their health and wellbeing, enhances their ability to self-care, increases health literacy, and keeps people healthy. Primary care will be personalised, responsive, timely and accessible, and provided in a way that is both patient-centred and coordinated.
Practices across Barking and Dagenham will show improvement in the quality of treatment for key cancer, COPD, diabetes, mental health and patient satisfaction indicators (including four patient access indicators), as measured by progress against baseline in the primary care transformation dashboard (Appendix C).

Issues around patient access will be addressed by providing seven-day primary care, with integrated IT allowing appropriate sharing of their records between services so that they receive high quality care no matter where they are. Joined-up services and shared records will enhance patients’ confidence in primary care, reduce their reliance on their GP where other professionals could help them, and reduce their frustrations around having to repeat their story to different professionals.

Localities will, for some specialties, enable a significant reduction in waiting times for elective care by putting in place alternative pathways and community-based provision.

The locality model will also allow patients that would previously have been treated in secondary care to be treated closer to home, for example by bringing consultants out of hospitals and into community clinics hosted in hubs.

Localities will actively engage with the population they serve, with the priorities and preferences of patients feeding into the locality vision and patients involved in the co-design of services with professionals.

6 The transformation needed in primary care

6.1 What is the transformation needed in primary care?

Within the next five years, care for Barking and Dagenham residents will move from reactive to proactive, with a focus on prevention, support for self-care, active management of long-term conditions and the avoidance of unnecessary hospital admissions. Patients will have a more joined-up care experience, be enabled to take more control of their care, and more of their treatment will be closer to home.

The figure below summaries the primary care transformation journey through to 2021.
The journey will involve achievement of the following objectives:

a) Improvement progressively of the quality of care provided by general practice through the use of data and proven quality improvement methods
b) Improved productivity and financial sustainability of GP practices through better management of workload and use of IT, freeing up GP time for patient care
c) The introduction/extension of collaborative working between GP practices on care delivery, quality improvement and administration on the basis of a clear operating model, designed with the benefit of learning from elsewhere
d) Transformation by locality teams of how care is provided and organised in each locality to deliver standards and use services established by other programmes for planned care, mental health, urgent and emergency care (CCGs) and prevention (boroughs and CCGs),

e) Formation of extended locality teams effective at designing local pathways, how work is shared and where care is delivered from, to best meet the needs of their population
f) Establishment of the resources and business intelligence needed for localities to monitor delivery, learn from experience and continuously improve their care quality and cost-effectiveness
g) Transparency and the ability to optimise use at locality team level of collective human (staff, skills) and physical capacity (buildings, equipment, IT systems)
h) Further evolution of the organisation form of locality working, reflecting national policy and learning from working as a virtual team.

6.2 What will be the outcomes of the transformation?
Operating effectively, locality teams delivering the majority of care, working within the BHR standards framework, should achieve a range of outcomes:

• Reduction in unnecessary duplicate assessments and diagnostic tests
• Enhanced outcomes at individual patient and locality population levels
• Better targeting of local resource to locality health needs
• Increased support for individuals’ self-management
• Enhanced life expectancy
• Better access to the right urgent care services
• Reduced unplanned A&E attendances and emergency admissions
• Reduced referral to treatment times for elective care
• Reduced re-admissions to hospital.

In addition, there are outcomes specifically related to general practice:

• Enhanced patient satisfaction with the general practice service
• Continued high levels of access to GP practice services
• Improved care quality outcomes directly associated with GP services, consistently across all practices
• Proportional increase in GPs’ patient-facing time
• Improved productivity and financial sustainability of GP practices
• Improved morale, teamworking and patient focus amongst locality-based staff
• Quality and financial benefits realised from investment in digital, IT and business intelligence solutions

These will all contribute to improved outcomes for patients, which will be monitored via the primary care transformation dashboard (see Appendix C).
6.3 How will implementation of the transformation agenda be organised?
The transformation agenda is multi-dimensional and, as shown in the table below, will be led from locality teams with support from a primary care transformation programme (PCTP) and adjacent planned care, mental health and urgent and emergency care transformation programmes, all at BHR system level.

<table>
<thead>
<tr>
<th>Transformation theme</th>
<th>Vehicle</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enabling general practice to improve care quality systematically and reduce variation in practice</td>
<td>PCTP</td>
</tr>
<tr>
<td>Improving the productivity and financial sustainability of GP practices through better management of workload and use of IT, freeing up GP time for patient care</td>
<td>PCTP</td>
</tr>
<tr>
<td>Introducing/extending collaborative working between GP practices on care delivery and administration on the basis of a clear operating model</td>
<td>PCTP</td>
</tr>
<tr>
<td>Developing BHR system strategies for planned care, mental health, urgent and emergency care and prevention, which define common standards and services for the BHR population</td>
<td>Adjacent BHR transformation programmes</td>
</tr>
<tr>
<td>Enabling localities to transform further how care is provided and organised in each locality, combining professionals in general practice with those in other primary and community-based health and social care providers into an extended team which provide a joined-up service for the majority of patients’ care, with GPs overseeing care for their patients</td>
<td>PCTP</td>
</tr>
<tr>
<td>Extending access to urgent care services</td>
<td>Urgent and emergency care programme</td>
</tr>
<tr>
<td>Locality teams working within this framework to decide local pathways, how capacity can be strengthened, work can be shared and where care can be delivered from, to best meet the needs of their population</td>
<td>Localities, with BHR adjacent programme input and PCTP organisational development support for first cycle</td>
</tr>
<tr>
<td>Locality teams having the governance, resources and business intelligence to monitor delivery, learn from experience and continuously improve their care quality and cost-effectiveness</td>
<td>PCTP</td>
</tr>
<tr>
<td>Developing a sustainable workforce for general practice and locality working</td>
<td>BHR System/CEPN/ Care City</td>
</tr>
<tr>
<td>Aligning contractual and funding arrangements with the achievement of population outcomes.</td>
<td>Place based care</td>
</tr>
</tbody>
</table>

The provider development objectives of the primary care transformation programme will be delivered as a side-benefit to the delivery work that practices and localities will undertake in conjunction with the parallel BHR transformation programmes. This approach will mean that organisational solutions will be tested more rapidly and more effective over time.

The PCTP will be directed by the Barking and Dagenham Clinical Director responsible for primary care and the BHR Director of Primary Care Transformation, and governed by the primary care transformation programme board which:
• Provides system wide leadership and accountability for the transformation of primary care in BHR
• Recommends the priorities for primary care strategy to the governing bodies of BHR CCGs and the respective health and wellbeing boards
• Oversees implementation of the strategic commissioning framework for primary care transformation in London.

A programme management office (PMO) will operate at BHR system level to ensure the four BHR transformation Programmes are co-ordinated and aligned so that localities are enabled to deliver the outcomes set out above.

6.4 Transformation Plan
The programme will be delivered in three phases:

<table>
<thead>
<tr>
<th>Phase 1</th>
<th>Establish effective localities, founded on productive general practice, to provide the majority of patient care</th>
<th>April 2016 to September 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase 2</td>
<td>Localities deliver care to meet local needs, and line with BHR standards, and continue to evolve through learning and trial new contractual and funding arrangements</td>
<td>April 2017 to April 2021</td>
</tr>
<tr>
<td>Phase 3</td>
<td>General practice and locality provider configuration, evolves where appropriate from virtual team to alternative provider form</td>
<td>April 2019 to April 2021</td>
</tr>
</tbody>
</table>

Phase one
Phase one (April 2016 to September 2017) will focus on establishing effective localities, where the majority of patient care will be provided, based around productive GP practices and effective collaboration between locality practices. The objective for this phase is that locality teams should be working at full capacity and across the full scope of primary, community and social care by September 2018, in time for the 2019 contracting round.

While the scope of the Primary Care Transformation Programme is organisation development, it is anticipated that in 2016/7 locality teams will work from a delivery perspective on:

• Reducing elective hospital referrals for three specialties through the development of pathways for locality-based care, in conjunction with the Planned Care Programme
• Improving the quality of general practice care for patients with long term conditions.

It is anticipated that the delivery focus for 2017/8 will broaden to include urgent care, mental health services, prevention and early intervention, as the figure below illustrates.
This delivery work will be used as a source of action learning and provide participants with a clear rationale for the development of localities and the associated development of working relationships and change in working practices.

A pilot locality will be selected in each borough and design and implementation of pathways and changes will be completed and initial lessons learnt before the remaining localities are established and services changes rolled out across BHR.

More detail on workstreams and plans will be provided in the PCTP Strategy and Delivery Plan.

7 Risks and assumptions

Risks

- Insufficient grass roots buy-in from GPs and other primary care professionals
- Insufficient capacity within general practice to participate
- Dependencies on other projects – IT, workforce, estates
- The pace of change demanded vs the time necessary to develop localities sustainably
- Compatibility of the strategy with main providers’ strategies
- Insufficient investment in the resources to enable the programme to succeed.

Assumptions

- Improving team working in localities will release significant quality and productivity benefits
- GP practices are receptive to opportunities to improve their practices
- This strategy will have top-level support
- Interoperable IT agenda sufficiently advanced to enable localities to provide continuity of care to patients.
## Delivery of specifications

### P1 Co-Design

<table>
<thead>
<tr>
<th>Year</th>
<th>Activity</th>
<th>Target Date</th>
<th>Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>Development of the new intermediate care model (ICM, CTT, IRS)</td>
<td>Q4 Jan 2017</td>
<td>✔</td>
</tr>
<tr>
<td>2017</td>
<td>Focus group to review central call centre initiative across the federations</td>
<td>Q4 Jan 2018</td>
<td>✔</td>
</tr>
<tr>
<td>2018</td>
<td>CCG to review service planning and tracking needs</td>
<td>Q3 Oct 2018</td>
<td>✔</td>
</tr>
<tr>
<td>2019</td>
<td>Map health services for over 75s to review the pathway algorithm</td>
<td>Q3 Oct 2019</td>
<td>✔</td>
</tr>
</tbody>
</table>

### P2 Developing assets and resources for improving health and wellbeing

<table>
<thead>
<tr>
<th>Year</th>
<th>Activity</th>
<th>Target Date</th>
<th>Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>MiDoS developed to include local asset database</td>
<td>Q4 Jan 2017</td>
<td>✔</td>
</tr>
<tr>
<td>2017</td>
<td>Work with the local council, community and voluntary services to input into MiDoS</td>
<td>Q3 Oct 2018</td>
<td>✔</td>
</tr>
<tr>
<td>2018</td>
<td>MiDoS used by ICM to locate support and care services close to peoples' homes</td>
<td>Q3 Oct 2019</td>
<td>✔</td>
</tr>
</tbody>
</table>

### P3 Personal conversations focused on an individual's health goals

<table>
<thead>
<tr>
<th>Year</th>
<th>Activity</th>
<th>Target Date</th>
<th>Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>Risk stratification in place to support targeting the top 1-3% for conversations</td>
<td>Q4 Jan 2017</td>
<td>✔</td>
</tr>
<tr>
<td>2017</td>
<td>Integrated case management (ICM) in place to manage the top 1%</td>
<td>Q3 Oct 2018</td>
<td>✔</td>
</tr>
<tr>
<td>2018</td>
<td>Care coordination and Frailty training being commissioned as part of the Locality Training Fund for 2014/15</td>
<td>Q3 Oct 2019</td>
<td>✔</td>
</tr>
<tr>
<td>2019</td>
<td>Review whether to roll out intervention pharmacists pilot as a CEPN scheme</td>
<td>Q3 Oct 2020</td>
<td>✔</td>
</tr>
</tbody>
</table>

### P4 Health and wellbeing liaison and information

<table>
<thead>
<tr>
<th>Year</th>
<th>Activity</th>
<th>Target Date</th>
<th>Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>MiDoS developed to include local asset database</td>
<td>Q4 Jan 2017</td>
<td>✔</td>
</tr>
<tr>
<td>2017</td>
<td>Clinicians use MiDoS</td>
<td>Q3 Oct 2018</td>
<td>✔</td>
</tr>
<tr>
<td>2018</td>
<td>Patients are able to use MiDoS</td>
<td>Q3 Oct 2019</td>
<td>✔</td>
</tr>
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</table>

### P5 Patients not currently accessing primary care services

<table>
<thead>
<tr>
<th>Year</th>
<th>Activity</th>
<th>Target Date</th>
<th>Achieved</th>
</tr>
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<tbody>
<tr>
<td>2016</td>
<td>Homeless patients encouraged to register at a practice</td>
<td>Q4 Jan 2017</td>
<td>✔</td>
</tr>
<tr>
<td>2017</td>
<td>Patients are able to use MiDoS</td>
<td>Q3 Oct 2018</td>
<td>✔</td>
</tr>
<tr>
<td>2018</td>
<td>Patients not currently accessing primary care services</td>
<td>Q3 Oct 2019</td>
<td>✔</td>
</tr>
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</table>

## How does the vision for locality-based primary care enable and accelerate cost-effective compliance with the standard?

- Patients and voluntary sector organisations will be a part of the locality team and will help co-design services within localities.
- Locally teams will include colleagues from the Local Authority, voluntary and community, health and third sector organisations and will work together to ensure best use of community resources (including social capital) to improve population health and wellbeing.
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- Locally teams will include colleagues from the Local Authority, voluntary and community, health and third sector organisations and will work together to ensure best use of community resources (including social capital) to improve population health and wellbeing.

## Clinical Commissioning Group

- Patients will collaborate to design ways to reach people who do not routinely access primary care, including a planned locality approach to working with the unregistered population.
- Patients will collaborate to design ways to reach people who do not routinely access primary care, including a planned locality approach to working with the unregistered population.
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### Transforming Primary Care

#### Live SPG delivery plan

**Clinical Commissioning Group**

<table>
<thead>
<tr>
<th>Year</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
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<tr>
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#### Delivery of specifications

**C1** Case finding and review

<table>
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<th>Q2</th>
<th>Q3</th>
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**C2** Case planning

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**C3** Care coordination

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<th>Q3</th>
<th>Q4</th>
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**C4** Patients supported to manage their health and wellbeing

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<th>Q3</th>
<th>Q4</th>
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<tr>
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**C5** Multi-disciplinary working

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<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
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<tr>
<td>2020</td>
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</table>

### activities Subject to SPG Confirmation

- 2017 activity date
- 2018 delivery date
- 2019 coverage

#### Key dates for localised primary care enable and accelerate cost-effective compliance with the standard

- 2017 activity date subject to SPG confirmation
- 2018 delivery date
- 2019 coverage

**Anticipated SPG confirmed**

- Q1 April 2015
- Q2 July 2015
- Q3 October 2015
- Q4 January 2016
- Q1 April 2016
- Q2 July 2016
- Q3 October 2016
- Q4 January 2017
- Q1 April 2017
- Q2 July 2017
- Q3 October 2017
- Q4 January 2018
- Q1 April 2018
- Q2 July 2018
- Q3 October 2018
- Q4 January 2019
- Q1 April 2019
- Q2 July 2019
- Q3 October 2019
- Q4 January 2020
- Q1 April 2020
- Q2 July 2020
- Q3 October 2020
- Q4 January 2021
Appendix B: Current localities*

*Current configuration is currently under review; it is proposed that place-based care be established after a joint review of the configuration of existing boundaries/localities – and will be agreed through a consensus approach between health and social care partners.

Barking & Dagenham GP Practices

### Locality 1
- **Cluster One**
  - Dr Kashyap & Mehta – Markgate Medical Practice
  - Dr Teotia – Green Lane Surgery
  - Dr Haider & Dr Finnigan – Valence Medical Centre
  - Dr Garcia – Highgrove Surgery
  - Dr Afser Surgery
  - Dr Gopiparthi – Tulasi Medical Centre
  - SLL: Monga Mafu
  - PIL: Stasha Jan
- **Cluster Two**
  - Dr A Moghal – Becontree Medical Centre
  - Dr Sharma & KaRa – Laburnum Health Centre
  - Dr Ola Surgery
  - Dr Bila – Heathway/Broad Street Practice
  - Dr Ehsan – Oval road Practice
  - Dr D Shah – Parkview Medical Centre
  - Dr Goyal/Dr Duodu – Church Elm Lane Medical Practice
  - SLL: Monga Mafu
  - PIL: Stasha Jan
- **Cluster Three**
  - Dr Abaniwo - Five Elms Medical Practice
  - Dr Mittal - Markgate Surgery
  - Dr Dallas - The Gables Surgery
  - Dr Jaiswal - Julia Engwell Health Centre
  - Dr Gopiparthi – Venkat Health Centre
  - SLL: Richard Clements
  - PIL: Kam Sahota
- **Cluster Four**
  - Dr Chandra - Broad Street Medical Centre
  - Dr Fateh – First Avenue Surgery
  - Dr Ahmed & Dr Monteiro – Hedgemans Surgery
  - Dr Alkaisy & Dr Islam – Urswick Centre
  - Dr Mohan – Urswick Medical Centre
  - Dr Adedjji Practice – Halbutt Street Surgery
  - SLL: Richard Clements
  - PIL: Kam Sahota
- **Cluster Five**
  - Dr K John - King Edwards Medical Centre
  - Concordia - Porters Avenue Doctors Surgery
  - Dr Kondeel - John Smith House
  - Dr Ansari - Ripple Road Medical Practice
  - Dr Kallat - Thames View Health Centre
  - Dr Prasad - Faircross Health Centre
  - Dr Haq - Abbey Medical Centre
  - SLL: Gemma Hughes/ Sarah D’Souza
  - PIL: Mary Smith
- **Cluster Six**
  - Dr Chawla – The Surgery
  - Dr Tolia - The Barking Group Practice
  - Dr Chibber & Dr Gupta’s surgery
  - Dr Niranjani - Victoria Medical Centre
  - Concordia - Child and Family Centre
  - Dr Rashid - Shifa Medical Centre
  - Dr Sharma & Dr Rai - The White House
  - SLL: Gemma Hughes/ Sarah D’Souza
  - PIL: Mary Smith
### Appendix C: Primary care transformation dashboard indicators

<table>
<thead>
<tr>
<th>Primary Care Indicator</th>
<th>Item</th>
<th>Performance Indicator</th>
<th>Description</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diabetes</strong></td>
<td>Proactive Care</td>
<td>Diabetic retinal screening uptake</td>
<td>The proportion of those offered diabetic eye screening who attend a digital screening event</td>
<td>HSCIC</td>
</tr>
<tr>
<td><strong>Treatment</strong></td>
<td>HbA1c 5.5 mmol/mol or less</td>
<td>The percentage of patients with diabetes, on the register, in whom the last HbA1c measured (measured in the preceding 12 months) is 5.5 mmol/mol or less</td>
<td>HSCIC</td>
<td></td>
</tr>
<tr>
<td><strong>Outcome</strong></td>
<td>% of newly diagnosed referred to education programme</td>
<td>The percentage of patients newly diagnosed with diabetes, on the register, in whom the last HbA1c measured (measured in the preceding 12 months) is 5.5 mmol/mol or less</td>
<td>HSCIC</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Avoidable blindness due to diabetes</td>
<td>Rate per 1,000 population aged 44-74 years</td>
<td>HSCIC</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preventable sight loss - diabetic eye disease</td>
<td>New Certifications of Visual Impairment (CVI) due to diabetic eye disease aged 12+, rate per 100,000 population. The numerator counts for this indicator includes sight loss due to diabetic eye disease as the main cause or if it is a contributory cause. These are not counts of diabetes with visual impairments due to any cause</td>
<td>PHE</td>
<td></td>
</tr>
<tr>
<td><strong>Cardiovascular Disease</strong></td>
<td>Proactive Care</td>
<td>Smoking cessation uptake</td>
<td>Crude rate of successful four week quitters per 100,000 population aged 16+ years</td>
<td>PHE</td>
</tr>
<tr>
<td></td>
<td>CHD001: The percentage of patients with coronary heart disease whose last measured total cholesterol (measured in the preceding 12 months) is 5 mmol/l or less</td>
<td>CHD002: The percentage of patients with coronary heart disease in whom the last measured total cholesterol (measured in the preceding 12 months) is 150/90 mmHg or less</td>
<td>HSCIC</td>
<td></td>
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<tr>
<td></td>
<td>CHD002: The percentage of patients with coronary heart disease in whom the last measured total cholesterol (measured in the preceding 12 months) is 150/90 mmHg or less</td>
<td>CHD003: The percentage of patients with coronary heart disease who have not been treated with anti-coagulation therapy, NICE 2011 menu ID: NM24</td>
<td>HSCIC</td>
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<tr>
<td></td>
<td>No. of hospital admissions due to COPD rate per 100 patients on the disease register</td>
<td>Emergency admissions due to COPD rate per 100 patients on the disease register</td>
<td>HSCIC</td>
<td></td>
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<tr>
<td><strong>COPD</strong></td>
<td>Proactive Care</td>
<td>Asthma self management plan</td>
<td>Percentage of patients with COPD who have had a review, undertaken by a healthcare professional, including an assessment of breathlessness using the Medical Research Council dyspnoea scale in the preceding 12 months</td>
<td>Health-Analytics</td>
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<tr>
<td></td>
<td>COPD severity</td>
<td>Percentage of patients with COPD whose last measured forced expiratory volume in one second (FEV1) is less than 30% predicted for this indicator includes COPD patients with severe or very severe COPD</td>
<td>PHE</td>
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<tr>
<td><strong>Outcome</strong></td>
<td>Emergency Admissions due to COPD</td>
<td>Rate per 100 patients on the disease register</td>
<td>HSCIC</td>
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<tr>
<td></td>
<td>% of newly diagnosed referred to education</td>
<td>The percentage of patients newly diagnosed with diabetes, on the register, in whom the last HbA1c measured (measured in the preceding 12 months) is 5 mmol/l or less</td>
<td>HSCIC</td>
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<tr>
<td><strong>Cancer</strong></td>
<td>Proactive Care</td>
<td>NHS Health Check uptake</td>
<td>Cumulative % of uptake amongst eligible population</td>
<td>PHE</td>
</tr>
<tr>
<td><strong>Outcome</strong></td>
<td>% of newly diagnosed referred to education</td>
<td>The percentage of patients newly diagnosed with diabetes, on the register, in whom the last HbA1c measured (measured in the preceding 12 months) is 5 mmol/l or less</td>
<td>HSCIC</td>
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<tr>
<td><strong>Cardiovascular Disease</strong></td>
<td>Proactive Care</td>
<td>Heart Disease and Stroke</td>
<td>Prevalence mortality: rate per 100,000</td>
<td>Healthier Lives, Mortality Rankings, PHE</td>
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<tr>
<td></td>
<td>Cardiac screening uptake</td>
<td>Cardiovascular disease mortality rate: rate per 100,000</td>
<td>Health Analytics Toolkit</td>
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<td>% of newly diagnosed referred to education</td>
<td>Emergency admissions due to COPD rate per 100 patients on the disease register</td>
<td>PHE</td>
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<tr>
<td><strong>Outcome</strong></td>
<td>Emergency Admissions due to COPD</td>
<td>Emergency admissions due to COPD rate per 100 patients on the disease register</td>
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<td>Bronchial asthma mortality rate</td>
<td>Emergency admissions due to COPD rate per 100 patients on the disease register</td>
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41
<table>
<thead>
<tr>
<th>Primary care Indicator</th>
<th>Item</th>
<th>Performance Indicator</th>
<th>Description</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proactive Care</td>
<td>New diagnosis of depression who have a review</td>
<td>DEP002: The percentage of patients aged 20 or over with a new diagnosis of depression in the preceding 4 April to 31 March, who have been assessed not earlier than 20 days after and not later than 50 days after the date of diagnosis, NICE 2013 menu ID: NM50</td>
<td>HSCIC</td>
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<tr>
<td>Dementia diagnosis rate</td>
<td>The Diagnosis rate indicates the proportion of patients with dementia on a practice list or in a group who have a diagnosis of dementia. The total number from the aPRD, and the number with a diagnosis on the QOF dementia register</td>
<td>HSCIC</td>
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<tr>
<td>Early interventions, psychosis</td>
<td>New cases of psychosis served by Early interventions team, annual rate per 100,000 population</td>
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<td>Mental health</td>
<td>Access to terminating mental health services to people from Black and Minority Ethnic (BME) groups</td>
<td>Local rates per 100,000 population</td>
<td>HSCIC</td>
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<tr>
<td>Treatment</td>
<td>Blood pressure recorded</td>
<td>MDDA: The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 12 months, NICE 2010 menu ID: NM17</td>
<td>NELFT</td>
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<td>Referrals to Psychological Therapies (HIPF)</td>
<td>The number of people who have been referred to HIPF for psychological therapies during reporting period</td>
<td>NELFT</td>
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<td></td>
<td>Referrals to Psychological Therapies (HIPF) Recovery</td>
<td>The number of people who have completed treatment and are moving to recovery</td>
<td>NELFT</td>
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<tr>
<td></td>
<td>Blood Glucose or HbA1c recorded</td>
<td>MDDA: The percentage of patients aged 40 or over with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose or HbA1c in the preceding 12 months, NICE 2011 menu ID: NM42</td>
<td>HSCIC</td>
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<tr>
<td>Outcome</td>
<td>Unplanned readmissions to mental health services within 30 days of a mental health inpatient discharge in people aged 17 and over</td>
<td>Indirectly age and sex standardised ratio of unplanned readmissions to a mental health service</td>
<td>HSCIC</td>
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<td>Learning Disabilities</td>
<td>LD Health Check uptake</td>
<td>Proportion of QOF recorded on population with learning disabilities who have had a health check in last 12 months</td>
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<td>GP Survey</td>
<td>ED 1</td>
<td>Rating of GP making time for you</td>
<td>GRPS</td>
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<td>ED 2</td>
<td>Overall experience of GP surgery</td>
<td>GRPS</td>
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<td>ED 3</td>
<td>Overall experience of making an appointment</td>
<td>GRPS</td>
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Appendix D: Workforce development in primary care

Solutions offered include using a greater skill mix of practitioners in primary care, offering a seamless integrated service with clear opportunities for career development for all members of the primary health care team.

Specific ideas for different members of the primary health care team are summarised below.

### GPs

| Attract young GPs | Fourth year fellowships in Barking and Dagenham for GP trainees. Provide “home” (perhaps a BHR-wide employment agency) with identity, peers and support for ongoing learning, personal and professional development, parental leave, study leave, management opportunities to lead small projects and research opportunities, whether a partner, salaried or long-term locum. Plurality of provider models to include independent contractors, federations, chambers, super practices, and increased salaried working, to achieve economies of scale in management, infrastructure, and clinical resources, and to provide wider ranges of patient services. Become exemplars of multi-professional working. |
| Attract returning GPs | By marketing package for returning GPs: ongoing support for personal and professional development, family friendly approach, parental leave and carers leave offer, easy to access Ofsted reports, Rightmove and Zoopla. Clarity on career path and ongoing development. |
| Attract international GPs | From Eastern Europe (via the IMG scheme) GP profile to match changing population profile. Offer IMGs a registrar-level salary while training (as they do in East Midlands) to enable senior experienced GPs to afford to come to London. |
| Promote sustainable model of General Practice | To promote fulfilling, rewarding and sustainable career. Become known as the place in London for excellent integrated care with primary, community and social care building on innovation of the Vanguard. Time to see patients and deal with issues properly. Interesting variety of patients. Integrated locality model of working with joint learning and co-development of services with other providers and patients. Identify, prioritise, implement and evaluate local models of QI initiatives. Social prescribing. Pharmacist prescribing. Support older GPs with retirement planning. |
| Market Barking and Dagenham as a place to live and work | Effective HASS in Barking and Dagenham with S75 agreements in place between LA and community provider. Affordable housing (for London). Good schools. Range of career development pathways identified. |
| Opportunities in Barking and Dagenham as a GP | To develop as clinical leader - locality lead, clinical lead, committee chair, CCG board member. To develop as educator and trainer. To develop as a researcher (with Care City, BHRUT, UCL Partners). |
| Ongoing learning and development | Protected time for learning with peers both in general practice and with rest of the primary health care team. Training in coaching for health. Training in solution focused conversations. Continue to develop skills e.g. joint injections, update on dermatology. |
| Use workforce modelling data | Available from April 2016 from NHS England (London) to identify existing workforce. Match to current and future models of care, identify gaps and plan to address. |
Identify areas to prioritise and work on collaboratively

Form localities/communities of practice
All GPs part of geographical network (including salaried and long-term locums)
Find ways to innovate/incentivise joint working e.g.
- top slice secondary care services and provide network enhanced services
- One HV for network of GP practices
- Share services across network of practices e.g. phlebotomy, direct access physio, counsellor
- Develop care pathways across the locality
- Share back office functions e.g. one book keeper, IT support, HR support
- Autonomy to use delegated budget at locality level to meet the needs of the local population

### Pharmacists

<table>
<thead>
<tr>
<th>Upskill community pharmacists</th>
<th>In behaviour change</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Train as health coaches</td>
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<tr>
<td>Develop role of practice pharmacists</td>
<td>Medicines reconciliation</td>
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<td>Medication review</td>
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<td>Prescription management</td>
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<td>Prescription safety/concordance</td>
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<td>Acute common conditions</td>
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<td>Chronic disease management</td>
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<td>Practice performance</td>
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<td>Primary care practice research</td>
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<tr>
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<td>Training in coaching for health</td>
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<td>Training in common clinical conditions</td>
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<td>Independent prescriber</td>
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</table>

<table>
<thead>
<tr>
<th>Upskill to become independent prescribers</th>
<th>For urgent prescriptions as well as LTCs</th>
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<tbody>
<tr>
<td></td>
<td>Career path to develop expertise in diabetes, asthma etc</td>
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<table>
<thead>
<tr>
<th>Recruit clinical pharmacists</th>
<th>Have “off the shelf” Barking and Dagenham offer, ready to advertise for new clinical pharmacists (London-wide initiative)</th>
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<table>
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<tr>
<th>Recruit local pharmacists</th>
<th>Through local pharmacy apprentice scheme</th>
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<tr>
<th>Ongoing joint learning</th>
<th>With GPs and other members of the primary health care team</th>
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<tbody>
<tr>
<td>Career paths identified</td>
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<tr>
<th>Family friendly</th>
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<tr>
<th>Introduce Pharmacy First scheme</th>
<th>Free OTC medicines for patients on benefits</th>
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### Nurses

| Attract young nurses | Multi-agency training: acute, primary and community  
| Key worker housing |
| Retain nurses | Career development pathways identified  
| Ability to work in primary care and community care  
| Supported by AHPs  
| Part of a learning community of practice  
| Key worker housing |
| Recruit international nurses |  |
| Train nurse prescribers | To work with patients with LTC |
| Train nurse practitioners | To work with patients with LTC  
| Career path e.g. community matron, specialist practice nurse |

### Allied Health Professionals

| Recruit physician’s assistants | London-wide scheme to train physicians assistants  
| Have a Barking and Dagenham offer “on the shelf” ready to advertise when PAs graduate  
| See patients for same-day appointments  
| Review test results  
| Booked appointments with patients with LTC  
| Home visits  
| Cryo therapy  
| Teaching  
| Clinical audit  
| Maintaining practice registers  
| Supervision of HCAs  
| Make Barking and Dagenham primary care an attractive place to work by offering apprenticeships (PAs have to find £9,000 tuition fees and loans and grants are not available)  
| NB PAs cannot gain prescribing rights as do not have registration. This is being addressed nationally. |
| Train generic staff to work across health and social care | Care City to provide mechanism to train generic health and social care workers to work across health and social care.  
| Care City to host peer networks, provide mentorship and facilitate apprenticeships  
| CEPN are developing care navigators |
| Family friendly | To recruit and retain |
| Life long learning | Framework for ongoing personal and professional development  
<p>| Career paths identified |</p>
<table>
<thead>
<tr>
<th>Admin and Clerical</th>
<th>Practice Managers Board</th>
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<tbody>
<tr>
<td></td>
<td>Could be developed to</td>
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<tr>
<td></td>
<td>• help PMs share work between them (QOF, call-recall)</td>
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<tr>
<td></td>
<td>• develop areas of personal expertise/sub specialisation</td>
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<tr>
<td></td>
<td>• develop career path</td>
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<tr>
<td>Receptionists</td>
<td>Develop reception staff skills in signposting</td>
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<td></td>
<td>Career path as care navigators</td>
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<tr>
<td>Family friendly</td>
<td></td>
</tr>
<tr>
<td>Life long learning</td>
<td>Opportunities to continue to learn and develop</td>
</tr>
<tr>
<td></td>
<td>Career paths mapped out and supported</td>
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To: Meeting of the NHS Barking and Dagenham CCG Governing Body

From: Jacqui Himbury, Nurse Director

Date: 24 May 2016

Subject: Transforming Care Programme

Executive summary
This paper provides the governing body with confirmation that the Barking & Dagenham, Havering and Redbridge health and care economy Transforming Care Partnership (TCP) have now finalised our joint plan in response to “Building the Right Support – Transforming Services for People with Learning Disabilities and/or Autism”.

The paper is seeking formal agreement of the plan by the governing body, confirms the immediate next steps for implementation during 2016/17 and provides members with an update on progress over the past two months.

Recommendations
The governing body is asked to:
- Note the progress made since the last update in March 2016
- Agree the plan and formally sign it off ahead of publication on the CCG website on 1 July 2016
- Agree to the next steps set out in section 4 of the report

1.0 Purpose of the Report
1.1 This report builds on previous updates that the governing body has received informing members of the requirement to establish a TCP and to develop a local plan that will deliver the requirements to transform services for people with learning disabilities and/or autism and behaviour that challenges as set out in the national plan “Building the Right Support”. This paper is seeking formal approval of the jointly developed plan.

2.0 Background/Introduction
2.1 We formally established our partnership board in December 2015 and since that time we have worked to collaboratively develop and finalise our three year plan to develop community services and close inpatient facilities. The partnership consists of the three CCGs, the London Boroughs of Barking & Dagenham, Havering and Redbridge, Specialist Commissioning NHS England, NELFT and people with learning disabilities/their carers.

2.2 The final plan was submitted to NHS England (NHSE) on 11 April 2016. Following submission the plan was formally reviewed by a panel of health and social care experts and people with a lived experience of using learning disability services.
3.0 Developing the BHR plan

3.1 The BHR TCP plan 2016/17 to 2019/20 details how we will work collaboratively to transform the services for people with learning disabilities and/or autism and behaviour that challenges including those with a mental health condition.

3.2 NHSE have confirmed that as a partnership with have made significant progress since our original draft submission and that we have responded to all of the initial areas that required further development. However, they have requested further detail on our implementation arrangements before they will fully assure our plan, although the plan itself has been assured and can progress to governing body sign off.

3.3 For 2016/17 the main focus of our plan is to ensure that all our patients who are currently in inpatient facilities are discharged on their agreed discharge date, that a standard risk stratification process is developed and implemented within the three community learning disability teams that very clearly identifies people at risk of an inpatient admission and that we have a standard community treatment review (CTR) process that prevents avoidable admissions and ensures all actions in care and treatment plans progress in a timely way.

4.0 Next Steps

4.1 The TCP will become a programme within the Mental Health Transformation Programme on 23 May 2016 and the senior responsible officer will change from the Nurse Director to the B&D CCG Chief Operating Officer.

4.2 The Nurse Director will continue to support delivery of the plan and will retain responsibility for managing the CTR and discharge processes.

4.3 We will continue to meet our NHSE Winterbourne View fortnightly reporting requirements and this will move from a borough team responsibility to a central responsibility to ensure consistency of reporting, reducing local variability.

4.4 A project manager will be appointed by 31 May 2016 to ensure the required actions to deliver the plan are implemented.

4.5 The work streams detailed in the project plan on page 52 of the document will be formally established with identified leads by 1 June 2016.

4.6 Our plan will be professionally designed and an easy read version developed and then published on our website on 1 July 2016.

5.0 Resources/investment

5.1 There are no resource investment implications arising from this report.

6.0 Equalities

6.1 There are no equalities implications arising from this report.

7.0 Risk

7.1 There is a separate risk log that outlines the risks and mitigating actions in relation to the programme plan.

8.0 Managing conflicts of interest

8.1 There are not any conflict of interest implications for this report.
Attachments:
1. Transforming care programme partnership plan 2016/17 to 2019/20

Author: Jacqui Himbury, Nurse Director
Date: 6 May 2016
Barking & Dagenham, Havering and Redbridge
Transforming Care Partnership Plan 2016/17 to 2019/20

Executive Summary

This three year plan sets out our vision and confirms the commitment of the Barking and Dagenham, Havering and Redbridge (BHR) Transforming Care Partnership (TCP) for improving the care and support available for children, young people and adults with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition. This plan addresses the needs amongst the diversity and complexity of the population for people with:

- A learning disability and/or autism who have a mental health condition such as severe anxiety, depression. Or a psychotic illness, and those with personality disorders, which may result in them displaying behaviour that challenges.
- An (often severe) learning disability and/or autism who display self-injurious or aggressive behaviour, not related to sever mental ill health, some of whom will have a specific neuro-developmental syndrome and where there may be an increased likelihood of developing behaviour that challenges.
- A learning disability and/or autism who display risky behaviours which may put themselves or others at risk and which could lead to contact with the criminal justice system.
- A learning disability and/or autism, often with lower level support need and who may not traditionally be known to health and social care services, from disadvantaged backgrounds, who display behaviour that challenges, including behaviours which may lead to contact with the criminal justice system.
- Adults with a learning disability and/or autism who have a mental health condition or display behaviour that challenges who have been in hospital settings for a very long period of time, having not been discharged when NHS campuses or long-stay hospitals were closed.

This plan, which we acknowledge is iterative, describes:

- Our TCP governance and programme arrangements for how we intend to deliver on our commitment
- The demographics of the outer north east London area covered by BHR
- The services that are currently commissioned and provided for people with a learning disability and/or autism
- Our ambition and shared vision to improve the quality of care and services over the next three years by implementing the national service model
- Our engagement plan and our high level plans describing how we intend to deliver our ambitious vision.

This plan, which builds on and further develops the good work already in place in each individual borough, has been developed through collaboration across our partnership and through

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1 Hereafter people with a learning disability and/or autism
engagement with people who have a lived experience of using the services, community and inpatient clinicians, social care staff, housing departments, health and social care commissioners and primary care providers.

Across BHR we have already made excellent progress in moving away from inpatient care and developing supportive community provision, however we will not stand still as we recognise there is much more to do. The work to be taken forward through this programme will be wide-ranging. Over the coming months we will continue to co-design and co-produce in partnership with people with a learning disability and/or autism, the BHR Learning Disability Partnership Boards, local third sector organisations, national organisations in the health and care system (such as Health Education England) and all members of the partnership.

Introduction and Context

The national vision described in Building the Right Support is that children, young people and adults with a learning disability and/or autism, have the right to the same opportunities as anyone else to live satisfying and valued lives, and to be treated with the same dignity and respect. They should have a home within the community, be able to develop and maintain relationships and get the support they need to live a healthy, safe and fulfilling life.

Locally across BHR our vision is consistent with the national service model and is that (subject to further stakeholder engagement to confirm exact wording):

“People with a learning disability and/or autism, with complex and challenging behaviour including those with a mental health condition, can lead fulfilling and rewarding lives while being part of a community that is able to support them with dignity and respect, ensuring their individual wellbeing is at the heart of decision-making”

We will achieve our vision by designing and implementing care and support services that:

- Provide support and interventions in the least restrictive manner and for the shortest time possible
- Provide respite for families and carers that enables at home placements to be maintained with positive family relationships
- Ensure that people who need inpatient care do not have to travel long distances to access it, unless this is necessary due to clinical need
- Strengthen multi-disciplinary and multi-agency working to reduce health inequalities
- Make the best possible use of community provision across the three boroughs
- Ensure that people have choice and control over their own health and care services
- Ensure that early identification and early support is commissioned and provided
- Enable people with learning disabilities and/or autism and their family and carers to have access to the right level of information, advice and advocacy.
Through this transformation programme we will put in place:

- A shared value base which places individuals and their quality of life at the heart of all we do
- Care and support that is delivered with the aim of improving quality of life for people with a learning disability and/or autism and their family/carers
- A service model across our entire geographical area that delivers the nine principles of the national service model (see below).

As a group of organisations, we recognise the scale of change required, and we are committed to working together to ensure that we succeed in transforming care for people with learning disabilities and/or autism. To enable that, we have established a strong partnership board and programme governance structure, with defined workstreams. As organisations we have different legal structures and accountabilities. However we have agreed to develop collaborative solutions bringing together resources, capabilities and expertise. A Business Case to form an Accountable Care Organisation (ACO), and based on collaborative and integrated working across the BHR health and care economy, is being developed for submission in June/July 2016. If the bid is successful we will move to implementation phase quickly - if we are unsuccessful we will develop a model based on the ACO for implementation over the next 3 years. In the meantime the TCP Plan will form the basis for closer working across the Partnership.

We intend to progress the transformation of services for people with a learning disability and/or autism through our Integrated Care Coalition (ICC). This was formally established in 2012 to bring together the lead organisations in our health and social care economy to support the commissioning of integrated care. As a result there is a strong history of successful collaborative working across BHR, with an emerging track record of true partnership, leading to real improvements for our local populations. The ICC is a leadership group which makes recommendations to and works closely with the local health and wellbeing boards in developing our longer term strategic plan and driving improvements at pace across the BHR system. The ICC’s purpose is to improve outcomes for local people through best value health and social care in partnership within the community. Through the ICC all commissioners have mature and strong relationships with the main providers across the geographical area – notably Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT) and North East London Foundation Trust (NELFT) – and these well-developed relationships mean that we are confident we can deliver on our commitment in this plan.

This plan is developed to cover the full range of commissioning and encompasses strategic, operational and individual/micro commissioning and is aligned to the development and implementation of our Local Transformation Plans for Children and Young People’s Health and Wellbeing, local plans for delivering the Mental Health Crisis Concordat and the ‘local offer’ for Personal Health Budgets (PHBs). It also incorporates our Winterbourne View Concordat plans, actions from the Francis Report Implementation plan and Learning Disability and Autism Self Assessments. When developing this plan the partnership also took into account our legal duties under the Equality Act 2010 and had regard to reducing health inequalities and our duties under the Health and Social Care Act 2012, Care Act 2014 and Children & Families Act 2014.
1. Mobilise communities

Describe the health and care economy covered by the plan

This plan covers the Transforming Care Partnership formed by the London Boroughs of Barking and Dagenham, Havering and Redbridge, the Clinical Commissioning Groups of Barking and Dagenham, Havering and Redbridge and North East London NHS Foundation Trust (NELFT). Already the three borough-level CCGs have formed a coalition and have shared executive and back office services.

There is currently no joint Local Authority commissioning across BHR, though commissioners cooperate and share information through the East London Leads Network and East London Solutions. There are a range of commissioning practices including frameworks and spot commissioning (the latter particularly for this cohort) currently in place.

We have a combination of NHS, independent and voluntary sector contracts to provide care for people with learning disabilities and their families and carers. While some providers are common across the boroughs, each of the three Local Authorities has slightly different formal governance arrangements. There are different integrated models of care across the boroughs in which Community Learning Disability Teams (CLDT) offer speech and language services, psychiatry, psychology, specialist nursing and care management. Community provision includes a range of residential, supported living, shared lives and respite.
Inpatient care for people with learning disabilities is predominantly provided by NELFT from the shared Assessment and Treatment Unit (ATU) at Goodmayes Hospital. NHS England London, specialist commissioning, commission placements both in and out of area.

The BHR CCGs commission from the independent sector some hospital placements for patients with learning disabilities who do not require a secure hospital setting (which would come under the remit of specialist commissioning); but are not able to be treated and cared for by the local NELFT ATU. The placements are not all in-borough, but some of these are local (e.g. Newham) and the most distant is less than 2 hours’ drive and most of the others 1 hour or less.

For a few such patients (currently two), the CCG makes a financial contribution to the patient’s independent sector provided care package jointly with the responsible local authority. Each CCG has a Section 75 arrangement with their respective coterminous Local Authority. Through these arrangements, the Local Authorities lead the commissioning and performance management of Community Learning Disability Teams.

In **Barking and Dagenham** a Section 75 agreement has been in place since 2015 with London Borough of Barking and Dagenham as the lead organisation and commissioner and NELFT as provider. Provider staff from the Council and NELFT are co-located at the Civic Centre. The CCG and the Local Borough of Barking and Dagenham have been working towards the development of collaborative commissioning arrangements under a Section 75 arrangement. Whilst a formal agreement has not yet been signed off, a joint commissioning manager has been appointed and progress has been made towards the development of a joint commissioning strategy. The Health and Wellbeing Board has received a consolidated action plan for the delivery of improved services for people with learning disability and autism, bringing a coherent single response to the delivery against a number of policy requirements, which has been shaped by the Learning Disability Partnership Board (LDPB). NELFT is a key partner and provides health services for people with a learning disability, funded by the CCG. The CCG also commissions Assessment and Treatment beds through a block contract arrangement at Goodmayes Hospital. In October 2015 B&D signed a new Section 75 agreement bringing greater formality to the long-standing integrated Community Learning Disability Team (CLDT), combining Local Authority and NHS services for people with learning disabilities. This comprises social work, nursing, psychiatry, psychology and therapy services, is co-located and is led by the Council. The Section 75 is governed by an Executive Steering Group that oversees operational issues relating to the performance of CLDT.

In **Redbridge** an Executive Board has monitored the delivery of the Section 75 agreement across the London borough of Redbridge, Redbridge CCG and NELFT. This expires in October 2016. NELFT is the provider, LBR is the lead organisation. LBR and NELFT staff work side-by-side in care management. The current arrangements have been developed and strengthened to build on our successful partnership working over the past ten years. LBR has a pooled budget with the CCG which funds the joint Learning Disabilities Commissioning Service. A revised broader Section 75 agreement has been developed that fully integrates health and social care staff in Redbridge; and from 1 April 2016 there will be a fully integrated health and social care partnership with many more services included in the new agreement. Care delivery will be split from a central location to four areas or hubs of excellence aligned with the CCG’s four localities. This will make care deliverable on a more local level and allow closer working with GPs and partners, and ensure the individual, their family and/or carers are at the centre of their care. It is also important to recognise that individuals using services are not aware of the boundaries drawn by the health systems. For example, a lot of patients who live in the west of
Redbridge travel to Whipp's Cross hospital which is located in Waltham Forest.

In Havering, commissioning for adults is undertaken jointly across adult social care and the CCG, with the Local Authority being the lead organisation for the delivery of services for people with learning disabilities, and the CCG leading on mental health. Frontline staff are co-located and have strong collaborative working arrangements. Havering CCG and Local Authority commission the Community Learning Disability Partnership. The current Section 75 agreement is under review. Havering Combined Learning Disability Team currently commissions from a number of providers both in and out of the borough, through a mix of block contracts and individual purchase. NELFT provide mental health services on behalf of the Local Authority and CCG and case manage a small number of this cohort of patients. The main provider of acute care is BHRUT, operating across two sites – Queens and King Georges Hospitals. The local authority also has a discrete Brokerage and Quality Assurance Team that source and quality monitor commissioned services.

The TCP will further develop joint commissioning arrangements so we are working to a common framework across the BHR partnership.

Describe governance arrangements for this transformation programme

The BHR TCP was established to provide leadership and governance on the delivery of the Transforming Care Partnership Plan, and is accountable for the delivery of the programme. The Transforming Care Programme has a Working Group and Shadow Board (an interim arrangement while the terms of reference and governance arrangements are finalised) which consists of representatives from the respective Local Authorities and Clinical Commissioning Groups (CCGs), and NHS England. At the time of submitting this plan the Transforming Care Partnership Shadow Board has met four times (as has the Working Group, and there have been two facilitated sessions).

The members of the Shadow Board are:

- BHR CCG Nurse Director (Chair)
- LBR Director of Adult Social Services, Health and Wellbeing (Deputy Chair)
- LBH Deputy Chief Executive of Children, Adults and Housing
- LBBD Deputy Chief Executive & Strategic Director for Service Development and Integration
- BHR CCGs Chief Operating Officers
- NELFT Executive Director Integrated Care (London) & Corporate Communications
- NHSE Specialist Commissioning
- BHRUT Chief Operating Officer

While there has been good representation from children’s commissioning from across the Partnership on the Working Group; we have yet to appoint a children and young people’s services representative to the TCP Board. We are currently identifying the appropriate representative.
The Transforming Care Programme has a senior responsible officer – Jacqui Himbury, Nurse Director of BHR CCGs. The deputy senior responsible officer is John Powell, Director of Adult Social Care at London Borough of Redbridge. We are seeking to appoint the Co-Chair of a Learning Disability Partnership Board, who has a mild learning disability, to become a member. In addition we are engaging with inpatient services, housing, Healthwatch, the Youth Offending Service, and community safety and safeguarding, in the respective boroughs, with a view to widening the membership. There is also intent, as the Board develops, to engage third sector organisations, the criminal justice system, Local Education and Training Boards and the Liaison and Diversion service. An Interim Programme Manager and Project Support Officer have been appointed and are supporting the delivery of the programme.

As we already have robust governance arrangements with all partners across the system for delivery of all our transformation programmes, the proposal is that the TCP Board accounts to the Integrated Care Collation (ICC). This is yet to be finalised as system wide governance arrangements across the BHR economy are being reviewed. The relationship of the TCP Board to each of the Learning Disability Partnership Boards (LDPBs) is yet to be finalised, as each has established its own governance arrangements and strategic plans for improving services. It is therefore vital that the Partnership incorporates the excellent work of the LDPBs, and that this plan reflects the local variations of need and governance arrangements. Each of the LDPBs has representation from people with learning disabilities and carers; and when developing and implementing this plan we will build on these engagement approaches that are already working well.
The following report to the Health and Wellbeing Board:

undertake an in-depth review of priority areas linked to the Havering Health & Wellbeing Strategy.

meetings and development sessions - the latter provide Board members with the opportunity to
goto the Board and an Annual Report is submitted to the Health & Wellbeing Board.

councillors, people with a learning disability and family carers. Regular reports on Transforming Care
parent-carer and a person with a learning disability, and has a membership including providers,

Redbridge has an LDPB, which is a sub group of the Health and Wellbeing Board. It is co-chaired by a
parent-carer and a person with a learning disability, and has a membership including providers,
councillors, people with a learning disability and family carers. Regular reports on Transforming Care
go to the Board and an Annual Report is submitted to the Health & Wellbeing Board.

Havering Health and Wellbeing Board meets monthly. Meetings alternate between formal business
meetings and development sessions - the latter provide Board members with the opportunity to
undertake an in-depth review of priority areas linked to the Havering Health & Wellbeing Strategy.
The following report to the Health and Wellbeing Board:

- Havering LDPB meets quarterly with membership including people with Learning Disabilities
and their carers, commissioners from the Local Authority and CCG, and providers from the
health, social care and voluntary sector. It is co-chaired by an elected service user and the
Assistant Director of Adult Social Care.
- Havering Mental Health Programme Board meets bi-monthly with membership as per the
Learning Disability Partnership Board, except the co-chairing arrangements are between the
CCG and Local Authority.
- Havering Autism Partnership Board was established in 2015 to drive improvements in access
to services, specifically for people with Autism and Aspergers Syndrome.
- Havering Joint Management and Commissioning Forum, made up of commissioners from the
CCG and Local Authority (across public health, children services and adult services) meets
monthly.
Barking and Dagenham Health & Wellbeing Board meets every 6 weeks. Its membership includes representatives from the Local Authority, CCG, NELFT, BHRUT, police, Healthwatch, with a place offered to NHS England, and the regular opportunity for attendance as an observer for both the chair of the Health & Adult Services Select Committee and the independent chair of both safeguarding boards. The Board regularly seeks assurance through subgroup reporting to ensure it is delivering the objectives of its programmes. The LDPB, a subgroup of the Health and Wellbeing Board, oversees the delivery of the Winterbourne View Concordat and the development of the commissioning and service delivery of Section 75 agreements for people with learning disabilities. It also oversees the delivery of the Autism Strategy, the Learning Disability Self-Assessment Framework (LDSAF) action plan; the Borough’s Challenging Behaviour Plan, and relevant aspects of the Carers’ Strategy. These and other pieces of work delegated to it by the Health and Wellbeing Board are monitored through a Delivery Plan. Barking and Dagenham’s Group Manager for Intensive Support has been appointed to the Shadow TCP Board to ensure CLDT representation.

**Describe stakeholder engagement arrangements**

*Guidance notes: who has been involved to date and how? Who will be involved in future and how? It is important to explain how people with lived experience of services, including their families/carers, are being engaged.*

The BHR TCP Board is clear that stakeholder engagement is about more than informing stakeholders of our plans and goals. It is about having a close dialogue with them (e.g. as we have with the chairs of the Learning Disabilities Partnership Boards), and developing with them the vision upon which this Transforming Care Plan is based. All three CCGs, Local Authorities and Learning Disability Partnership Boards within the BHR footprint have played an active role in the drafting of this plan. Stakeholder engagement in the development of the Transforming Care Partnership Plan includes:

- Presentations to Redbridge, Havering and Barking and Dagenham Learning Disabilities Partnership Boards, Autism Partnership Boards, Mental Health Partnership Boards, Health and Wellbeing Boards, and both the Safeguarding Adults and Safeguarding Children Boards. This has included discussion of [DH Winterbourne View Review – Concordat: Programme for Action](#). There will be quarterly updates on progress to each Board.

- A stakeholder event across the three boroughs on 30 March 2016 with attendees from the Local Authorities, CCGs, Learning Disabilities Partnership Boards, Mental Health Partnership Boards, Voluntary and Community Sector, representatives from Children and Young People, carers groups and from people with lived experience of services. A summary of the discussions can be found in Appendix 5.

We actively and widely engage with people with learning disabilities and autism, and carers and families, to improve our services. We are always keen to know what our users feel we do well, do not so well and where they feel we can improve. All Boroughs have stakeholder forums where we seek feedback on strategies and service delivery. Each CCG has a Patient Engagement Forum (PEF) with people from different backgrounds, representatives of young people, people with learning disabilities, parents and carers, and community groups with an interest in learning disabilities and Autism. The CCGs and Local Authorities engage directly with parent and carer groups that focus specifically on the needs of people with learning disabilities and autism; and will continue to do so as
we develop this plan. We know that not all people with learning disabilities or autism, or their families and carers, are part of groups or networks. So we look for other ways to involve them. For the purposes of this Transforming Care Plan, we will conduct surveys (including online), continue to utilise the CCGs’ lively social media channels and commission easy read versions of key documents to ensure all children, young people and adults are able to take part in its development.

There is good practice in engagement across the partnership. As part of the implementation of our CAMHS Transformation Plan we have established a BHR ‘Participation and Outcomes Group’ which is specifically focussed upon engaging with children and young people with learning disabilities, Autism and mental health problems. This will enable us to harness their views and inform the further development and implementation of both our CAMHS and Transforming Care Plans. In Redbridge, for instance, an Adult’s with Autism Working Group, Children’s ASD Planning Group and Parent/Carer Focus Group meet to consider key strategies and plans including the Autism SAF. There is also a Respite Carers Forum and Day Services Forum; and the Borough uses a locally co-produced Quality Checker System for Day Services, and involves service users in staff recruitment. In Havering, in March 2014, Healthwatch (a member of the Health and Wellbeing Board) conducted a review of Services for People who have Dementia or a Learning Disability based on a series of workshops including service users and carers, volunteers and professionals from across health, social care and the voluntary sector. In Barking and Dagenham, the Learning Disability Partnership Board has a Service User Forum, Carer Forum and Provider Forum. These groups discuss and comment upon items that go to the Board, and escalate issues facing people with learning disabilities and Autism. A representative from each forum, two of them service users, sits on the Board. The Board also oversees engagement events, particularly over Learning Disability Week, with carers and service users on a variety of topics including community safety and transport. All providers of learning disability services are encouraged to attend the Provider Forum. It is an opportunity to engage on national and local priorities. Over the past 6 months they has been asked to develop a more resilient workforce; and to ensure Positive Behaviour Support (PBS) is core mandatory training for all staff working with people with a learning disability.

Our ongoing planning will build on the existing Barking and Dagenham, Redbridge and Havering wide partnership structures and stakeholder engagement arrangements; and make sure this continued engagement results in a coordinated approach to addressing the needs of individuals, carers and families, and any challenges or barriers that we meet. As we begin to implement the TCP Plan and develop new community-based housing solutions we will engage stakeholders in the process of putting together detailed design plans. This will include ensuring that the locations, environment and the aesthetics are fully disability compliant, robust, sound resilient, and designed with appropriate colour co-ordinated features; to assist service users with sensory support needs alongside their learning disability.

Our Communications and Engagement Plan aimed to inform and involve all stakeholders in the development and implementation of this plan can be found in Section 5.
Describe how the plan has been co-produced with children, young people and adults with a learning disability and/or autism and families/carers

We fully recognise the importance to the success of our plan in engaging extensively with people with learning disabilities and autism, their families and carers. In addition to meetings, workshops and events with all stakeholders, we will continue to engage these individuals in particular, and in a variety of ways, as appropriate to their needs and circumstances. We are seeking their advice on:

• Which aspects of our services are working well?
• Which aspects of our services are not working well and why?
• How can we improve on these services?
• Which additional services do we need to expand upon and commission more of?
• Which new services do we need to look to start commissioning?

Indeed, it is fundamental to our approach that those stakeholders with lived experience are central to our Transforming Care Plan:

• On 30 March we invited health and social care professionals, former users of inpatient care and current users of community care and their families, to a Transforming Care Workshop at Redbridge Central Library to discuss services and how they could be improved. It took place in the middle of the day at the suggestion of our Learning and Disability Partnership chair. This ensured parents and carers of children and young people with learning disabilities and Autism, who need to meet school buses in the morning and in the afternoon, were able to attend. A summary can be found in Appendix 1.

• Commissioning of National Development Team for Inclusion undertook 10 days of engagement work across BHR. Through March the facilitator arranged 1-1 sessions and small focus groups with people with lived experience of being in inpatient settings and now living in the community. A summary of this work can be found in Appendix 2.

• Borough-based Community Teams for People with Learning Disabilities (and Mental Health Services) met with current inpatients in March to discuss the Transforming Care Partnership Plan and how it affects them as individuals. This will form a part of their discharge planning and moving back into the community.

We will build on good practice across the Transforming Care Partnership engaging people with lived experience in the coproduction of both their own care and support, and wider provision, in the development of this Plan.

In LBR, children with Special Educational Needs Support or an Education, Health and Care Plan are encouraged to share their views about their needs, outcomes and future aspirations; and they participate in the process to determine needs and shape the provision and support they receive. There is the Supporting those with Aspergers or Autism in Redbridge (STAAR) group for parents of children with an Autistic Spectrum Disorder, and a Social, Emotional and Mental Health (SEMH) group for parents of schoolchildren with social and emotional difficulties. The CCG Engagement Officer routinely meets with these groups and engages the families, including children and young people, with particular areas of service development. These groups are engaged with the Child and Adolescent Mental Health Service (CAMHS) Transformation work; and will co-produce with
professionals the workstream for extra and early help focussing on behaviour support pathways; and will contribute to the development and implementation of this plan.

**LBH** has successfully involved people in the coproduction of their own care, discharging them into accommodation with services that are bespoke in meeting their care and support needs. At Care and Treatment Reviews the Community Learning Disability Team (CLDT) ensures that inpatients are active participants in planning for their future accommodation and support needs in community settings. LBH has recent experience of successfully engaging those with lived experience, and co-designing new specialist housing provision for people with complex learning disabilities and mental health issues. For instance with those admitted or at risk of admission into hospital settings and in the opening of Great Charter Close – 6 independent living flats with onsite 24 hour support – last year. Service users, including future residents and one person discharged into the new provision from an inpatient setting after 8 years in an ATU, were actively involved in the commissioning process. A workshop organised by the health sub-group of the LDPB in March 2015 included people who had lived in ATUs, and families and carers. They were able to tell us what worked and didn’t work including support on moving back into the community or in times of crisis. We also worked with user groups that support and inform the delivery of services from two key providers of services in Havering.

**B&D** engage an active group of Carers and Experts by Experience on initiatives including e.g. working with Community safety to develop the Safe Place Scheme across the borough for vulnerable people. Commissioners have engaged with stakeholders on the development of the Challenging Behaviour Strategy, the implementation of the Winterbourne View Concordat, the Adult Autism Strategy and the development of collaborative commissioning arrangements between the CCG and the Council. Service users and carers were also involved in the evaluation process of the borough’s Supported Living tender in late 2014, leading a ‘speed dating’ event in which they formulated and asked ‘quick-fire’ questions to prospective bidders. This formed part of the quality score for the tender.

To inform the development of our CAMHS Plans we have already met across the boroughs with a wide variety of user/carer and community-based groups. These include Youth Councils, Young Cabinet and Children In Care Council, parent / carer forums, learning disability and Autism support groups, CCG Patient Engagement Forums, provider/patient participation groups and other groups such as Ab Phab youth club, STAAR, True Colours and Fun4all. We’ve set-up thematic engagement groups, and are currently planning on how we will engage with harder to reach groups (including those with learning and communication difficulties). Other work has also commenced to engage with children and young people as part of a meaningful and ongoing dialogue on the theme of mental health. We will further develop these mechanisms including incorporating feedback from engagement on our local Children’s Autism Strategies; and learning from the Education, Health and Care planning process which includes meetings with children, young people and families. Also the ‘Participation and Outcomes Group’ which includes children and young people with learning disabilities, Autism and mental health problems, will report back to the Children’s Services Lead TCP Board Member once appointed. We will accelerate this work in Year 1 to ensure that young people are able to shape this plan from the very start; and work with us to ensure it transforms services, and transforms their experience of services and the quality and nature of support that is available.

Please go to the ‘LD Patient Projections’ tab of the Transforming Care Activity and Finance Template (document 5 in the delivery pack) and select the CCG areas covered by your Transforming Care Partnership
2. Understanding the status quo

Provide detail of the population / demographics

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2015</th>
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<tr>
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<th>2020</th>
<th>2025</th>
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<tr>
<td><strong>People aged 18-64 predicted to have a learning disability</strong></td>
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<td>Barking and Dagenham</td>
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<td><strong>Total</strong></td>
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<tr>
<td><strong>People aged 18-64 with a learning disability, predicted to display challenging behaviour, projected to 2030</strong></td>
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<td></td>
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<tr>
<td>Redbridge</td>
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<td>102</td>
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<tr>
<td>Barking and Dagenham</td>
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<td>69</td>
</tr>
<tr>
<td>Havering</td>
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<td>74</td>
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<tr>
<td><strong>Total</strong></td>
<td>206</td>
<td>245</td>
</tr>
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</table>

Source: Projecting Adult Needs and Service Information (PANSI), February 2016.

There are, according to PANSI, 11,207 adults with learning disabilities in Barking and Dagenham, Havering and Redbridge. This is projected to increase to 13,350 by 2030. There are 206 people aged between 18 and 64 with a learning disability and challenging behaviour. This is projected to increase to 245. There are 4514 recorded on the autistic spectrum, and this is projected to increase to 5368 over the same period.

Children with Disabilities Teams across BHR have identified approximately 150 young people currently in the TCP cohort who are likely to need adult social care support. This number shows increases year on year: from 28 in 2013/14 to nearly 50 per borough in 2016/17.

<table>
<thead>
<tr>
<th></th>
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<th>Havering</th>
<th>Redbridge</th>
<th>Total BHR</th>
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<td>5-9</td>
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<td>21,099</td>
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<td>10-14</td>
<td>13,352</td>
<td>13,735</td>
<td>18,912</td>
<td>45,999</td>
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</table>
The data for children and young people (above) need to be considered with a little caution as the variation in projected numbers may reflect better recording in some boroughs than others. This is something we will address as part of the Right Care Programme Data and Information workstream. The data held locally on children in this cohort and the wider population is in some places incomplete and in others contradictory. For instance, the SEND databases record only the primary special educational need in most cases and not co-morbidities. Local SEND data indicates numbers of children with particular needs as significantly lower than national prevalence rates. We expect that the majority of the young people in the TCP cohorts will be known to existing services and receiving support.

Across the BHR area there are 204,161 0-19 year olds – a small minority of whom will come into contact with Local Authorities as part of their SEND work, with their Children with Disabilities Teams, Transition Teams, Youth Offending Teams or alternatively with Community Health or Mental Health Services. Those young people with SEND but without social care input, and care leavers or those being supported by Youth Offending Teams are not necessarily picked up for transition planning. Others in this cohort may not be known to services at all. This presents a challenge for how we work across the Partnership and with schools to identify those at risk and to support them at the earliest opportunity. Some we do not know because they don’t meet the eligibility criteria for adult services and may, consequently, be at greater risk of admission or contact with the Criminal Justice System.

Across the agencies working with children, cohorts differ, reporting protocols are not aligned and data is collected in different ways. The population and demographic details we have collated from our partners indicates the need for better data recording and definitions, particularly for children and young people.

### Analysis of inpatient usage by people from Transforming Care Partnership

The trend in recent years has been towards a reduction in the number of inpatients at our principal...
ATU in Goodmayes Hospital.

### BHR CCGs- Moore ward - No of inpatients

- **2013/14:**
  - B&D CCG: 7
  - Havering CCG: 5
  - Redbridge CCG: 9

- **2014/15:**
  - B&D CCG: 3
  - Havering CCG: 3
  - Redbridge CCG: 8

- **2015/16 (M10 FOT):**
  - B&D CCG: 8
  - Havering CCG: 2
  - Redbridge CCG: 5

### BHR CCGs- Moore ward - Occupied Bed days

- **2011/12 - 2013/14 (3 yrs average):**
  - B&D CCG: 750
  - Havering CCG: 398
  - Redbridge CCG: 966

- **2012/13 - 2014/15 (3 yrs average):**
  - B&D CCG: 1002
  - Havering CCG: 414
  - Redbridge CCG: 1147

- **2013/14 - 2015/16 (3 yrs average):**
  - B&D CCG: 1042
  - Havering CCG: 280
  - Redbridge CCG: 877

### BHR CCGs- Moore ward - Bed days cost (in Thousands)

- **2011/12 - 2013/14 (3 yrs average):**
  - B&D CCG: £339
  - Havering CCG: £180
  - Redbridge CCG: £437

- **2012/13 - 2014/15 (3 yrs average):**
  - B&D CCG: £453
  - Havering CCG: £187
  - Redbridge CCG: £519

- **2013/14 - 2015/16 (3 yrs average):**
  - B&D CCG: £471
  - Havering CCG: £127
  - Redbridge CCG: £397

### BHR CCGs- Moore ward - Average length of stay

- **2013/14:**
  - B&D CCG: 245.75
  - Havering CCG: 129.33
  - Redbridge CCG: 113.45

- **2014/15:**
  - B&D CCG: 190.50
  - Havering CCG: 192.67
  - Redbridge CCG: 160.17

- **2015/16 (M10 FOT):**
  - B&D CCG: 162.28
  - Havering CCG: 150.00
  - Redbridge CCG: 150.00
There are 17 inpatients across BHR. This figure consists of 8 at Goodmayes Hospital, 7 of which are in Moore Ward and 1 in Picasso Ward. The remaining 9 patients are currently being treated out-of-borough. We are treating one further inpatient at Moore Ward on behalf of Barnet CCG.

<table>
<thead>
<tr>
<th>Inpatients by borough</th>
<th>Barking and Dagenham</th>
<th>Havering</th>
<th>Redbridge</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>8</td>
<td>6</td>
<td>3</td>
<td>17</td>
</tr>
<tr>
<td>Inpatients in Moore Ward – Discharge Dates (DD) below</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient 1</td>
<td>30/06/16</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient 2</td>
<td>30/06/16</td>
<td>Patient 1</td>
<td>May 2016</td>
<td></td>
</tr>
<tr>
<td>Patient 3</td>
<td>30/09/16</td>
<td>Patient 2</td>
<td>October 2016</td>
<td></td>
</tr>
<tr>
<td>Patient 4</td>
<td>30/09/16</td>
<td>Patient 1</td>
<td>30/04/16</td>
<td></td>
</tr>
</tbody>
</table>

The discharge dates for the 7 inpatients in Moore ward are:

<table>
<thead>
<tr>
<th>B&amp;D</th>
<th>Havering</th>
<th>Redbridge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient 1</td>
<td>May 2016</td>
<td>Patient 1</td>
</tr>
<tr>
<td>Patient 2</td>
<td>October 2016</td>
<td>Patient 1</td>
</tr>
</tbody>
</table>

A planned reduction of 50% for our CCG-commissioned patients over the next 3 years will bring our current inpatient number down from 17 to 8.
This will bring us from our current figure of 29 inpatients per million (based on a BHR population of 579k) to a figure of 14 per million which would be by more than half; and inside the NHSE guidelines of 10-15 inpatients per million. The current number of 9 patients commissioned by NHS England across BHR represent a figure of 16 inpatients per million of population (well within the current guidelines of 20-25 per million of population). This is projected to reduce further to 10 per million of population. The number of inpatients, both CCG and NHSE-commissioned, is projected to fall from 45 to 24 per million of population.

As of 1 April 2016, 15 of the CCG-commissioned inpatients had a length of stay of less than 5 years; with 2 more than 5 years. Of the former, 7 were placed in Moore Ward and 1 in Picasso Ward (a mental health ward); 3 were placed out-of-borough by Barking & Dagenham, 2 by Havering and 2 by Redbridge; the latter were placed out-of-borough by Barking & Dagenham and Havering.

We are aware that due to their length of stay some of these patients have developed connections to these areas and have expressed a wish to be discharged there. Admissions into the local Assessment and Treatment Unit have resulted in discharge placements mostly within the community or close to the location of relatives. One current inpatient at Moore ward is being treated on behalf of Barnet CCG.
All the Assessment and Treatment units we commission include a Multi-Disciplinary Team (MDT) of health professionals. The MDT is overseen by a Responsible Clinician. All patients receive 6 monthly Care Plan Approach meetings (CPA) and Mental Health Tribunal hearings (usually annually). On being recommended for discharge patients are supported with a discharge plan. Issues relating to funding, provider identification, and the current and future responsible authorities, are covered to ensure the discharge plan is successful. For all people who require inpatient care, both the Community Teams for People with Learning Disabilities and Mental Health Services remain involved in the patient's care whilst in a bed, and work with the inpatient clinical teams around discharge planning from the point of admission.

CLDTs and Mental Health services across BHR use inpatient settings as a last resort, and have protocols in place to ensure all community-based interventions have been exhausted before an inpatient setting is considered. Out of area placements are also avoided where possible. If an out of area placement/inpatient stay is considered necessary this is only where the move is clinically justified and all other options have been exhausted.

As part of the aspiration to keep people cared for in their own home or as close to home as possible it is necessary to avert crises and support partner services to deliver this aim. Havering Community Learning Disability Team (CLDT) has a local protocol in place that no placement should take place out of area. This is something that we would like to roll out across BHR. The CLDT works proactively to avoid crises occurring by planning effectively and ensuring that robust contingency arrangements are put in place. The CLDT refer to this admission avoidance arrangement as the ‘blue light’ protocol. All 3 boroughs undertake regular CTR analysis of service users in inpatient settings as well as community or blue light CTRs for people believed to be at risk.

The Havering CLDT local protocol describes when this “Blue Light” response is needed. The protocol is referred to and determines the preference of support arrangements:

- **1st preference** - Support the person at home with the relevant help taking place there. Additional support packages will be considered favourably by commissioners.
- **2nd preference** - the person is supported in a local non-inpatient unit, using residential nursing, or short breaks services.
- **3rd preference** - a local inpatient service in the Goodmayes area
In Mental Health Services, again, referral to a specialist inpatient setting is considered as a last resort. An individual is supported to remain in the community with a range of services, including being supported by care coordination, home treatment team, inpatient stay in one of the specialist NELFT inpatient beds and so on. Where this is exhausted, there are two avenues for referral into an inpatient setting outside of the:

- Tertiary referral process, where the case is referred for agreement of funding from the CCG or NHS specialist commissioning. Referral via this pathway will usually be for people who require an initial period of assessment to support diagnosis and treatment.
- Individual Service Agreement (ISA) process, where a referral is triggered for people who may need a period of ongoing treatment and where this cannot be managed in the community. The ISA process is a risk share agreement between NELFT and the 4 CCG’s where funding for specialist treatment has been passported to NELFT to manage.

In Havering, patients who are currently in ATU / inpatient settings are monitored monthly by the CLDT and CCG, with all current inpatients having an allocated case manager (social worker) who proactively works with the inpatient clinical team around discharge planning, including attending 6 monthly Community Treatment Reviews, working with commissioning and housing around ensuring appropriate community provision is sourced as part of the discharge planning process. Patients are reviewed monthly by the CLTD worker and as above are visited at least 6 monthly (including attending CTR’s and/or CPA meetings) or more often as required particularly when the patient is nearing discharge.

The challenge is to develop discharge plans with patients with severe and enduring needs that require a high level of support, and with the relatives and providers, over the long term in the community rather than as inpatients. There are lessons the boroughs and CCGs can learn from each other. For B&D, this year’s usage is higher than last year, but not as high as the year before. Havering’s use is very much lower. But the overall BHR profile shows a distinct downward trend since 2012-2013. B&D inpatients amount to about half the BHR total. However, Redbridge has a consistently lower intake of inpatients – despite having a larger population – and Havering have a shorter average inpatient length of stay than their neighbouring areas. So we will be working together to see exactly why these differences exist and share best practice we find across BHR.

Beyond these figures, it should be acknowledged that we are now working with inpatients with much more complex needs and we expect this to continue. We are constantly reviewing our provision at MooreWard accordingly, and are currently discussing how we can develop our relationship to support alternatives to inpatient admissions too (see briefing in Appendix 3). We anticipate an increase in forensic bed needs. Currently, there are 9 patients in these NHSE-commissioned beds - 1 from B&D, 2 from LBH and 6 from LBR; 3 of them occupying medium secure beds, 4 in low secure beds and 2 in CAMHS beds.

Also, whilst there are only a small number of in-patient beds for children and young people locally (at the Brookside Unit), a number of those of school age are likely to reflect the TCP cohort. LBH place 169 young people, and Barking and Dagenham, 63 young people in OOB residential educational units to support their complex social, emotional and behavioural, and mental health difficulties. This is another reason for ensuring we develop good quality alternative all-age provision.
Describe the current system

Across BHR, we have developed registers of all people with a learning disability or autism. We are currently aligning our approach to reviews of placements. We are ensuring that, across the BHR area, they are carried out every six months through a comprehensive Care and Treatment Review (CTR) following the national guidance. It is likely that practice will differ but this should ensure that a range of stakeholders are involved: including individuals, their carers and families, commissioners, specialist clinical experts, experts by experience, and advocates. Each CTR assesses the quality of care and treatment an individual is receiving, their level of progress and outcomes and options for providing support within the community. CTRs enable us to ensure that the right patient care is being provided at the right time, based on an individual response. We conduct community CTRs (pre-admission), urgent blue light CTRs (where a patient is in “crisis” and there is not time to pull together the community CTR) and inpatient CTRs.

Two years ago, in response to the Mencap’s *Death by Indifference* report and *Six Lives*, BHRUT and Barts Health created a specific Learning Disability Liaison Nurse role for adults – a senior post aimed at working with the hospital staff, raising awareness and ensuring that reasonable adjustments are made for people who are inpatients or visiting the hospital. The role provides an essential link between the hospital and the community learning disability team staff, to ensure that discharges are planned properly, that hospital passports are being used and health inequalities are addressed. It has proven to be extremely successful and BHRUT have also appointed a paediatric Learning Disability Liaison nurse. BHRUT are committed to improving the inpatient experience for people with learning disabilities and have also signed up to the Mencap Getting it Right Charter.

NELFT runs a number of clinical groups as part of its own governance structures. For instance, Challenging Behaviour Pathway Group: All heads of learning disability clinical disciplines meet monthly to ensure Positive Behaviour Support (PBS) approaches are used in relevant settings. NELFT-led Learning Disability Task Group: Senior clinical leads and CLDT Managers meet monthly at strategic group which feeds into NELFT Community Practice Board.

Children and young people who are covered by this TCP plan are managed by the Children and Adults Disabilities Team (CAD). This consists of social workers (key workers), education advisors, educational psychologists, commissioners and brokerage. There are a range of partners working with children and young people who make up the TCP cohorts. Some children will be known to multiple services. Others will not, and others may not be known to services at all. Some, with mental health needs, may be managed by local Tier 2 or 3 mental health services. Many of those within the TCP cohort are also likely to have a special educational need. They may receive SEN support in schools or have an Education, Health and Care (EHC) Plan. A number of children with learning disabilities and/or autism who display particularly Challenging Behaviour can be placed in OOB residential educational placements. Children known to children with disabilities social work teams will be offered care and support packages to meet their needs; and will be referred to the Adults Transition Team as they prepare for adulthood. This process starts from at least age 14 to provide an alert to adult services and planning and preparing for adulthood. The partners, across BHR, are also part of the North East London Liaison and Diversion pilot, designed to reduce the risk of offending.

Across BHR OOB placements are only agreed where there is no alternative or where someone wishes to live elsewhere. This recognises that keeping people closer to their families and social networks is critical to their wellbeing and the sustainability of placements. An OOB placement may be required in certain circumstances, including service user choice, or where there are clinical or
legal reasons for a placement out-of-borough.

While there are differences across BHR, in LBH, the cohorts of adult patients covered by this TCP plan are looked after primarily by the CLDT with a small number known to Mental Health Services. The decision as to which service is best placed to work with this cohort of patients is based on primary presentation. In terms of the five needs groupings in the Transforming Care cohort. The two primary areas of need for LBH, are

*Children, young people or adults with a learning disability and/or autism who have a mental health condition such as severe anxiety, depression, or a psychotic illness, and those with personality disorders, which may result in them displaying behaviour that challenges.*

and

*Children, young people or adults with a learning disability and/or autism who display risky behaviours which may put themselves or others at risk and which could lead to contact with the criminal justice system (this could include things like fire-setting, abusive or aggressive or sexually inappropriate behaviour).*

For the cohort of individuals who are not currently in an inpatient setting, services commissioned include a mixture of residential care (currently six placements) and supported living placements (also currently six), with one individual living with their family and in receipt of a direct payment. Services are commissioned as a mixture of block and spot purchase care.

LBH’s Community Learning Disabilities Team is multidisciplinary, consisting of social workers, nurses, SALT, psychiatrists and psychologists. It also includes a Challenging Behaviour specialist. The CLDT commissions:

- Local Authority or joint funded residential and nursing placements for around 146 people (78 in borough and 68 out-of-borough). In the Borough we utilise approximately 20 providers for residential and nursing care.
- Local Authority or joint funded supported living placements for around a further 94 people (75 in borough and 19 out of borough). In the borough we commission from approximately 15 providers.

Mental Health services, run by NELFT and with social care seconded into the service, are similarly multidisciplinary. They commission:

- Local Authority or jointly funded residential and nursing placements for around 40 people both in and out-of-borough.
- Local Authority or joint funded supported living placements for a small number of people both in and out-of-borough.

Havering Mental Health Services operate in-house Group Homes: catering for a number of residents with a step-down model to transition them from high levels of support (residential care or supported living) to independent living. People who are diagnosed with autism and meet eligibility criteria are supported primarily through the learning disability service, with some in our mental health service. Other services include the Autism Hub, which offers information, advice and signposting, as well as other tailored support to individuals, families and other organisations, to raise awareness of the services available.
The borough has four block respite beds for people with learning disabilities. These are provided by Outlook at Neave Crescent. If it requires anything over and above this it has to spot purchase it. It has no nursing respite and spot purchases where necessary. There is a lack of housing availability and a need for providers to enhance their offer on Positive Behaviour Support (PBS). However, housing services are very engaged in supporting the development of appropriate accommodation options for people with care and support needs, and is able to provide access to social housing properties when required. There are 57 people living in their own home (generally with a family member) and receiving a care and support service; and a cohort of 68 regularly accessing planned and unplanned respite services (usually in a residential setting). The borough has more supported living provision than is needed for its own residents and as such is a net importer of people who need care services. The excess provision tends to be supporting living that caters for lower level need, with insufficient provision available for people who have high or complex needs – such as people with a learning disability who also have mental health issues and/or complex physical disabilities. LBH operates a day opportunities resources directly (Avelon Resource Centre) and commissions a number of places from small private and voluntary sector providers. Approximately 121 people with a learning disability attend a day opportunities centre – of which 95 are registered to attend the Council’s in-house service for anything between 1-5 days.

LBH seeks to meet the needs of pupils with special needs in their local mainstream schools. For children whose needs cannot be met in their local school there are eight schools who are specially resourced to meet particular needs. As well as local provision, Havering commissions specialist education provision out of borough: 169 pupils across 95 providers in maintained and non-maintained provision, pre- and post-16. For children with mental health issues, Havering CAMHS service is provided by North East London Foundation NHS Trust.

In LBR the CLDT is multidisciplinary, consisting of social workers, nurses, SALT, psychiatrists and psychologists. Respite provision includes residential. There are two accommodation options with a total of 15 bed spaces, 9 of which can provide nursing care. The borough has developed an at risk register which covers all people from age 14. The list is RAG rated. All priority cases have a community CTR carried out. While there are differences across BHR, the following tiered approach adopted in this Borough is typical:

**Tier 1** services are focused on the health of the whole of our population with learning disabilities. This includes adequate housing provision, transport and leisure facilities, education, and employment and volunteering schemes for people with a learning disability and/or autism (e.g. Ellingham, Jackson’s Lane and Cherry Tree café).

**Tier 2** is about making sure people with learning disabilities have regular checks in mainstream health services, and advice and support on lifestyle decisions. For instance, Redbridge is introducing GP hubs aligned with expertise in learning disability and mental health, so as to ensure patients receive the right care at the right time.

**Tier 3** consists of specialist ongoing support from the community teams for people with learning disabilities or autism and a moderate degree of mental ill-health. These symptoms could manifest themselves as anxiety, depression or psychotic traits about which individuals would be referred to one of a number of community healthcare providers.
Tier 4 addresses the needs of individuals who pose a severe risk to themselves and the wider community, with chronic treatment resistant mental illness which often results in challenging and offending behaviour. Inpatient services are often required with a 24/7 assessment and treatment package to enable them to make a safe return into a community-based treatment programme. Services include assessments and treatment using a combination of behaviour support services, forensic teams and a combination of crisis and home treatment teams.

B&D has a combination of established providers alongside a number of small and new providers covering a range of activities. The Council provides supported living to 64 people with learning disabilities via a block contract. The contract was retendered in 2014. The Council is currently working with the provider to roll out a new personalised model, which incorporates core support but with the majority of services paid for with PBs. The Council contracts over 12 supported living places from external providers. The Council and CCG commission a number of care and nursing home beds from the private and voluntary sector. New placements are rare. The Council also directly provides a home for 12 people with moderately challenging needs at 80 Gascoigne Road. Health-related care (or Continuing Healthcare) and support is being provided to people with learning disabilities in a range of settings that are community-based and allow for maximum independence. In 2015 day services were modernised following a consultation with, and the involvement of, people with learning disabilities. Fifty services users were moved from centre-based provision onto Personal Budgets and services for 60 people with Autism and other complex needs were consolidated at the Heathlands Day Centre. The CCG commissions a local Enhanced Optometry Service for people with a learning disability. This forms part of the Bridge to Vision Service ensuring support by specially trained clinicians to access extended appointments. This is regarded by See Ability as being one of the most successful services of its kind in the country. Commissioners from Children, Adult and Carers services meet to ensure the commissioning intentions are aligned, at the Special Education Needs and Disability (SEND) Board. For instance, the recent re-tendering of the Carers Support Hub and the Advocacy service. The relationship between the commissioners ensures service specifications are designed to meet future need. The contract monitoring process includes engagement with families on the quality of the service and comments for improvements. This is fed back to the provider to implement. The borough has limited housing stock available to meet the needs of those of vulnerable adults; but a growing population of small providers offering shared accommodation of 3-4 bedrooms.

What does the current estate look like? What are the key estates challenges, including in relation to housing for individuals?

We have a BHR CCGs (Draft) Estates Plan, but more work is being undertaken to identify and understand the BHR Estate for this cohort as a whole across the health, social care, housing and education sectors, and across and out-of-boroughs, however funded.

An Assessment and Treatment Unit is situated in Moore Ward at Goodmayes Hospital in LBR. We (and Waltham Forest) have access to 12 beds, provided by NELFT, as part of the contract with BHR CCGs, with beds allocated using a three-year rolling average. We have additional facilities such as Picasso Ward (principally a mental health ward, also at Goodmayes Hospital) with care beds for up to 10 male patients and 5 female patients. We are in discussion with NELFT regarding our use of Moore Ward across BHR; with a view to reducing inpatient usage, aligning practice and process, and building a new care model. There is also Brookside Child and Adolescent Inpatient Unit with 18 in-patient beds covering the Barking, Havering, Redbridge and Waltham Forest area – 14 beds in Reeds Ward with and 4 high dependency beds in Willow Ward.
Patients are supported after discharge (e.g. from Moore Ward or Brookside Inpatient Unit) in a variety of settings including living at home, supported living, residential homes and ‘Shared Lives’:

- Our residential providers are Airthrie Homes, Alpam, Ashbrook Nursing Home, Care Link, Care Tech, Care UK, Clearwater Care, CMG, Fari Care, 80 Gascoigne Road, Leyton Lodge, MCCH, Mencap, Norwood, Outward, Russell Lodge, Saffron Care Homes, Sahara House, Teakl Services, Tomswood Lodge, Venus Healthcare, Vibrance and Voyage Care.

- Our providers of Supported Living are Access Living, Care Tech, Cogni Care, Divine Lodge, East Living, Footsteps, King’s Lodge, Look Ahead Care and Support, Mencap, Norwood, Outlook, Outward, PICAS, Spencer and Arlington and Three Cs.

Residential and special schools also form an important part of the support we offer our children and young people. There are 10 Special Schools across the three Boroughs: 4 in LBR (Newbridge, Hatton, Roding, Little Heath) 3 in LBH (Ravensbourne, Corbets Tey, Dycorts) and 3 in B&D (Trinity, Hopewell, Riverside Bridge). There are also a number of mainstream schools with a special educational needs specialism.

What is the case for change? How can the current model of care be improved?

The case for change is very clear across BHR. We believe that the majority of people with learning disabilities and/or autism are not best treated in an inpatient setting. A number of admissions, including individuals placed OOB (including children placed in residential schools), could have been prevented had there been an appropriate community-based or respite provision, with trained staff and quick access to community clinical support.

We need to ensure that no person is admitted to any inpatient facility unless a CTR finds this to be clinically necessary, and to be the only course of treatment that meets the person’s current needs. We also need to ensure that no one remains in an inpatient facility any longer than necessary, through continual monitoring, CTRs, and putting in place community provision that can meet their needs at the point of discharge. Close assessment of current inpatients and enhanced community programmes will allow for as early as possible discharges.

We need to strengthen community assessment by better identifying at risk individuals, closely monitoring them with community of, if necessary, ‘blue light’ CTRs. In this way we can pick up on any crisis moments in their lives at the very earliest opportunity, before their situation escalates further and they need admittance to an inpatient facility. By identifying potentially at risk individuals, and enhancing our community clinical and social care programmes, we can reduce the number of admissions in the first place.

We believe that more can be done to ensure individuals are at the centre of their own packages of care and support and those systems and processes need to be made more person-centred. Enhanced community provision, and complex needs schooling provision, needs to take into account the different demands and complexity of needs for different individuals. It also needs to be tailored to the needs of children, young people and adults, including the transition from one to the other.

The current approach to supporting children and young people is embedded across a number of
services e.g. social care, education and health with different routes in to support. There has been limited focus on these children as a single cohort. They are supported on an individual basis but without a strategic plan for how we manage risk for them as a group overall. The TCP provides an opportunity for joining up commissioning, decision-making and care (e.g. across the SEND team, social care and health) and provide a more integrated and seamless care package.

We need to ensure that people with learning disabilities or autism have the same rights that any other resident of our boroughs enjoys. We need to build the right community-based services to support them to lead active lives in the community and to reduce the current inpatient provision. To do this we need to implement plans that give people more choice and control over their own care. An important part of this is the expansion of PBs, PHBs and integrated budgets.

Please complete the 2015/16 (current state) section of the ‘Finance and Activity’ tab of the Transforming Care Activity and Finance Template (document 5 in the delivery pack)

Any additional information

<table>
<thead>
<tr>
<th></th>
<th>Barking and Dagenham</th>
<th>Havering</th>
<th>Redbridge</th>
<th>BHR Total</th>
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<tr>
<td>NELFT cost of Moore Ward by CCG</td>
<td>£623,192</td>
<td>£267,082</td>
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<td>Cost of all OOB inpatients by CCG</td>
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<td>Total cost of inpatient care by CCG Y/E 30/03/16</td>
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<td>£782,759</td>
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Havering has the lowest cost of inpatients at Moore Ward and Out of Borough, perhaps due to the high investment in resources (~£901/-) to support LD Patients in the community.

Table: Tier 4 activity and costs (NHS England)

<table>
<thead>
<tr>
<th>CCG Name</th>
<th>Cost 2014/15</th>
<th>Activity 2014/15</th>
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<tr>
<td>NHS Havering CCG</td>
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<tr>
<td>NHS Barking and Dagenham CCG</td>
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<td>1,979</td>
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<tr>
<td>NHS Redbridge CCG</td>
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<td>1,413</td>
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</table>

3. Develop your vision for the future

Describe your aspirations for 2018/19.

While there is not likely to be a reduction in ATU capacity in the short term, we plan to reduce the number of admissions and average length of each stay by enhancing current ATU procedures and improving our community provisions. We are planning, for instance, to more than halve CCG-commissioned inpatient bed usage by 2018/19 (see above).
No person should be newly admitted to an OOB inpatient facility unless it is not possible for them to be treated in Moore Ward, our ATU in Goodmayes Hospital. Circumstances have arisen in the past where two patients cannot be treated in the same facility at the same time due to a personality clash and risk of violence. However, only in such exceptional circumstances or where it is clinically necessary will we in future use an OOB inpatient facility.

It is important that the community provision is robust, substantial and adequate and there are other alternatives for people with learning disabilities and/or autism to be fully supported in the community. We are determined that no patient will be admitted to an inpatient facility due to a lack of the community provision needed to treat them at the point of need.

Where appropriate we will always treat people in a community setting as opposed to an inpatient facility and will make sure that the community provision available always matches the needs of the person however complex their demands may be.

We aspire for children, young people and adults with a learning disability and/or autism, and their families, to be able to say:

- I have choice and control
- I manage my health with the level and quality of support I need
- I am part of a community
- I have a home I can call my own
- I direct my care

We will achieve this aspiration by developing pathways and services with them that:

- Are community-based where possible, with a reduced reliance on inpatient facilities
- Have staff with the right skills and experiences to manage complex needs
- Provide respite for families and carers to maintain at home placements
- Accommodate people with a learning disability and/or autism locally wherever possible

These services and pathways will help us to achieve:

- Timely access to assessment and treatment for learning disabilities and/or autism
- Reduced numbers of admissions to hospital settings (both secure and non-secure) and shorter stays if admitted
- Improved health and educational outcomes
- Improved quality of life

In BHR our aspirations are aligned with the NHSE vision of empowering children, young people and adults with learning disabilities and/or autism. This means enabling them to lead active lives in the community and to live in their own homes as opposed to being treated as inpatients. In addition to reducing their and our dependence on the ATUs, we are actively seeking to improve the quality of care we offer. We will give genuine choices to individuals, and their carers and families, so they have both an improved quality of care and, in turn, can enjoy a better life.

**How will improvement against each of these domains be measured?**

We are reviewing our data infrastructure and reporting protocols across BHR. This will ensure that the Transforming Care Partnership Programme has a standardised register of every patient at risk, a
risk stratification process for identifying those most at risk of inappropriate admissions; a step-down from the specialist commissioning pathway, a standardised CTR process across the area; a reporting mechanism to HSCIC, and establishment of KPIs for the NHS England Standard Contract and quality measures. Existing tracking systems will continue for inpatient use e.g. HSCIC portal, fortnightly returns and monthly tracking meetings.

The Insight Programme and Quality Assurance workstream has begun to identify Key Performance Indicators to ensure a measurable improvement in life chances for this cohort. KPIs will be fully developed during May 2016, but initial measures are:

• An increased number of individuals in employment
• An increased number of individuals maintaining their tenancies
• An increased number of individuals accessing educational opportunities
• Increased confidence in patients leading their own life measured by pre and post questionnaires, and the number of patients accessing leisure activities
• An increased number of patients enjoying high standards of physical health and making informed choices concerning their lifestyle.
• A reduction in the number of hospital admissions for health related issues and a reduction in the number of patients admitted via emergency services.
• An increase in the number of timely and effective interventions due to improved quality of CRT and care plans. This would be measured by audit processes.

We will also monitor reduced reliance on inpatient services with measures including:

• Number of CTRs (including inpatient, pre-/post-admission and blue light) undertaken
• Number of new admissions to inpatient care
• Average length of stay in inpatient care
• Number of forensic beds used and complexity of inpatients’ needs
• Numbers of patients discharged from inpatient care
• Number of re-admissions
• Number of patients with a planned discharge date
• Number of patients whose discharge dates change
• Numbers of people on the at risk register
• Numbers of patients admitted to inpatient care who were not on the risk register
• Number of hospital admissions for health or emergency reasons
• Numbers of in-borough and OOB placements

We will monitor the quality of care experienced by this cohort. In part we will do this by adopting the basket of indicators recommended for local use by the panel of experts who conducted the Department of Health review. They looked at indicators to monitor the quality of care and progress in implementing the national service model. These are:

• Proportion of inpatient population with learning a disability or autism who have a person-centred care plan, updated in the last 12 months, and local care co-ordinator
• Proportion of people receiving social care primarily because of a learning disability who receive direct payments (fully or in part) or a personal managed budget
• Proportion of people with a learning disability or autism readmitted within a specified period
of discharge from hospital

- Proportion of people with a learning disability receiving an annual health check
- Waiting times for new psychiatric referral for people with a learning disability or autism
- Proportion of looked after people with learning disability or autism for whom there is a crisis plan

Beyond this, we also want to ensure that individuals in this cohort and their carers, have received an assessment. Beyond the health and social care elements of each package we will monitor:

- Access to a range of options for housing that meet individuals’ needs
- That we increase supported living options vs. residential placements
- The numbers of safeguarding issues and adverse events recorded in all settings

Across BHR we have developed sets of ‘I statements’. For instance, as part of the development of the Integrated Health and Adult Social care Service (HASS) LBR has used them for a snapshot survey in a range of locations. This will be followed up to compare experience of contact with health and social care services since implementation.

We will also build a picture of people’s quality of life and that of their carers/families:

- Social care related quality of life (via adult social care surveys)
- Individuals who have control over their daily life (via adult social care surveys)
- Individuals who reported that they have as much social contact as they would like (via adult social care surveys)
- Their participation in volunteering
- Whether they are able to use transport that meets their needs
- Whether they are able to access community facilities e.g. respite or leisure

Describe any principles you are adopting in how you offer care and support to people with a learning disability and/or autism who display behaviour that challenges.

We are adopting and localising the Building the Right Support principles:

1. People should be supported to have a good and meaningful life (see our ‘aspirations’)  
2. Care and support should be person-centred, planned, proactive and coordinated (see our ‘model of care’)  
3. People should have choice and control e.g. by co-producing services with people who have lived experience of inpatient stays (see our ‘personalised support packages’).  
4. People should have support to live in the community from and for their families and carers as well as paid support and care staff (see our ‘model of care’).  
5. People should have choice about where and with whom they live e.g. with the development of the market to ensure specialist and high quality providers are able to work in-borough (see our ‘personalised support packages’).
6. People should get good care and support from mainstream NHS services e.g. with a more integrated and co-ordinated approach to planning and commissioning, and better cross-organisational working (see our ‘model of care’).

7. People should be able to access specialist health and social care support in the community e.g. with specialist staff working in our community support teams able to manage more complex cases (see our ‘model of care’).

8. People should, where needed, be able to get support to stay out of trouble e.g. with early access to the right clinical support when behaviour triggers are reached and closer working relationships with other sectors such as criminal justice (see our ‘model of care’).

9. People should be able to access high quality assessment and treatment in a hospital, staying no long than they need to, and with discharge planned on admission e.g. with a reduced reliance on inpatient admissions and usage (see our ‘model of care’).

Please complete the Year 1, Year 2 and Year 3 sections of the ‘Finance and Activity’ tab and the ‘LD Patient Projections’ tab of the Transforming Care Activity and Finance Template (document 5 in the delivery pack)

4. Implementation planning

Overview of your new model of care

Across BHR we have three different health and care delivery models of services for people with learning disabilities and/or autism. However the same principles are used by all partner organisations with the overriding ambition of reducing the use of inpatient facilities including OOB ATUs. To reduce inpatient care at the Goodmayes ATU by 50% over the next 3 years, BHR and NELFT are redesigning the service specification to meet the current and future needs of people with a learning disability and/or autism. We will conduct an in-depth review of respite services, especially for those with complex needs. We will further discuss with providers how they support people with behaviours that challenge.

Our model of care will be inclusive, apply to people of all ages, and be tailored to each individual’s needs and desired outcomes. We will be working closely with our stakeholders beyond health and social care e.g. public protection unit, probation, diversion service, community safety, education, leisure and housing. Our model of care will be totally inclusive and tailored to each individual patients with PBs, PHBs and integrated budgets that gives the individual the ability to make choices regarding their own care and treatment. We will review the current advocacy and brokerage offers across BHR to support this. There will be a greater emphasis of joint funding from health and social care. We will create bespoke packages of care; and we will work with individuals, carers and families to develop ‘I statements’ that better reflect the outcomes they would like to see, and to ensure care planning is genuinely person centred for all ages.

For children and young people the model of care will include:

- Early identification of learning disabilities, autism, including with mental health and/or challenging behaviours
- Risk register for those at risk of admission or CJS contact (including those not in receipt of services)
• Developing mainstream community provision so that it is accessible to and supportive of this cohort with inclusive policies and practices
• The use of PBs to increase their, and their families, independence, choice and control over their care
• Identifying and supporting this cohort throughout the SEND assessment and planning process including post-16
• Reducing OOB placements in residential schools
• Joint commissioning and partnership working across health, social care and criminal justice, to build a local offer that meets the needs of the cohort in-borough

Currently transition planning and assessment for adult services tends to start just prior to a young person leaving school. We will put in place a process across health and social care to identify these young people as early as possible and start to plan their transition towards adulthood from Year 9. A young person becomes an Adult at 18 but will start the transitioning process in year 9 aged 14-15 across BHR. We will strengthen transition planning and arrangements, and support for those who do not meet adult services criteria but still may be at risk of in-patient admissions or contact with the criminal justice system. We will remodel pathways for accessing activities, including education, training and employment. We will learn from the ‘Preparation for Adulthood’ service developed by B&D to improve the transition pathways for children into adulthood; with greater emphasis on life skills and raising the ambitions of young people with disabilities, and building on their strengths as individuals and increasing resilience. There will be a greater focus on building the aspirations and resilience of young people starting from their mid-teens around living as independently as possible once they reach adulthood, and preparing them for life as an adult, including moving into education and work where possible, including volunteering.

By building on the successes of the current integrated partnerships agreements, the new model will look to establish:

• An enhanced front door with experienced Wellbeing Co-ordinators, a greater focus on early intervention and prevention through appropriate signposting and a proportionate response.
• Cluster-based provision to reduce the likelihood that people move around the system.
• Integrated Multi-Disciplinary Team Approach to reduce the number of assessments a person needs to go through.

We will not simply close acute beds on Moore Ward but do so in order to accommodate crisis beds, explore the use of expertise from this, our main ATU, to support community services; and seek to develop an outreach service that utilises the skills of the current inpatient hospital staff to work in the community with individuals in crisis. Moore Ward’s inpatient management staff and specialist psychiatrists and psychologists have been meeting to develop crisis team pathways. The focus is on reducing the cross-borough beds on the ward from 12 to 10 by September 2016. The two beds that will be released will be used differently to facilitate a 24/7 response to crisis which will be supplemented by outreach support.

This will be at the core of our enhanced community offer to accommodate crisis (both social care and health-related) in the community. We will create a centre of excellence across the BHR region with a single pathway offering access to the best local care, prevention of admission, fast track rehabilitation (where Inpatient care is needed) and a comprehensive clinical, social care and community support system. This will include reinvesting funds currently included in our block contract into the up-skilling of staff as part of an active outreach service able to support individuals...
entering crisis in a number of community settings; and in a 24/7 combine learning disability / mental health community support service that will support people in their own homes. It will also allow us to reduce the use of OOB placements, and contribute to an overall reduction in both the number if inpatient spells and the average length of stay.

If this model is to be effective, and if we are to manage more complex patients in the community, we will need to remodel the services that will enable us to support crisis at an earlier stage, working to mitigate the need for admission to inpatient settings. We will reflect on CTRs to inform a review of current provision including contributions of individuals, carers and families; and providers will be held to account to deliver on the outcomes of support or treatment plans. There will be a lower usage of beds but at a higher intensity, achieved by ‘topping up’ our contract with NELFT. These beds will come with acute, mental health, social care and emergency support as required. We will develop the market to ensure a greater range of services that support choice and control – personal assistants, more flexible use of personal budgets for people living in supported living schemes etc. Having the right skill mix of clinical and non-clinical staff (both in statutory services and within the provider market) to support this cohort of people, including managing crisis, will be vital.

We will need to have a respite (and short breaks) resource available for children and adults from across the BHR area to support individuals that develop increased short-term need but do not, necessarily, require assessment or treatment; or who are at risk of placement breakdown. The lack of respite/in-borough residential units is largely responsible for avoidable admissions to Moore Ward. So there will also need to be an increase in the provision of the right mix of accommodation and support options for looking after this cohort. We will, for instance, build on our success in co-developing new-build and service provision with individuals e.g. Greater Charter Close development in Havering. We will work with providers to develop flexible support packages to manage crises when the needs arise, in particular when individuals first come out of hospital and are at highest risk of crisis or readmission.

The service will also deliver a range of interventions and support including:

• Diagnostic assessment
• Behavioural Support
• Psychological Therapies
• Risk assessment and management
• Crisis and emergency planning
• Medication management
• Improving physical and mental health, and wellbeing
• Skills development
• Promotion of social inclusion

We will:

• Improve facilitating of ‘blue light’ CTRs and ensure we have options to support people in the community. Upon completion of a planned CTR we will ensure the recommendations identified are resourced to meet the timescale
• Review the service specification of the current ATU to include the offer of support to individuals in crisis in the community. We will also work with providers to develop ways of supporting individuals in crisis in the community: using a range of legal options such as DoLs or Community Treatment Orders
• Consider ways of developing accredited PBS support training and development of an NVQ in conjunction with local universities; and facilitate workshops to offer training to family carers
• Develop respite care options locally that prevent the need for an ATU admission where assessment and treatments are not required.

As part of the service redesign we will:
• Improve clarity for individuals, carers and families, as well as external partners, regarding the services and outcomes that are provided by specialist learning disability services.
• Assist individuals to make informed choices about the outcomes they would like to work towards, with input from specialist health staff.
• Help develop skills and capacity in the wider care system to effectively meet the needs of people with learning disabilities.

Taking effect from April 2016, this will build on two new operating models that have been developed in Redbridge jointly across Adult Social Services, Public Health, NELFT and the CCG. This will comprise an Integrated Health and Adult Social Care Service (HASS) and the HUB. The latter will provide the statutory and business delivery functions of the Directors of Adult Social Services and Public Health; and comprise: commissioning, public health, safeguarding, strategic planning, performance, systems and resources functions. The HASS will draw together staff and services from both the Local Authority and NELFT and will build on the existing Learning Disabilities and Mental Health Partnerships. It will include social workers, occupational therapists and support staff; services including day opportunities and extra care, memory clinic, palliative care, tissue viability, continence and nursing services.

We will improve tracking, risk management and admission avoidance:
• Close assessment of current inpatients to allow for as early as possible release
• Monitoring of potentially at risk individuals in the community with an all-age register – i including post-14 age group, those coming via health, social care, children and young people’s services and education; and those not eligible for transfer to adult services.
• An embedded community awareness programme of supporting people “at risk” with all commissioned services and providers
• Specialist support to reduce the risk of inappropriate hospital admission, breakdown of home support arrangements, contact with CJS or difficulty accessing mainstream services
• To have trained and supported individuals and carers on the “at risk register” to self-support to recognise their own triggers to crisis and coping mechanisms and reduce the immediate reliance of support from the authority.
• Creating a wider community awareness of support to people “at risk” and ensuring all commissioned services and providers support the copying and alerting strategies of service users.
• Develop an ‘action alliance’, building on the success of the Dementia Action Alliance and ‘Safer Places’ (autism) in Havering as a model for working with community leaders, communities businesses and so on, to increase awareness of people with learning disabilities including those with complex needs such as with this cohort.
• Strengthen and standardise the risk stratification process we use to identify people with LD
and/or autism who are potentially at risk of admission to hospital; and ensure that if people are becoming unwell further community support is put in place.

- We will standardise intake assessments into ATUs across BHR
- We will develop an all-ages strategy on behavioural support (PBS) to – get people out of ATUs, prevent them going in, advise families to prevent escalation, and support providers to avoid placement breakdown.
- A strategic oversight group appointed from across BHR TCP will review packages of care, identify patterns, tensions, resource issues, be a critical friend and challenge care and placement decisions where appropriate for this cohort.

To support the working of the Transforming Care Partnership we will recruit a specialist case manager, supported by a social worker, and a specialist team for crisis response/prevention as part of the new model described above. These changes will ensure that by year 2 we are able to manage Moore Ward inpatients in the community; and by year 3 provide intensive care packages with reskilling, CLDT and respite provision in place.

**What new services will you commission?**

There will be more joined-up commissioning of services, particularly specialist services, across the BHR footprint. There will be a scoping review of services to determine what new services we need to commission to meet the needs of this cohort and reduce reliance on inpatient and out-of-borough provision. Where the current provider base does not present a viable or sustainable option we will commission services in collaboration across the BHR area. We will aim to commission services from a range of specialist providers. New services will have a more defined service specification. This will mean:

- Redirecting investment towards supporting local community provision and enabling local schools to manage challenging behaviour; putting in place respite and short breaks, parenting support programmes, resilience building in schools and supporting them to retain children in local schools.

- LBH has a commissioning strategy in place to address the need for additional school places including for children and young people in this cohort. The strategy is also about supporting schools to develop improved capacity to deal with complex needs, including complex behaviours. For example, developing with schools Additionally Resourced Provision such as buildings for specialist provision which, in the longer term, will support a reduction in OOB placements. LBH is also developing new post-16 provision locally, which will open in September 2016 with a small number of students, but with plans to grow to supporting approximately 50 students within the first two years; and with integrated health and social care support on-site.

- In the first year, an additional nurse will be recruited to work closely with young inpatients helping develop care pathways and liaise with other agencies including Specialist Commissioning and CJS. They will ensure no discharges are delayed due to lack of adequate provision or because CTRs or reviews are not undertaken on time. They will monitor at risk patients and prevent unwarranted admissions by making sure the care needed is in place. We will also take on a social worker and administrator to support this work, build a new 7 unit scheme based on the model of the current flagship scheme at Great Charter Close, in LBH, which opened last year;
and build a 4-bed scheme in B&D. In the second year we will also recruit a quality assurance officer, extend CLDT team hours to cover week days 5-9pm and weekends 9am-9pm, and an ‘on call’ doctor 40 hours a week for an initial 6 month trial period.

- We will develop an outreach service that utilises the skills of the current inpatient hospital staff to work in the community with service users in crisis.

- There will be a particular focus as part of our scoping review on the development of respite options across BHR as an alternative to inpatient admission.

- We will commission more services through PBs, PHBs and DPs. We will also review the support (i.e. advocacy and brokerage) available for people in this cohort to help them make the best choices for themselves.

- We have identified a need to develop a service specification that meets the need of people that display challenging behaviour. It is recognised that there is a national and regional lack of providers with the expertise to develop bespoke packages of care, and to sustain support to people with challenging and complex needs. We are collaborating with neighbouring boroughs across North East London on preliminary work to develop a framework of expert providers to be in operation by April 2017. We will also support local providers to achieve PBS accreditation.

- We would like to micro-commission more complex, bespoke packages of care but the lack of appropriate tenancies has been an inhibiting factor. In many cases individuals with complex needs require their own bespoke living space. We are reviewing our current housing stock which, as with most London boroughs, is in short supply; and will develop new housing solutions that meet the needs of individuals without isolating them from the community. There will be a range of independent self-contained flats within close proximity of each other to ensure the level of support required can be utilised flexibly according to need. We will support and encourage services that provide imaginative supported living schemes with ‘life skills’ that allow clients to move on. We will also improve the accommodation offer, working with Mental Health Services, to support clients with learning disabilities and co-morbid personality disorder and forensic needs.

B&D are developing an Independent Living Strategy with Housing Services for people with learning disabilities and Autism. Commissioners have met with a number of developers willing to invest in housing specific to meeting the needs of people with a learning disability and/or autism. One such scheme would see a new build of 6-8 flats on church land. Havering too are working with Housing Services and the market to commission specialist supported living schemes (such as Great Charter Close) that are able to address more complex needs than is currently available in the borough over the next 3-5 years. As it is expensive to increase the provision and in order to develop a joint resource, we are exploring the option of pooling resources to create new provision on a number of sites which can be shared across the three Boroughs.

- We are also planning to increase awareness among the community of the needs of this cohort, including employment opportunities and access to key services. A recent initiative in Havering
has established a shop in the Mercury Shopping Centre designed for people with autism, which will provide a safe space as well as information and advice. This is something we will build on across BHR.

**What services will you stop commissioning, or commission less of?**

We are already actively reducing the number of inpatient usage days in our ATU. We have discharged the remaining 3 April 2013 cohort of patients into alternative long term provision that meets their on-going needs. There will be a reduction of ATU bed usage (in Goodmayes Hospital and NHSE inpatients via Specialist Commissioning) over the next 3 years as we develop more community-based support. We will commission less assessment and treatment within the hospital based ATU and offer assertive outreach support where appropriate. We will reduce the commissioning of OOB ATU, residential and supported living placements, and will repatriate individuals placed outside BHR unless they choose to remain or a clinical or legal decision makes it necessary that they stay. In order to allow for this shift in the way we provide care to this cohort, there will be changes to existing services, different commissioning arrangements will be put in place, and we will develop new services where there remain gaps in provision (see below).

**What existing services will change or operate in a different way?**

The commitment of the TCP is to develop services that support people to be as independent as possible, and to actively discourage long term provision that does not enable full realisation of potential for those receiving services. These changes will help to avoid unnecessary inpatient admissions and reduce length of stay. They will also allow us to scale back bed usage and numbers at the ATU in Goodmayes Hospital. We are currently looking at wide ranging changes across BHR to enhance and improve our community support and care experience, and provide the basis for a greater quality of life for individuals and families.

We are conscious of our reliance on family carers to provide vital support to people with learning disabilities, so we will be closely looking at the crisis and respite support we currently provide. This will entail a remodelling of current statutory services (including CLDTs and Mental Health Services) to ensure an improved response to crises and expanding the ‘blue light’ protocol. We will ensure that CLDTs are equipped to respond within the community by having learning disability nurses and social workers skilled in forensic work. We will also review as part of our workforce development plan our training offer across care settings, including to carers and families e.g. on Deprivation of Liberty Safeguards (DoLS) and PBS. We will seek to develop an outreach service that utilises the skills of the current inpatient hospital staff to work in the community with individuals in crisis.

We will engage stakeholders in the process of reviewing existing respite provision and extending access to it, as necessary, to meet people’s needs across BHR. Our ambition is to work with local providers to remodel their service offer to be able to work with those with higher and complex needs, enabling people to return to the borough where they wish to do so. In Havering, despite provision being used by other funding authorities, making the area a net importer of people with learning disabilities; it has a number of supported living schemes that do not provide the level of support needed for this cohort of patients, and that are often not of sufficient quality. Across the BHR area there is insufficient local accommodation for people in this cohort who have complex and specialist needs (including those with dual diagnosis of mental health/autism). Consequently some
individuals are placed out-of-borough away from family and local networks (other than through making a choice that they wish to live in another area). So the approach will be the same: to increase the availability of appropriate accommodation and support for this cohort of patients.

**Describe how areas will encourage the uptake of more personalised support packages**

Individuals have been using PBs and DPs for several years across BHR. Around 750 people currently use them. However PHBs are a newer addition with less than 20 people currently receiving them. Beyond personalisation of budgets and care planning, BHR is improving person centred care in a number of other ways. For instance, with the successful introduction of a hospital liaison nurse for people with learning disabilities and Autism, the participation of BHR in the Liaison and Diversion Scheme; and creation of HASS in Redbridge with the potential for development, with the ACO, across BHR. We will also make sure that all service provision, including housing and crisis care, are in place to meet people with learning disabilities’ and their families’ needs. There will, therefore, be an increasingly person-centred approach to both assessment and the delivery of care over the coming three years.

We will, nevertheless, greatly increase the uptake of PBs, PHBs and DPs across BHR too. Where PHBs are used we will make sure the right level of support and advice is given to accompany the payments; so the individual is always in the best position to make the right choices regarding the right care for themselves. We are currently developing a package of support for case managers to ensure each patient in receipt of a PHB gets a detailed care plan. The quality of care plans will be regularly reviewed by the PHB Panel. We will also develop formal mechanisms for delivering integrated personal budgets; and ensure there is sufficient advocacy and respite care available for this service user group across the BHR area.

CLDTs consist of a team of integrated professionals that carry out a range of assessments, reviews and support planning. At each stage individuals and their carers are encouraged to consider a model of support that is personalised and keeps them in control of their support plan. The CLDT works with providers to ensure that as individuals’ needs increase, all efforts are still to maintain, reduce or delay increased dependency. The CLDTs also work closely with commissioners to ensure tailor-made solutions are identified that are personalised to the individual.
The Continuing Healthcare Team (CHT) has undergone significant changes over the last few years and therefore the progress with PHBs has been affected. Nevertheless, the CCGs are committed to developing the take up of personal health budgets as well as the options to increase joint PHBs alongside PBs. The current local offer is clear and the CHC Team offer PHBs to all patients when they are notified of their eligibility for NHS Continuing Healthcare. Once an individual requests a PHB and are assessed as being eligible, a care plan is then developed (in partnership with the patient) and their budget is set. Individuals are informed of the ways in which they can manage their budget, e.g. direct payments, third party or notional payments, after which time their care plans are agreed and payments are set up. Risk assessments are carried out at a very early stage and potential risks are monitored throughout the process. Care Plans and budgets are regularly reviewed and individuals are able to contact their care-coordinator at any point. To date, uptake has been slow. However, over the last year the number of patients with PHBs across BHR has increased by 130%, and we expect there to be an increase across all cohorts over the next two to five years. The table below shows the number of individuals with personal health budgets as of January 2016.

<table>
<thead>
<tr>
<th>Borough</th>
<th>No. PHBs</th>
<th>Cohorts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Redbridge</td>
<td>1</td>
<td>CHC Adults</td>
</tr>
<tr>
<td>Barking &amp; Dagenham</td>
<td>8</td>
<td>CHC Adults &amp; transition from CHC Children</td>
</tr>
<tr>
<td>Havering</td>
<td>7</td>
<td>CHC Adults</td>
</tr>
</tbody>
</table>

The draft plans for development and expansion of PHBs set out the CCG’s improvement priorities over the upcoming years:

1. Further engagement with service users, partners and third sector organisations to identify where improvements can be made. This will be an ongoing process through development of
the PHBs
2. Development of literature for service users, carers, etc. to ensure individuals eligible for PHBs are well informed and empowered to take control of their care
3. Supporting young people with complex health needs transitioning to adulthood – offering personal health budgets to enable young people to develop packages of care to meet their needs
4. Expansion of the budget tool to include non-traditional care, or requirements not currently captured
5. Develop governance arrangements for PHBs for additional cohorts, ensuring appropriate representation on any panels/groups
6. Streamlined payment mechanisms ensuring that patients have a clearer understanding of their budgets and spend
7. Development of a support package for both staff and patients:
   a. Expansion of the brokerage team’s Directory of Services to include third sector offers, increasing support available to individuals
   b. Training programme for staff to include, for example, care planning, having difficult conversations and enabling self-care. Care co-ordinators will be able to successfully build collaborative partnerships with individuals and develop care plans through a person-centred approach
   c. PHB information pack for patients that have decided to take up the offer, ensuring they are able to make informed decisions
8. Development of capitated budgets to allow patients with long term conditions to take greater control over their care
9. Working with commissioning leads, contracting and finance colleagues and providers to identify mechanisms to increase flexibility and allow for a more personalised approach to care, e.g. the disaggregation of certain block contracts.

A small number of children are in receipt of a PHB in respect of a continuing healthcare package, and some children across the BHR local authorities are in receipt of either direct payments or personal budgets. Care packages for young people transferring from children to adult social services are allocated based on their needs as assessed through a transition assessment. Young people are offered the opportunity to receive their packages of support through commissioned services, personal budgets and / or a mix of both. However, no Resource Allocation System (RAS) is used to allocate an Indicative Budget. PBs are allocated based on costs of care packages agreed at panel. Take up of PBs is quite high, especially for school leavers. This is because they offer the opportunity to use services that are not commissioned by the local authority.

Discussions routinely take place with Housing Service to develop personalised housing solutions to meet assessed needs of individuals. The need for further work to be undertaken across BHR to review respite options available for younger people and those with complex needs has been identified. In B&D personalisation of services starts at an early stage in life. Their Parenting for Adults pathway (PfA) begins to address some of the expectations around personalisation. The PfA explains at which points key decisions need to be made and lists the stages various services become available, such as:

• Careers advice at the ages of 14, 16 and 18
• The Department of Work and Pensions Benefits advice from the age of 16.
• The availability of Adult Social Care Assessments from the age of 18.
The transfer to Adult Health Services at 18.

The PfA aims to raise aspirations and expectations for young people as they move into adulthood; and to increase their independence between the ages of 14 and 25. As young people move along the PfA their needs are increasingly seen as independent of their family. It ensures that everybody knows how to support young people to achieve positive life outcomes in the areas of, employment, maximising independent living, good health, friends, relationships and community participation. In some instances, it is explained, it is possible for elements of a PB to be paid directly to a family or young person as a DP, enabling them to directly purchase some of the services that are stipulated in their EHC plan. This could include transport, respite care, domiciliary care, and equipment. In many cases a young person’s view on how to spend DPs may differ from the views of their parents or carers. It is essential that wherever possible, young people between the ages of 14 and 18 are involved in the negotiation and management of PBs and DPs. From the age of 16 young people can apply for a PB and be in receipt of a DP independently of parents or carers.

The Council was an early adopter of PBs and a large proportion of adults arrange their own support packages using a direct payment. This includes some people with very complex needs who require support 24/7. The Council provides detailed information to people on what a PB is and how to manage it. The Borough’s Care & Support Hub encourages and supports individuals to take up, and where possible manage, their own personalised package of support. It includes a Personal Assistant (PA) finder. This allows individuals (and their carers) to have more independent access to support without the need for Council intervention. As at February 2016, Barking & Dagenham Council expects to spend £2.6m on daycare, homecare and direct payments for people with needs related to their learning disability, with 190 service users receiving a total of £2.46m in Direct Payments. (Figures gross, with expected £100k income from client contributions.)

In LBR the number of people with a PB or DP, as of January, 2016 was 237. The proportion of people with a learning disability receiving a funded service who were on a DP was 35%. In 2016/17 this is projected to increase to 276 and 36%, and by 2017/18, to 317 and 39%.

LBH is developing the market and increasing the number of personal assistants that enables people to buy in their support workers directly as this is currently underdeveloped. There are currently 202 people with learning disabilities who have taken up DPs, and 57 people for whom the Council manages their budget on their behalf and commissions community based services for them. In addition a number of people with learning disabilities in receipt of DPs buy their day opportunities from both our internal service and local external providers. There are also 12 people known to mental health services in receipt of DPs; with a further 25 people for whom the Council manages their budget on their behalf and commissions community based services for them.

What will care pathways look like?

Some of the children and young people’s pathways are already in place e.g. transition from children’s to adult’s social care (below), and for EHC and CHC assessment and planning. These are not, though, currently integrated. The CAMHS Plans include the development of a care pathway for vulnerable children and young people, including those in this cohort. This will be developed with NEFLT to ensure that these children receive prioritised access to services (within 4 weeks); and that the service or treatment is delivered by a professional with expertise in working with this group e.g. learning disability or CSA trained therapist.
There is ongoing work on the development and alignment of existing pathways across the BHR area. LBH, for instance, as part of its review of the S75 for Learning Disabilities (currently underway) is

Age 12-14 yrs
- Transition introduced, and explained.
- PLDLN emailed and informed. Meets with family.
- Transition easy read leaflet given.
- Questions answered, a chance to raise queries.
- Letter sent to GP explaining conversation has taken place.
- Treatment Plan completed.
- Hospital Passport completed.

Age 14-15 yrs
- Meet and greet with adult services, joint consultations with patient – physio / OT / Dieticians etc.
- Patient starts to take more responsibility, answers questions about self: Medications / allergies / medical history. Offered chance to stay overnight alone in hospital.
- Letter sent to GP of progress and timeframe.
- Questions and concerns answered.
- Transition easy-read leaflet given. (if applicable)

Age 16-18 yrs
- Cares continue on paediatric ward and with PLDLN.
- Taking responsibility for own cares: Medications / allergies / medical history etc
- Staying overnight alone on the ward.
- Now seen by adult services – physio / OT / Dieticians etc
- Contact and supporting referral letter sent from Paediatrician to lead clinician for adult services. A date of handover of care is confirmed.
- Cares continue with Paediatrician. Adult doctor invited to consultations.
- Letter sent to the GP detailing the Name of the Adult Speciality Clinician taking over and when handover will occur.

Age 18-19 yrs
- Cares now taken over onto Adult wards. Now seen in adult outpatients. Consultations with Adult doctor.
- At first consultation with Adult Clinician, Paediatrician is invited to attend.
- Liaison continues with PLDLN / LDLN

Age 19 yrs
- Cares handed over to LDLN.
reviewing care pathways, including those specific to this cohort of patients e.g. response to crisis. The new ‘Preparation for Adulthood’ services will be reviewing transition pathways to ensure this is as seamless as possible for children moving into adulthood. A learning disability admission care pathway is currently being updated (estimated completion April 2016). Dedicated therapy resources have been identified as part of the redesign to ensure appropriate clinical input is available to people who need admission to an ATU.

We will work with providers and other partners to design and develop robust, ‘Right care, Right place’ pathways – from discharge to community support, and also from the point of identification to preventative support. NELFT have developed a number of policies and pathways that boroughs use e.g. a transition policy (see below) and a learning disability assessment and management of Challenging Behaviour Pathway, and an Autism Diagnostic Pathway. A learning disability mainstreaming care pathway is under development. NELFT, the CLDTs and CCGs have arranged a TCP Joint Away Day on May 9th to discuss Challenging Behaviour Pathways.

How will people be fully supported to make the transition from children’s services to adult services?

In LBR between 28-48 of this cohort are transitioning to adulthood in each of the next three years. B&D have 48 children and young people with a learning disability and/or on the Autistic Spectrum Disorder and/or with Challenging Behaviour, on their transition list. In 2015/16, across the BHR area, seven young people (at least half of whom were previously ‘looked after’) aged 17/18 were transferred from children’s services to adult services. In 2016/17, eleven young people (of whom 7 were ‘looked after’) aged 16/17, were transferred. Thirteen of these young people were living in Barking and Dagenham, and one in Havering; the others out-of-borough. Twelve are recorded as having Aspergers Syndrome Disorder, three as having a learning disability and two as having Behavioural, Emotional or Social Difficulties (BESD).

There is good practice across BHR on supporting young people making the transition to adult services.

• We have a transition pathway in place for children using our hospital services (see above) and BHRUT has put in place a Treatment Plan for children with learning disabilities who are in transition from child to adult services.

• As part of the service development work undertaken to implement the Children and Families Act, B&D has launched a new, integrated team serving young people from 0 – 25 requiring Education, Health and Social Care Plans. In developing the service the borough has worked closely with Trinity School (for children with learning disabilities). In order to support the transition of young people to adulthood, this team incorporates two dedicated social workers. In an effort to further integrate services and eliminate the ‘cliff edge’ between services for children and adults, the Council is currently scopeing a disability service for people aged 0 – 55.

• LBH is setting up a ‘Preparation for Adulthood’ service to improve the way they support children moving into adulthood. The key focus of this service is to support young people with complex disabilities to access a range of services to assist with moving towards independent living and adulthood, including accessing further education and employment. Existing arrangements include a monthly Transition Monitoring Group, reviewing the health, social care and education
plans of those aged 14 to 25. This is led by Learning and Achievement within the Council, and Adult Social Care and CCG colleagues participate in the discussions; with providers including B&D College, Havering College and Prospects (who are commissioned to provide advice, information and support to young people and their families). Through this Group young people’s progress against their outcomes is tracked and informs planning for future care and support once they transition to adult services. Adult Social Care attends support planning reviews from the age of 17½. LBH also facilitates an EHCP Panel, which includes discussing CAMHS support where this is an assessed need within the EHC Plan. The 5-19 support team will work with schools if there is an indication of the need to refer to CAMHS and to support the sharing of information during, for example, review meetings. Information from the Panel is provided to the monthly Transition Monitoring Group, including costs and placements details, to support the planning of the future service provision as young people get closer to adulthood.

- In LBR the Transition Team is a joint children and adult’s team working across social care, education and health services. The work of the Transition Team is based on processes and practices defined in the Disabled Young People Transition Protocol. The protocol is a living document and any change to it is agreed and signed off by the Transition Steering Group. The Transition Team supports young people to plan for their transition from Children’s into Adult Services; from school into further education; and any care and support need they might have. Transition Assessments are carried out prior to an individuals’ 18th birthday. For those eligible for Adult Social Care, Transition Assessments and Care Plans are also presented to the relevant Adult Panel or decision-maker. The funding transfers to the appropriate adult team the week following a young person’s 18th birthday. The Transition Team continues to case manage, review and monitor young people’s needs and support until they are ‘settled’ and ready to be transferred to the relevant adult team. A package is considered settled when a clear transition plan is identified and implemented after young people have left school (usually when they are aged 18 – 19). Support with transition planning for school leavers is available from Outward Brokerage Service (commissioned by LBR Children’s Services).

However, despite support for young people transitioning from one set of services to another being well developed in each borough, it is not integrated across BHR to ensure there is seamless provision for those in this cohort wherever they live, or whichever services they use, across the geographical area. This is something we will address over the coming period with a view to sharing best practice and aligning processes across BHR.

**How will you commission services differently?**

In order to encourage a more person-centred approach we will ensure all contracting has provision for a core and flexible model. This way, individuals will experience more tailored provision, and will be able to commission their own choice of provider and service if they choose. This will mean developing micro-providers and capacity-building to ensure a wide range of quality services are available to choose from. The TCP will also identify the needs of this cohort and plan population and service level commissioning, rather than relying on individual purchasing of more expensive and often inappropriate residential provision. In order to minimise the number of OOB placements we will work as a partnership (including non-health and social care partners) to jointly fund placements, working with providers and landlords to develop services in our locality.

In B&D, for instance, meeting the housing needs of people with learning disabilities is a priority for
the LDPB and a part of its commissioning intentions. The borough is on a working group led by the Tizard Centre at Kent University, one of the world’s leading research and study centres on learning disability. The completion of a service specification, resulting from this joint work, will assist with commissioning providers to design services for people with challenging behaviour and achieve good outcomes for people with learning disabilities and autism. Sahara Homes, currently a residential facility, needs up-skilling and development, to provide the necessary support for this cohort and flexible options for potential residents. LBH will have a Joint Commissioning Plan agreed by the end of September 2016 (across adult’s and children’s services). Plans are currently being reviewed and will include a market development piece around expansion of the personal assistant market (currently underdeveloped); and increasing the number of people who have greater choice and control through integrated PBs and DPs. Increased in-borough specialist education provision to reduce reliance on out-of-borough education placements will also feature in the plan.

**How will your local estate/housing base need to change?**

We have a developing proposition around devolution and ACO. Until we have completed that work, it will be unclear what options there are for specifically linking future estates plans to the LD strategy and BHR TCP. However, the three CCGs across BHR do have an initial draft local Strategic Estates Plan in place that describes the health estate across the boroughs:

- articulates the commissioner’s vision for the estate, based on the Five Year Forward View (5YFV) and commissioning plans;
- assimilates core information about the current estate in the area;
- identifies the current and planned broad locations for the delivery of services in the area;
- outlines the opportunities that exist within the properties in the area to meet the requirement for the delivery of services; and

This will support new models of care planned for the system, including the new care model being developed for this cohort, using infrastructure as an enabler. More specifically plans for the NELFT estate include:

- A hub and spoke model of service delivery will be developed in each locality, the first one being the central hub development on the current Thorpe Coombe Hospital site (in Waltham Forest).
- There will be a programme of estates rationalisation working in partnership with other organisations to maximise the use of local health economy fixed assets
- There will be a maximum utilisation of freehold estate and less reliance on leased property- this will link in with the development of hubs in each locality, which, where possible will be developed on freehold estate, taking the opportunity to reduce reliance on expensive leased accommodation.

The provision of housing, rather than the health estate as such, though is critical to meeting the needs of people with learning disabilities and/or autism in the community, and avoiding OOB and inpatient admissions. B&D has committed to develop a vulnerable people’s housing strategy to shape future provision. There is considerable difficulty in finding suitable stock to provide supported living or step-down into independence. The borough will be transformed over the years to come,
with very significant new housing developments, but in the meantime will continue to source options for small supported living developments particularly by working with local community sector organisations who wish to develop their sites. Across the TCP, there is very limited social housing stock for this cohort; so we will work with providers to identify innovative solutions and suitable housing options e.g. utilising social housing bonds as LBR has with Golden Lane. It is anticipated that wider engagement with stakeholders and providers will help identify any further housing needs and can ensure these needs are included in housing strategies and commissioning plans.

Alongside service redesign (e.g. investing in prevention/early intervention/community services), transformation in some areas will involve ‘resettling’ people who have been in hospital for many years. What will this look like and how will it be managed?

We recognise, first of all, the need to develop and/or commission provision that can meet the needs of clients with complex needs and who have been an inpatient for a long period. We have used a number of approaches to reintroduce people back into the community. A common challenge is encouraging people to go out unsupported. We put in place support to increase their confidence going out, we provide travel training and help them with their budgeting skills. We will continue to do this, encouraging peer support and working closely with families, to increase their independence. LBR has only one person who has been an inpatient for a long period of time – on a Section for over 12 years. The specialist broker has been working with CLDT, the provider and family to assess the individual’s needs and has identified a suitable move-on service. In B&D there is a rolling programme of exploring repatriating people back to the borough through service user reviews. The borough works with patients in long stay hospitals with a view to discharging them nearer home, or family and friends, where appropriate. Some have actively chosen to remain in the community where they were placed having established new social networks and support. The borough’s approach to resettling people who have been in hospital for a many years has been to allow sufficient time for individuals to re-adjust and regain their confidence. In LBH, placements are reviewed annually, and options for repatriation are considered wherever possible; including where the individual has been an inpatient in an ATU for a significant length of time. Of the current cohort one has been an inpatient for more than 5 years, another for over 10 years. Through CTRs and regular monthly review visits, discussion is ongoing with each of the patients and their clinical team, as to the kind of accommodation and wrap around service they will require as their discharge is planned.

How does this transformation plan fit with other plans and models to form a collective system response?

Links are already in place between BHR, and being built on as part of the proposed creation of the ACO across the three boroughs. This new model will include:

- Community service and primary care teams, hospital specialists and local authority services will work together in a multi-disciplinary team serving populations of approximately 50,000 patients.
- Local General Practice will be the provider and coordinator of services for patients.
- Local general practice will focus on the proactive management of patients with complex care needs. They will be supported by the wider health care system to achieve this.
- Where patients with urgent but minor illness are unable to get an appointment with their GP, they will be treated on the same day at a local urgent care hub.
- In-hours same day access to ACP level hub arrangements, General Practice will be supported to
have longer, higher quality consultations with the most complex patients.

BHR System Resilience Group (SRG) also aims to create a simplified, streamlined urgent care system delivering intelligent, responsive urgent care for 750,000 residents in the most challenged health economy in the country. The SRG believes there is a need to do things differently and that patients are confused by the many and various urgent and emergency care services available to them – A&E, walk-in centre, urgent care centre, GPs, pharmacists, out of hours services.

Each borough has agreed a Crisis Care Concordat Action Plan and is progressing work to:

- Extend the hospital-based and CAMHS-based support for children and young people at high risk
- Review CAMHS outreach services to ensure children and young people identified as high risk are supported to remain out of ED

The CCGs actions, to be carried out by CLDTs, include:

- The development of registers of all people with a learning disability or autism in NHS funded care
- Maintenance of the register
- A comprehensive review of all placements for individuals identified as being resident within Assessment and Treatment units (ATU)

B&D will be the lead partner taking forwards the pathway and protocols of implementing the CTR process. This will include agreeing how ‘blue light’ and community CTR are facilitated. The work steam will be the vehicle for sharing outcomes of the CTR and ensuring that the BHR Partnership is able to plan and develop potential services for this cohort that are identified in the process. Over the next 4 months we will agree a protocol for sharing the “at risk register”. We will raise awareness of being “at risk” via the LDPB Provider, Carer and Service User Forums and Groups. The Challenging Behaviour, Crisis Concordat and Carers Strategy will each frame the implementation of supporting the “at risk” register.

Each borough has agreed a Children and Young People’s Mental Health and Wellbeing Transformation Plan. Our vision is that children and young people are empowered to be resilient and able to cope with the challenges of everyday life; with services that are flexible and integrated, responding to varying levels of need and responding well to the additional needs of vulnerable children and young people. We have committed to:

1. The development of a local model for Children and Young People (CYP) mental health services that meet the needs of all CYP in the three boroughs
2. Better support for CYP and their families who have emerging behaviour difficulties through the development of a local pre-specialist behaviour pathway
3. The development of an integrated health and justice pathway for young people to access the youth offending services

Each borough has agreed a Crisis Care Concordat action plan and is progressing work to:

4. Extend the hospital based and CAMHS based support for children and young people at high risk
5. Review CAMHS outreach services to ensure Children and Young People identified as high risk are supported to remain out of ED

The CAMHS Transformation Plans comprise one core offer across the BHR area. All three have
themes on building resilience, early and extra help focussed on supporting behavioural challenges, improving access to evidence based treatments for diagnosable mental health conditions, improved access to crisis support, supporting vulnerable children and young people and improving outcomes and participation. All of this will be delivered through Wellbeing Hubs (one in each CCG area). They include a range of workstreams and care pathways to be developed that will support children and young people in the cohorts of CYP defined in the Transforming Care Programme:

- Resilience building for all children and young people including those with learning disabilities and Autism and with Challenging Behaviour, supported by specific training for professionals.
- A specific work-stream and delivery group focussed on early and extra help with a focus on early intervention and effective support for behavioural difficulties, including support for children with learning disabilities and/or autism and their families (including parental support programmes).
- Vulnerable children and young people have been prioritised as a specific cohort and a work stream has been established to ensure they receive prioritised access to services; and are supported by trained professionals with expertise in that area of vulnerability. That includes children in this cohort. This is being led and progressed by a multi-disciplinary group and includes representatives from youth offending service, social care, education and adult services.
- Developing an Outcomes Framework including specific outcomes for vulnerable children, including those with learning disabilities and/or Autism and Challenging Behaviour.
- One of the key objectives of our plan is to focus upon strengthening services and support in the community and a commitment to explore new ways of delivering services working with the voluntary and community sector.

The TCP dovetails with the strategic direction of travel for LBH including:

- Health and Well-being Strategy – priorities include integrated support for people most at risk and improving the quality of services to ensure that long term health (and social care) outcomes are the best they can be.
- Havering’s market position statement – setting out our intentions around how we want to change our relationship with our market including prevention and managing demand, commissioning differently to facilitate better outcomes for residents, and improving working in partnership with a range of stakeholders, including residents and providers, including co-production as a default.
- Havering Better Care Fund plan – including a joint scheme specific to learning disabilities, with the key outcomes of people with learning disabilities and autism have access to safe appropriate services, are encouraged to lead healthy lifestyles (that reduce health inequalities), service promote wellbeing through encouraging citizen engagement, and that we review and design services via co-production
- Havering Children and Young People’s Mental Health Transformation Plan – with 5 key themes for specific development and investment – including building resilience and promoting prevention, establishing a Wellbeing Hub, maximising use of digital resources and promoting self-support, and importantly, reviewing and improving support for children, young people and their families with mild and emerging behaviour difficulties.

In LBR the Autism Plan has recently been refreshed and is out for consultation. Its priorities include:

- Improved involvement and engagement of people with ASD
- Addressing low hate crime reporting
- Helping adults/older people living unsupported in the community to access mainstream services including employment support
- Review take-up and impact of Autism Training in terms of making reasonable adjustments; and providing Care Act compliant needs assessments and reaching BAME Communities;
- Exploring transition, preventative and carers support needs
- Meeting information, advice and advocacy needs, including for people with complex needs
- End of life issues

B&D is implementing the strategic commitments made in **Addressing Behaviour that Challenges Services**, its Challenging Behaviour Plan. The key actions relating to this plan are:

- Developing local services that have the expertise to support behaviour that challenges.
- Developing services that offer service users and carers a respite during short term crisis.
- Working regionally to develop provisions that are feasible and sustainable across the neighbouring borough boundaries.
- Sharing good practice across the region and nationally.

The following actions have been achieved in the first phase of the Challenging Behaviour Plan:

- Improved integration with health and social care. Many service users that display behaviour that challenges often have a combination of health and social care support needs, joint assessments and joint funding solutions have been a successful outcome to meeting the needs of the service user.
- Raising awareness understanding, and knowledge of good practice in supporting service users that have challenging needs. This has included encouraging Providers through the Providers Forum to implement Positive Behaviour Support as a core training element of their induction programme for staff.
- Supporting Providers to implement the Safeguarding reporting and DoLS in a transparent, non-risk aversive approach that leads to service improvements.
- Reshaping the CLDT to include specialists in behaviour that challenges and ensure these specialists offer training and crisis intervention.
- Working with existing providers/specify in the supported living tender the need to move people who have attended day services for a long time and who wish to move on to find mainstream opportunities.

The next phase of the Challenging Behaviour Plan will take place over the next 5 years and has been captured in the LDPB delivery plan.

B&D are also implementing their Prevention and Independent Living Strategies. An ongoing challenge is the availability of housing which can be tailored to ensure that services for individuals with challenging behaviour can be delivered. This will include developing links with landlords and the Housing department. This will be incorporated into the Independent Living Strategy and monitored through the LDPB meetings.

The B&D Prevention Strategy is all about enabling social responsibility and encouraging residents to
do as much as they can for themselves. This means that individuals, with support where necessary
from communities and local networks, will be primarily responsible for making their own decisions
about their personal life choices; and for seeking the advice and information they need to achieve
the outcomes they desire. Individuals with the highest levels of need will continue to receive support
from statutory agencies such as the NHS and, for those who meet the national eligibility criteria,
from the local authority. Improved social responsibility relies on good community and individual
resilience, supported by an effective infrastructure and access to a range of appropriate, high quality
local services. This work has started with the development of community hubs and empowerment of
local people through better use of local assets such as children’s centres, libraries, leisure centres
and neighbourhood networks.

This Prevention Framework – prompted by the Care Act 2014, with its emphasis on local authorities
and the NHS, and other agencies, promoting people’s wellbeing and independence – acknowledges
that wellbeing is essentially personal and by no means the same for everyone. The impact of life
events may impact very differently on each individual and may influence their wellbeing. Some
communities and individuals may have greater or lesser resilience for sustaining wellbeing. Our
approach to prevention is therefore flexible, diverse, and responsive to individual need. The
prevention framework has three guiding principles - prevention is only effective when individuals
(Me), communities (Us) and public services (You) work together. This promotes the strengths-based
approach to assessing needs and supporting people that BHR will build on in Transforming Care.

LBR have a multi-agency Autism Working Group for Children which is developing a Child Autism
Strategy. LBH’s Market Position Statement sets out its commissioning approach and intentions. It
will deliver appropriate community based services at scale, including joint work between social care
providers and providers of clinical service and develop a robust local response to any emergencies.
Havering will access the investment needed to expand and improve at pace including potentially
through social investors. In addition it will explore the option of securing capital to deliver high
quality housing in community settings, including social investment solutions such as charity bond
issues. It will work alongside providers to mobilise new services and housing in the community and
with HEE, Skills for Health and Skills for Care; and support current inpatient staff to develop skills to
work in our community care programme. Inpatient provision will only be reduced when people are
supported to move in an appropriate and timely way to high quality services that meet their needs.

5. Delivery

What are the programmes of change/work streams needed to implement this plan?

We have drawn up a programme of work (see below) for implementation, and a cross-sector alliance
of organisations is already committed to support BHR TCP to deliver on our ambitious agenda. We
need to fully identify the team but the Working Group and Shadow Board are in place, and we have
a framework of workstreams (see below) upon which the operational delivery of the local
programme can proceed. Our workforce development plan is underway and we are currently
conducting workforce analysis (see below). We are also developing our Estates Plan to be finalised in
2016/17 – as discussed above.

Communications and Engagement Plan

It is our aim to transform care and develop community services for people of all ages with learning
disabilities and/or autism across BHR, by involving stakeholders in developing the local TCP Plan, and
shaping, commissioning and implementing new service provision. To achieve this we have been engaging a range of stakeholders to ensure it includes insight from individuals, family carers as well as organisations and our partners who work to support individuals. Engagement with these groups will continue as we begin implementing the three year plan from April 2016.

**Aims and objectives**
- To engage key stakeholders in the development of the TCP Plan
- To raise awareness among key stakeholders of our ambitions and plans to improve the service
- To engage stakeholders in developing and coproducing the new service provision
- To raise awareness of the new service provision and how it is improving the lives of those with learning disabilities and/or autism.

**Stakeholders**
A number of key stakeholder groups have been identified who we will engage and communicate with throughout the development and implementation of the TCP Plan.

<table>
<thead>
<tr>
<th>Stakeholder group</th>
<th>Key stakeholders</th>
<th>Communications and engagement methods</th>
</tr>
</thead>
</table>
| Individuals, family carers, patient/carer groups | Individuals with experience of lived-in care (experts by experience)  
Individuals who live in the community  
Families of individuals                   | One-to-one sessions  
Small focus groups  
Easy read materials  
Workshops  
Attend group sessions                      |
| Interest groups and voluntary sector     | Learning Disabilities Partnership Boards (LDPB)  
Borough Forums  
Patient Engagement Forums  
Healthwatch  
Community and Voluntary Sector (CVS)     | Presentations at meetings  
Email briefings / communications  
Workshop  
Social media                               |
| NHS and Local Authorities                | Local Authority Health and Wellbeing boards  
Mental Health Partnership boards  
Autism Partnership Boards  
Local Safeguarding Boards  
GPs and clinicians  
CCG and Local Authority staff  
Police                                     | Presentations and updates at meetings  
Email briefings  
Workshops  
Intranet  
Newsletters                              |
<table>
<thead>
<tr>
<th>Councillors and MPs</th>
<th>Health Scrutiny Committee members</th>
<th>Presentations and updates at meetings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cabinet Member for Health, Adults and Children</td>
<td>Face-to-face briefing (MPs)</td>
</tr>
<tr>
<td></td>
<td>Local MPs</td>
<td>Email briefing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Workshop</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Social media</td>
</tr>
<tr>
<td>General public</td>
<td>Media</td>
<td>Using Council and CCG communications channels:</td>
</tr>
<tr>
<td></td>
<td>Local residents</td>
<td>Websites</td>
</tr>
<tr>
<td></td>
<td>Parents</td>
<td>Newsletters / publications</td>
</tr>
<tr>
<td></td>
<td>Carers</td>
<td>Media releases</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Social media</td>
</tr>
</tbody>
</table>

**Strategy**

Engagement and communications will be delivered in two phases. The first phase involved engaging stakeholders in shaping the TCP Plan. Once the plan is finalised the second phase of engagement will begin and we will continue to work with our stakeholders to shape the new service provision, and raise awareness of our ambition and plan to improve services. As the new services provision is implemented we will also raise awareness of the impact it is having on those with learning disabilities and/or autism in BHR.

**Phase one**

To involve individuals in the development of our plan we commissioned the National Development Team for Inclusion (NDTI) to deliver targeted engagement. One-to-one sessions were held with inpatients and former inpatients now living in the community.

We also worked with a number of pre-existing boards and groups formed by the local authority, NHS and voluntary sector, as the basis of our engagement with our providers and partners; to gain feedback and to provide strategic insight to ensure our plan fits with the wider social care and health economy across the area.

Our engagement in this phase culminated with an all-stakeholder workshop where we discussed our TCP vision and gained feedback from attendees, which we used to finalise the strategy.

**Phase two**

Having established networks and relationships with our target stakeholders we will continue to engage with them as we implement the plan and develop the service specifications. Through regular communications and meaningful engagement we will continue to build positive relationships, and work with them throughout the course of the strategy to ensure it meets local need. As well as engagement, we will use existing Council, CCG and provider communications channels, as well as those of our partners, to raise awareness amongst our stakeholders and the public of the TCP Plan and new service provision as it is implemented across BHR.

**Key messages**
• Help us shape services for people with learning disabilities and/or autism in BHR
• We are improving services for people with learning disabilities and/or autism in BHR
• We are improving care and helping people live more independent lives

Implementation

<table>
<thead>
<tr>
<th>Audience</th>
<th>Action</th>
<th>Key message</th>
</tr>
</thead>
</table>
| Councillors, Local Authority officers | Presentation to each borough:  
  • Health & Wellbeing Board  
  • Safeguarding Adults Board  
  • Local Safeguarding Children’s Board  
  • Stakeholder event  
  • Workshops/meetings with Cabinet Member and Local Authority Directors  
  • Health Scrutiny Committee | We are improving services  
Help us shape our services  
Tell us how we can improve |
| Partners | Presentation and regular updates to each borough:  
  • Learning Disabilities Partnership Board  
  • Autism Partnership Board  
  • Mental Health Partnership Board  
  Stakeholder event | We are improving services  
Help us shape our services  
Tell us how we can improve |
| Individuals (inpatient and community-based) and family/carers | 1-1 sessions with individuals  
Small focus groups  
Stakeholder event | |
| Voluntary and Community Groups | Stakeholder event | |
| Carers’ groups | Stakeholder event | |

A detailed engagement and communications plan will be developed to deliver targeted communications with our stakeholders as the new model of care is developed and new service provision is implemented. This plan will focus on communicating and engaging on the detail of the service improvements, showcasing the new model of care, good news stories, and clear, concise information on the impact of the new service provision on individuals.

Monitoring and evaluation

We will measure the engagement and communications through:  
• Number of stakeholders engaged with  
• Attendance at stakeholder workshops  
• Feedback from partners and councillors
- Number of visits to webpages about the plan
- Social media engagement

When we move into phase two and deliver communications to the public, we will also monitor media coverage.

**Who is leading the delivery of each of these programmes, and what is the supporting team.**

The BHR TCP workstreams (and leads) are as follows:

- Empowering People and Families (Barbara Nicholls, LBR)
- Right Care, Right Place (Karel Stevens-Lee, LBB&D)
- Insight Programme and Quality Assurance (Sue Elliott, BHR CCGs)
- Workforce Transformation (CEPN)
- Right Care Programme Data and Information (LBR / RCCG)
- Transition Special Educational Needs and Development (Sue Elliott, BHR CCGs)
- Finance and Estates (Rob Adcock, B&D CCG)
- Implementation and Risks Management (Christine Kane, BHR CCGs)

We will continue develop the Transforming Care Partnership Project Team and governance processes. This will include signed-up Terms of Reference, secondment of resources to the Transforming Care Partnership, and robust governance and reporting to the Programme Board. There will be a full time Programme Manager and Project Leads from each of the organisations are already identified above. Each organisation will delegate responsibilities to other members of staff to report up through the governance process. In this way we will ensure a smooth transition from existing services to the Transforming Care Programme and full integration across the Barking and Dagenham, Havering and Redbridge area.

**What are the key milestones – including milestones for when particular services will open/close?**

The plan includes tasks and activities to define each workstream going forward:

Empowering People and Families
TCP has held stakeholder workshops and will continue to conduct sessions with people with lived-experience (see above).

Right Care, Right Place
Workshops were held across the BHR economy to map out local Borough CTR processes to support patients with LD/Autism in the community, and to understand trigger points for patients being admitted to ATU. This included a workshop at Moore Ward (NELFT) which was attended by NHS England, Moore Ward Manager and NELFT Psychiatrist. The step-down process from Specialised
Commissioning is currently being mapped. The next steps are to strengthen CTR processes to include education, LAC and CYP. The mapping process has identified a number of different data sources across Health and Social Care which identify patients at risk. This includes GP patient lists, data uploaded to HSCIC and local spreadsheets. A key task in the delivery plan is to identify a mechanism to consolidate and share this information across BHR, to ensure that all parties know exactly who is at risk, and that there is one mechanism to ensure that these patients are monitored using a standardised Risk Stratification Process.

Insight Programme and Quality Assurance
The Insight Programme and Quality Assurance workstream has begun to identify Key Performance Indicators to ensure a measurable improvement in life chances for individuals with learning disabilities and/or autism. KPIs will be fully developed during May 2016. Initial measures are described above. The plan includes tasks to develop a pathway for learning from incidents to embedding practice change, by defining a reporting system to report and investigate incidents. Root Cause Analysis will be carried out on all admissions to ATU.

Workforce Transformation Workstream
The case for change will mean reviewing the skill sets and numbers of our workforce who support people with a learning disability and/or autism: including those, currently working in an inpatient facility in need of retraining prior to being relocated to a community setting. Detailed workforce data has been received from all three boroughs, identifying the existing skill mix and costs for Local Authority and NELFT management of this cohort and resources specifically assigned to CLDTs. Initial analysis of the make-up of the CLDT Teams shows, for instance, that Havering (NELFT) CLDT team has a high number of clinicians across different specialities:

- Challenging Behaviour (1 WTE)
- Psychology (1.5 WTE)
- Speech and Language (1.5 WTE)
- Psychiatry (1 WTE)
- Physiotherapy (1 WTE)
- LD Nurse (4 WTE)
- Community Therapy (2.1 WTE) – includes an Art Therapist

Havering has the lowest cost of inpatients at Moore Ward and out-of-borough, which may be due to this high investment in resources to support individuals with learning disabilities and/or autism in the community. By comparison, Redbridge (NELFT) has:

- 5.7 WTE Nurses
- Occupational Therapists
- 2.5 Physiotherapists
- 1.2 Speech Therapists

Redbridge does not currently employ a challenging behaviour specialist, or provide psychology or psychiatric services. Barking and Dagenham has:

- 2 Occupational Therapists
- 1 Physiotherapist
- 2 Community Nurses
- 1 LD Practitioner
- Speech and Language Therapist
The TCP is collating a complete list of services, and the next steps will be to devise a new workforce model starting in June 2016. Workforce transformation tasks will include the development of personalised care support and treatment approaches through holistic assessments and non-aversive treatment strategies.

**Right Care Programme Data and Information**

The Right Care Programme Data and Information workstream will define the data required to inform TCP; and will devise a Standard Operating Procedure for reporting patient status. This work is due to commence in April/May 2016.

**Transition Special Educational Needs and Development**

The Transition SEND workstream tasks will map local care pathways by TCP cohort and need, and develop multi-agency assessments linked to CHC and Annual Reviews. This workstream will develop a universal & preventative local offer on building and preparing for adulthood, and review services for crisis support and respite. Further development of the capacity of CAMHS will be linked to the workforce transformation plan.

**Finance and Estates**

We are currently developing our Estates Plan and it will be finalised in 2016/17 (see above).

**What are the risks, assumptions, issues and dependencies?**

There are currently 23 risks on the register. These, and the mitigations we have in place, are detailed in the TCP Issues and Risk Report:

![TCP Issues and Risk Report 290316.pdf](tcp_issues_and_risk_report_290316.pdf)

**What risk mitigations do you have in place**

See above

**6. Finances**

Please complete the activity and finance template to set this out (attached as an annex).

**End of planning template**
Appendix 1: Transforming Care Workshop, Redbridge Central Library on 30 March 2016

VISION

Individuals, their carers and families, service providers and others were invited to take part in a Transforming Care Workshop to help us develop the vision underpinning our plan. John Powell Vice-chair of the BHR TCP Partnership explained to those present that ‘the dialogue will continue’.

1. **Provide support in least restrictive way**
   - Additional package arranged by hospital that can be accessed by family and friends
   - Communication to be strengthened regarding any key workers, health action plans that can be accessed for example by schools and HE
   - Staff training/expertise in BTC will support services/care to be delivered in least restrictive way – supporting them at their worst is where we should focus.
   - De-escalation techniques
   - Techniques and de-escalation techniques for parents/carers – training
   - Admission avoidance
   - Strengthened out of hours crisis care
   - How we support transient population eg students and re-registering
   - Staff trained in how to communication effectively to elicit response
   - Include voice of child especially transition

2. **Have good respite that supports families**
   - Continued investment especially in children’s services respite/short breaks
   - Links to commissioning intentions from 14
   - 2 types of respite: a) for child/YP/adult
   - b) for carer/parents
   - Means testing under Care Act is limiting access to respite for carers/parents
   - How do we consider effect of means testing to access respite/short breaks?
   - Expediency of getting respite package in place
   - Strengthen inclusivity in mainstream rather than just acute respite
   - Shared lives
   - Living ‘ordinary lives’ like that of any other family eg holidays
   - Why does it need to separate families to ‘achieve respite’? most families will come together
   - How does system ‘enable’ not ‘disable’?

3. **Have inpatient care as near to home as possible**
   - SPG Level Tier 4 commissioning – BHRCCGs & LAs
   - Support for BTC in supported living – limited/no local provision/support
   - Awareness raising – eg GPs, school nurse, teachers re MH-autism/BTC
   - Too much focus on parenting; makes it more difficult to get issues identified correctly.
• Better training/expertise to recognise/identify indicators underlying BTC and underlying conditions
• Transient staff is an issue in identifying needs
• Transition tracking needs to start at 14 years of age
• Develop ‘long list’ of those not meeting criteria for adult services who are actually likely to be more at risk
• Life course approach from Early Bird programmes potentially – how does all of this translate into commissioning intentions?
• Additional services required (Darren Q)
• Befriending parents
• Parent support group (currently not resourced)
• Build on what support is already in place (funded and unfunded)
• See plan before 8th April
• Meaningful input
• Further detailed input/engagement
• Action plan to consult on; How we do IT
• Publish on websites – LA/CCG/BHRuT/NELFT/Vol organisation; have feedback button
• Survey monkey out to ALLS; Link to plan (accessible); suitable to audience – pictures not words
• Reasonable adjustments: example of waiting 35 mins to see GP

4. Keep trying to reduce health inequalities

5. Make good use of community provision

• Respite:
  - weekend provision more
  - Booked so far in advance
  - Share facilities BHR wide
  - Provider facility
  - Accessible community
  - Audits for individuals
  - Training
  - Use resources that want to be involved

• Capacity
  - services
  - space
  - suitability

• Ensure quality of services
  - PBS training
  - Meet individual needs

• Current services expected to do more in same provision. Impacts on quality outcomes
• Better 1:1 care when needed
6. **Ensure people have choice and control over their health services**

**Choice and control:**
- Checks – money used for that individual
- Clear outlines for what it is for
- Menu of services to guide and support: expertise, quality
- Direct Access Methods: Accounting, support JLA (B&D)
- Access to more mainstream services
- Availability
- Cost of services – budget has to be realistic to private costs, not to our budgets
- Facilitate the process; brokerage, advice and guidance
- Q: could register with LD expert GPs rather than current postcode lottery

7. **Early Identification of needs and support**

**Children needs – transition**
- Treatment plans (BHRuT)

- **Raising awareness in schools**
  - Mainstream
  - Special needs
  - Support for individuals
  - Diagnosis earlier
  - Transition Team in Redbridge working well (E&H Care Plan)
  - Schools to support – What does adult services need to offer individual
  - Some doing well/others not so well
  - PBS at a Young Age – prevention
  - Guidance/support/process for those with complex needs/challenging behaviour/family and staff training

- **MAP process**
  - communication tools
  - Full Access to history

8. **People have access to information, advice and advocacy**

- Autism HUB (Romford) – successful : satellite to other areas
- Advocacy
- HUB/groups
- Health Drop Ins
- Website/Leaflets

- **Council to produce list of individuals**
  - A4 sheet – issue with updating
- Social Services to distribute
- Website – guided by A4 sheet
- Cover all needs/LD/autism/MH/physical disabilities
- Equipment and support in various locations

- **Support to research**
  - Find services

- **Information to GPs on health pathways**
  - Autism
  - Easy read/accessible – BHruT example
  - Alerts to clinical staff to give them info and support (BHruT)

There was ongoing and broad discussion about the challenges this cohort face and how we might work better together to address them – e.g. we should share facilities BHR-wide to meet individuals needs such as with Challenging Behaviour. We should promote better access to supermarkets and cinemas and provide training. We need to improve capacity and have the right services in right places, supported by brokerage able to choose from a menu of services including access to mainstream services. We need more 1-to-1 support, for instance, and there needs to be resourcing of community providers to do more specialist work. The Havering Autism Hub, based in Romford and run by the Sycamore Trust, should be built on with satellite sites in different areas (with information, equipment and support).

**Respite**

- There are two types of respite: for the child and for the carer. Respite is being shifted to the Carer Assessment. It’s a double whammy. Parent/carers are being means tested [in B&D, not in Havering] and refusing to be financially assessed. Many are not entitled to any provision. Services won’t cope with carers.
- It’s taken nearly 3 months to get just 5 hours of respite per week. No respite holidays are available. Why is respite only used to separate a family and not to enable them to spend quality time together?
- Why am I being means tested for respite for myself as a parent and carer of a child with learning disabilities? It means I will not accept the service and have to struggle on without it.
- We’d like to be a family unit again. I don’t think it will happen again until we have some separation from her.
- Respite doesn’t include family holidays – we could use funds for activities etc. Family cruises are brilliant. They’re totally safe and they can’t get away. Surely you want an integrated family?
- There is not enough respite provision at weekends and key dates such as Easter or holiday periods.

**Staff Training and Mainstream Services**
• A representative from NDTI talked about the importance of building expertise and confidence in young people in using mainstream services (especially schools) so that they are able to manage Challenging Behaviour.

• Commissioners [says a carer / volunteer] need to build resilience and confidence-building, and an approach that reduces individuals' isolation, into services.

• It is too black and white. They’re either disabled in a disabled system or in a mainstream system without support. There doesn’t seem to be any grey area.

• Diagnosis needs to be earlier – educate clinical staff.

• People are still not getting diagnosed until their teens or beyond.

• Raise awareness in schools.

• Schools hold a lot of history on children – this is important for transition.

• GPs and other health professionals need more training on identifying and dealing with learning disabilities.

• The school nurse told her [his mother] that she was not a bad parent as the GP had told her [he has Autism]. It is important to raise awareness particularly with GPs.

• There needs to be better understanding and training for key professionals across all local services in particular health and education.

• Health and care plans need to link more closely with schools and teachers need PBS training as do staff in non-secure residential placement settings.

• Provision needs to be in place to support my child at her worst as carers are not trained properly to deal with her abusive and violent behaviour.

• She doesn’t see herself as disabled and yet she can’t function in mainstream without support.

• My son doesn’t want to mix with disabled kids – he wants mainstream.

• We’re told ‘you’ll benefit from parenting classes’. We are the first to be blamed for everything.

• It shouldn’t be us providing support [another carer/volunteer] … but there needs to be funding for parents groups like Face 2 Face who have the experience to support parents in similar situations. Additional funding of such groups would allow more support to other parents. It would also allow them to spend more time talking to health professionals and schools to educate them on dealing with people with learning disabilities from people with real life experience.

• Often parents with a child with a learning disability feel like they are bad parents and they are doing something wrong, but they are not. It is the system that needs to adapt to their needs and not the other way around. They would benefit from help and support of others with this lived experience.

• There needs to be constant support e.g. university following a Section [of her daughter’s friend] gave her no support. Friends cleaned up the blood of her suicide attempt. Her daughter knew what ward she had been on. Students have to re-register and go back on waiting lists when they’re at home. There is no continuity of care.

• It is about communicating appropriately – we [people with Autism] can have difficulty with communicating. I remember at school meeting to assess my needs I was asked can I use the bus. I said yes. What I didn’t say was that I was not travel trained. I am glad my mum was there. As we become adults they say ‘shut up parent’. But they are almost like our lawyer, fighting our corner since we were a little kid. Empowerment is great but if my mum hadn’t been in that meeting that would have really screwed up my support.
Case study

My daughter has Asperger’s Syndrome and we are currently falling between gaps in service provision. The CLDT team say she is brighter than average and hasn’t got a learning disability. But the mental health team tell us it’s not a mental health issue as she has a form of Autism. So she doesn’t get the psychological or befriending support that she needs. We are fighting against her ending up in prison or a mortuary. That other stuff about our hopes and dreams for her and all of that amazing potential she has is irrelevant without that support. There is nothing in the area that will support people with Challenging Behaviour in a Supported Living setting. We see a new person every 6 months to carry out an assessment. Support is not about numbers [3 or 4 to 1] but about being consistently and appropriately robust and effective. Getting staff to do, asking relatively inexperienced staff to deal with frightening behaviour, is really complex. It is about staff training and management, and keeping them motivated. Her Supported Living placement crumbled to nothing. It couldn’t support her at her worst. She sits at home on the sofa all day doing nothing. My eldest daughter has moved out. Everything can become catastrophic if she’s not supported at her worst. Challenging Behaviour makes everything fall apart. She can be verbally abusive including using racist words. Train your staff not to take offence. Teach them de-escalation techniques and how to do an emergency drill with her. What part of her Care Plan is ringing the police? It’s about knowing what her triggers are. They don’t know us and all they do is fill out some forms and tick some boxes and we never see them again. There is no continuity of care personnel. My daughter wasn’t diagnosed until she was 13.
Appendix 2: NDTI-facilitated engagement with in-patients, those now living in the community and their families

This piece of work involved speaking to a number of providers over the phone and in person to learn from their experiences of supporting individuals in community placements, both successfully and otherwise. It involved meeting several people with learning disabilities being supported in the community, as well as people who are currently in-patient on Moore Ward in Goodmayes Hospital. The work also included speaking to several carers in order to gain family perspective. We asked them - What has worked well? What didn’t work out? What would improve matters for the individuals concerned? How the various agencies involved can work together more effectively?

The report included a number of observations:

- The community support package for people who are a danger to themselves and others needs to be carefully planned for the person to feel secure and confident in their staff, and also to get the backing of families who often have a history of disappointments (and worse) in regard to the services provided. Good clear communication across the board is essential.
- Make the best use of the specialist knowledge that Moore Ward can contribute to the Discharge Plans i.e. regarding what the support package consists of.
- The Commissioners should draw on the expertise of those local organisations that have successfully taken on potentially difficult people when looking to widen the pool of provider sources.
- Look closely at how each person processes information and events, understands what is happening, and how they respond. If you can talk with the person, make sure that you go at their pace and use simple, clear words and instructions. Don’t overload people with too much information.
- Make sure that when you present a potential option for community support it has been properly thought through, so that you don’t then turn round to the person and their family and say that it isn’t going to be suitable or affordable.
- Sometimes, the person’s mental ill health dominates their life and they do need specialist care and treatment. At other times, their learning disability is the bigger factor which may impact on their ability to keep themselves safe and well.
- This group of people is totally varied in terms of how they live their lives day to day. They are different in regard to what sort of routines are of benefit or interest, and in how they respond to anything new and different. So the type of support that they each need must vary according to their personalities and needs in order to continue to be successful.
- There are good examples of where services have been developed around and with the person (sometimes with the full participation of their family). A strong staff team has been established that connects well to the individual (sometimes after initial “teething troubles”). The provider shows that they can adapt their support approach, learning from actual experience with the service user, rather than relying on historical reports.
- When they are well, it is important for individuals to do local activities (including work opportunities) that enable them to access the wider community, and build up their self confidence.
• Some people find it hard to take responsibility for their own situations. Support services then have to focus on keeping these service users and others around them safe.
• BHR need to identify local providers with a proven track record.

It also included recommendations for action to support the continued contribution of people with learning disabilities and family members to put the TCP plan into practice during 2016/2017:

• The BHR Transforming Care Plan needs to fully reflect the information collated on the care and support of people it currently provides services for (an approximate number of 16 adults has been given) with short term and longer term goals.
• This information needs to be regularly updated at a known reference point. (Some of the contact information I was given was not clearly defined).
• It also needs to take account of the number of children and young people coming up through transition who will expand the local risk of admission.
• A useful resource in this area with examples of effective local services is: http://pavingtheway.works/ “Early intervention for children with learning disabilities whose behaviours challenge”
• Measures need to be put in place to ensure that there is good, clear communication between all the local organisations involved in providing specialist care and support, and crisis intervention to the individuals concerned.
• It is important that the results of their mutual exchanges are made available and are accessible to the individual and their families wherever possible.
• The contacts made during this piece of work underline the view that when the support provider’s approach is geared to the individual (e.g. in a single service package) there is a better chance of success.
• With this approach the person receives a consistency of staffing, a daily structure that means they know what to expect and a stimulating range of activities that offers progression on their own individual terms.
• The BHR Transforming Care Partnership (TCP) should continue to work on sharing the learning from the experiences of local providers (in-patient and Supported Living in the community).
• It should explore the further involvement of the Shared Lives approach for individuals within this group of people who are at risk of re-hospitalisation.
• Drawing on the positive examples in other localities, the TCP should ensure that the voices of people with learning disabilities and family carers continue to be heard during the work of the Transforming Care Board so that the Board’s Plan can be scrutinised and publicly held to account.
Appendix 3: Moore Ward Briefing 22 March 2016

Attendees: Finola Syron (NHSE), Amelia Howard (NHSE), Gordon Mutuvi (NELFT), Ian Milne (NELFT Moore Ward Manager), Sean Gravestock (NELFT Psychiatrist), Christine Kane (BHR CCGs)

Routine Admission Process:

Admission to Moore Ward requires the following:

1. CLDT Care Coordinator who sponsors the admission sends a pre-admission request to Moore Ward.
2. NELFT perform an eligibility step back to the CLDT
3. NELFT has a threshold for admission, which includes needs assessment, legal framework, mental capacity and whether funding is in place
4. A routine admission typically takes up to 2 weeks.
5. A pre-admission CTR is not standard practice at Moore Ward, i.e., not an established process across the patch, and is dependent on local variations/appetite for CLDT involvement/Psychiatrist on duty.
6. A pre-admission assessment proforma is completed from the following steps/sources of information:
   i. Meeting with the patient and family/carers
   ii. Clinical assessment
   iii. Requires a health action plan
   iv. Hospital passport
   v. GP history
7. Admission is only agreed if the CLDT provides an outcome of admission – what treatment is expected for this patient and an anticipated timeline of length of stay, based on CTR.

Emergency Admission

1. Sean and Ian said that emergency admissions typically occur when a patient is not optimally managed in the community.
2. An emergency admission may bypass the steps above, with patients sectioned and then admitted without following the routine admission steps.
3. An example was a patient living at home had to be moved to residential care as the mother had a TIA. The patient had been taken in by the grandparents, but proved too challenging for them, and, following several attendances at A&E over a couple of days was sectioned and taken to Moore Ward by the Grandparents.

Reasons for not admitting to Moore Ward:

1. The Sponsoring CLDT has not provided a clear pathway to discharge from Moore Ward – Moore Ward will not accept a patient who does not have a clear treatment need and an anticipated timeline for length of stay
2. Where there is no need for treatment
3. Where a patient does not want to be admitted
4. Where a patient’s challenging behaviours would risk other patients. In these cases, some alternatives are:
   i. St Andrews, which is a private specialist Autism unit
   ii. John Howard, which is a locked rehabilitation unit
   iii. Cambian
5. Approximately 25% of admission requests are declined by Moore Ward.

Discharge Planning

1. There is currently no formal pre-discharge CPN or CTR (GAP)
2. The discharge steps are:
   i. Outcome of admission is achieved
   ii. There is a vision of where the patient belongs after Moore Ward and local authorities and/or healthcare have provisioned for this
   iii. An OT placement profile is performed to assess the patient’s needs. This is mapped to the Environment, the patient’s care needs and clinical risks
3. It was noted at the meeting that CPA reviews are performed every 6 weeks, but the CLDTs do not always attend.
4. For short admissions, a CPA is carried out within 6 weeks
5. For longer admissions, the CPA is carried out at 3 months.
6. It is noted that patients often remain in Moore Ward beyond their planned discharge dates due to lack of involvement/engagement from CLDTs and lack of planning for placement following discharge.
7. Sean stated that there would be additional capacity (2-3 months/long stay patient) if discharge planning was started pre-admission, and CLDTs remained engaged with the process.

Gaps:

• Patients with mild LD (MLD) (categorised as IQ 50-70) and social vulnerable may not be known to CLDT.
• High functioning Asperger’s patients with challenging behaviours may also not be known to CLDT.
• CLDT Risk Registers are not available to Moore Ward and/or not integrated between the 3 CCGs.
• There is a lack of capacity for SALT for Moore Ward patients
• There is no agreed pathway for patients with challenging behaviours. NELFT has a draft pathway and this is reviewed at monthly meetings, but has not been agreed.

Good Practice:

• LB Waltham Forest has a very good challenging behaviours model
• LB Havering has a good triage model for challenging behaviours
• LBBD has a good CPA

Suggestions for TCP
NELFT offers outreach services from external providers, such as Spencer and Arlington, which is not often taken up.

Moore Ward can take patients from Tower Hamlets, Waltham Forest, City and Hackney and Newham. Makes sense to contact them to see what their good practices are.

More training on dealing with challenging behaviours is needed for families of LD patients at home – positive behavioural support.

The meeting highlighted that there are many assessment tools and that different aspects of assessment are done at different times and are challenged by capacity in these services (for example, psychiatric assessment at NELFT Moore Ward is done within days, whereas SALT assessments can take up to 6 months). TCP must look into this.

CLDT workforce is not consistent across the three Boroughs – some boroughs have high forensic and psychiatric resources, others have high LD nurse contingent. This is the focus of the workforce transformation workstream.

NELFT is having a Challenging Behaviours workshop on 9th May, and suggestion is that this is extended to CLDT/CCG under the TCP umbrella.

New providers are emerging: Lilly Close in Rainham, owned by ’Partners in Care, which consists of three bungalows with shared occupancy.
To: Meeting of the NHS Barking and Dagenham CCG Governing Body  
From: Sahdia Warraich, Lay Member - Patient and Public Involvement (PPI)  
Date: 24 May 2016  
Subject: Patient Experience Report

Executive summary
As part of the Clinical Commissioning Group’s (CCG) commitment to improving patient experience and outcomes, this paper summarises our patient feedback and insight over the last two months and how it will be used.

The report includes a summary of:
• The last patient engagement forum (PEF) meeting and activities of PEF members.
• Our liaison with the community and voluntary sector
• Progress in developing our new engagement strategy
• Progress in our Equality and Diversity Standard 2 (EDS2) work

Recommendations
The governing body is asked to:
• Consider the feedback provided from the range of sources by local patients

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 CCG Patient Engagement Forum (PEF)
2.1 The Barking and Dagenham (B&D) PEF last met on 17 March 2016. At the meeting we received the latest update about the CCG’s Primary Care Transformation strategy, which is being considered at this governing body meeting.

2.2 The main speaker was Sarah See, Director of Primary Care Transformation. Sarah gave an engaging and interesting presentation about the development and contents of the strategy. The overall programme and approach was well received by PEF members.

2.3 PEF members asked how patients and public were involved in this work and the difference the programme would make for patients. Sarah explained how the plans could help to provide more responsive primary care. PEF members suggested making links with residents’ associations.
2.4 Sarah also provided background information about the Personal Medical Services (PMS) review affecting many GP practices in the borough.

2.5 PEF members also received an update about transforming urgent and emergency care services in Barking and Dagenham, Havering and Redbridge (BHR). Two members had attended the stakeholder workshop on the subject earlier in the day. This will be the main topic at the May meeting.

2.6 On 25 February the PEF held an extra meeting to discuss the stroke consultation. Clare Burns, Deputy Chief Operating Officer for Havering, gave an overview about the proposed changes to BHR stroke rehabilitation services. Some PEF members highlighted the importance of healthy eating and prevention in relation to stroke. Members were supportive of the recommendations for a combined early supported discharge (ESD) and community rehabilitation service (CRS) to cover all three boroughs, and having one inpatient unit based at King George Hospital.

3.0 **Engagement with the community and voluntary sector**

3.1 We continue to be involved in the planning of the Council-led International Day of Disabled People (IDDP). event. The next meeting of the steering group is on 17 May.

3.2 We continue our work with the community and voluntary sector. A meeting has been arranged with the B&D CVS Director in order to find out more about latest developments in this organisation and sector. We will also shortly be visiting Heathlands Day Centre in Dagenham. This centre provides day services and activities for adults with learning disabilities.

3.3 Our PPE Advisor attended a health and wellbeing hub workshop on 23 March. The workshop was very well attended and included members of local community and voluntary sector organisations, patient representatives, public health and local authority colleagues. The main aim of the workshop was to discuss the format of the wellbeing hub and how best to provide joined up children and adolescent community mental health services (CAMHS).

4.0 **Engagement strategy**

4.1 The strategy has now been produced and is to be discussed later on this agenda. The PEF are discussing the strategy at their May meeting and a number of suggestions from the chair have already been incorporated.

5.0 **Resources**

5.1 There are no resource issues relevant to this report.

6.0 **Equalities**

6.1 The work on engagement in Barking and Dagenham, 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.

6.2 On 5 April we attended a pan-London Diversity and Inclusion Leads meeting. There were updates about workforce race equality standard (WRES), workforce disability equality standard (DES), Equality Delivery System (EDS2) and the Accessible Information Standard (AIS).
6.3 The AIS is a requirement from 1 April 2016. This standard must be implemented and followed by all NHS providers and adult social care organisations. Although we, as commissioners, are exempt from implementing the standard, we should ensure that we enable and support provider organisations from which we commission services to implement and comply with the requirements of the Standard. Arrangements are currently being established for supporting and monitoring.

6.4 Our CCGs are required to monitor and oversee the implementation of the EDS2 and WRES of our local health service providers. We are assured of progress through information provided through the NELFT organised EDS2 Working group.

7.0 Risks
7.1 There are no identified risks in relation to this report.

8.0 Managing conflicts of interest
8.1 There are no conflicts of interest relevant to this report.

Author: Boba Rangelov, Patient and Public Engagement Advisor, BHR CCGs
Date: May 2016
To: Meeting of the Barking and Dagenham Clinical Commissioning Group Governing Body
From: Tom Travers, Chief Finance officer
Date: 24 May 2016
Subject: Contract Report

Executive summary

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

BHRUT are failing to meet several of the national standards required in the Operating Framework. Commissioners continue to actively manage performance through a number of forums held on a weekly basis and as a consequence Contract Performance Notices have been served. There are action plans in place to recover the standards for A&E, Referral to Treatment (RTT), Cancer and Diagnostics. The Trust is held to account on actions required with associated penalties enforced in accordance within the contract.

Barts’ operational and performance issues are being managed by the Lead Commissioner (Newham CCG) in line with the contractual governance framework. Barts are failing to meet several of the national standards required in the Operating Framework. There are a number of action plans currently in place for 18 weeks, Cancer, serious incident (SI) management and data quality that are being actively managed by the Lead Commissioner. The Trust is held to account on actions required with associated penalties enforced in accordance within the contract.

Poor performance at both acutes’ has led to them being placed in special measures. National reporting of 18 weeks has been suspended for both BHRUT and Barts Health.

NELFT are performing to contracted standards in their Community and Mental Health Service contracts with the significant exception of Increasing Access to Psychological Therapies (IAPT) services.

PELC performed well over the 4-day Easter Period within the NHS 111 service and this has been compared to the national data set against other London Providers. Green ambulance re-triage for lower acuity calls were in the region of 60% of all calls re-triaged.

The London Ambulance Service (LAS) continue to be very challenged in their delivery of the 8 minute response standard, with the year to date for the Barking and Dagenham CCG at 62.7% 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 M11 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 performance for Month 11 2015/16 for Acute, Community and Mental Health services and agree any actions required.

2.0 Background/Introduction
This is the monthly report, from the Chief Finance Officer, to inform the Governing Body of the position of Acute, Community and Mental Health contracts.

3.0 Contract updates

BHRUT – Contract Value for Barking and Dagenham CCG - £92.4m
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.

3.1 A&E

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| No. of waits from decision to admit to admission (Trolley waits) over 12 hours | BHRUT | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 3 |
| % Patient records captured electronically: | King George Hospital | 40.26% | 44.80% | 46.13% | 47.16% | 36.25% | 36.90% | 35.40% | 33.35% | 31.18% | 31.39% | 33.1% | 34.52% | 35.69% |
| | Queens Hospital | 35.25% | 34.86% | 41.32% | 38.94% | 32.83% | 35.81% | 35.18% | 33.35% | 31.18% | 31.39% | 33.1% | 34.52% | 35.69% |
| | BHRUT | 36.56% | 37.24% | 42.50% | 40.94% | 33.73% | 36.06% | 35.23% | 34.54% | 32.04% | 31.10% | 32.6% | 35.69% | 35.69% |
| Number of Accident & Emergency and Ambulance Handover breaches: | King George Hospital | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | Queens Hospital | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | BHRUT | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 |

| % Patient records captured electronically: | King George Hospital | 82.58% | 80.27% | 81.26% | 81.26% | 76.89% | 72.31% | 72.78% | 76.81% | 81.37% | 87.76% | 87.10% | 89.71% |
| | Queens Hospital | 93.00% | 93.77% | 91.41% | 91.81% | 89.91% | 90.96% | 91.61% | 93.64% | 90.01% | 90.81% | 92.01% | 90.30% |
| | BHRUT | 90.30% | 96.48% | 99.49% | 99.01% | 96.04% | 96.70% | 96.54% | 96.36% | 96.97% | 98.64% | 90.70% | 87.71% |
Current Position

The un-validated March performance for BHRUT is 75.6% with a full year unvalidated position of 87.83%; deterioration has been seen throughout Quarter Four with significant issues at both sites but particularly at Queen’s Hospital. Site performance in March was 82.1% (un-validated) at King George Hospital and 71.27% at Queen’s Hospital.

A&E performance continues to be impacted by high attendances reported in January and February continuing through March; an increase of 18.7% has been recorded compared to 2014/15 for these months. High levels of breaches are resulting in the wait for a specialist in A&E, not for triage or for the time to see an A&E consultant, and a rising number of breaches for A&E triage due to volume of attendances and staffing issues with late/short notice absence and a low proportion of shifts filled with permanent staff. A review of demand for A&E and urgent care services has been undertaken which has not identified a specific trend in increased activity compared to 2014/15 by age cohort or condition. Compared to similar sites (Barts Health) the increase experienced by BHRUT is being replicated with a 14.6% increase in attendances seen across all sites in the locality. Nationally a 10% increase in attendances has been reported for January alone.

Risks to Delivery

Key risks to delivery of the Trusts’ action plans are:

- Increasing demand for A&E and urgent care services
- Clinical leadership in emergency department (ED) and clinical recruitment
- Staffing resilience
- Patient flow both through the hospital and into the community

Mitigating Actions

A key risk continues to be staffing issues, with long term vacancies in senior decision making roles, and high levels of reliance on locum / temporary staff. The Trust continues to seek recruitment to vacancies and review bi-weekly. Additional Consultant shifts are in place Monday – Thursday with plan to expand to Monday – Friday.

The Trust is working to full capacity plan during periods of high pressure to support patient flow and with the Joint Assessment and Discharge (JAD) to maximise discharges.

In addition the System Resilience schemes introduced in 2014/15 and continued in 2015/16 continue to support the UEC pathway. These include:

- LAS/Community Treatment Team (CTT)
- Additional GP appointments
- Reduced pressure at the ED front door including Enhanced Psychiatric Liaison
- Frail Older People’s Assessment Liaison Service (FOPAL)

Within the Trust the following continue to be implemented

i) Majors-Light
ii) A&E Urgent Care Triage
iii) More effective Assessment Units
iv) More timely discharge including developing discharge lounges
v) Additional Community beds (Primary Care)

There are also schemes in place to support discharge (JAD) and additional resource for social care packages).
In addition to the system resilience and other actions described above, the CCGs are using contractual levers to address Trust (and where necessary other providers) poor performance. This includes Contract Performance Notices (CPNs) on A&E performance and ambulance handovers.

A Contract Performance Notice was issued in July for non-delivery of the 4hr standard in Q1 15/16. This remains open due to the performance not achieving the required standard.

**Governance structure:**

Daily teleconferences are undertaken to review current pressures and seek mitigating actions from the system.

There are regular forums in place – Service Performance Review (SPR) meeting, Clinical Quality Review meeting (CQRM), Technical Sub Group (TSG) meeting, Systems Resilience Group, and Performance Assessment Group (PAG) that review activity levels and the actions being taken to continue improvement across the national operational standards.

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

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<td></td>
<td></td>
<td>95%</td>
</tr>
<tr>
<td>Non-admitted – No of failed specialties</td>
<td>BHRUT</td>
<td></td>
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<td></td>
<td></td>
<td>No threshold</td>
</tr>
<tr>
<td>Non-admitted &gt;52 week waits</td>
<td>BHRUT</td>
<td></td>
<td></td>
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<tr>
<td>18 Weeks RTT Incomplete Pathways</td>
<td>BHRUT</td>
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<td></td>
<td></td>
<td>92%</td>
</tr>
<tr>
<td>Incomplete – No of failed specialties</td>
<td>BHRUT</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>No threshold</td>
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<tr>
<td>Incomplete &gt;52 week waits</td>
<td>BHRUT</td>
<td></td>
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<td></td>
<td>0</td>
</tr>
<tr>
<td>6 Weeks Diagnostic Waits</td>
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<td>99.3%</td>
<td>99.3%</td>
<td>98.6%</td>
<td>98.0%</td>
<td>99.5%</td>
<td>98.3%</td>
<td>96.4%</td>
<td>94.0%</td>
<td>92.5%</td>
<td>92.8%</td>
<td>96.8%</td>
<td>99%</td>
<td></td>
</tr>
<tr>
<td>Cancelled operations (Breaches of 28 day standard over number of cancelled operations)</td>
<td>BHRUT</td>
<td>90.2%</td>
<td>96.2%</td>
<td>90.4%</td>
<td>92.2%</td>
<td>100%</td>
<td></td>
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<tr>
<td>Urgent Operations Cancelled for the 2nd or more time</td>
<td>BHRUT</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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</table>
Current Position

BHRUT has not reported RTT performance since November 2013 following reporting, data quality and process issues identified following a CQC outpatient’s inspection and a system upgrade to the Trust PAS system. The issues identified following internal review were:

• Trust Systems and Processes for management of waiting lists were weak
• Data Quality was poor
• Demand and Capacity were not aligned
• Clinical Leadership and Governance was weak

An internal recovery plan to address and assure the CCGs together with quality and process management was, and continues to be, implemented by the Trust; however NHSE and the TDA (now NHS Improvement-NHSI), with the CCGs requested that an external independent review is to be carried out with two main phases:

1) RTT PTL Data Quality Review: Assessment of system and user error
2) System wide recovery: Demand and Capacity Modelling and testing of assumptions

This review will deliver a number of outputs and assurance that the PTL is accurate and underlying modelling assumptions are correct. Once this review has been completed a report will be provided. It has been agreed that the IST audit and work is now too long ago to provide this assurance.

A recovery and improvement plan agreed by the System Oversight and Escalation Group (NHSE/NHSI / CCGs) to address reducing the numbers of patients waiting longer than 18 weeks is being implemented and monitored. The Trust and Commissioners are working jointly to address the core issues of internal productivity, additional internal and external capacity (outsourcing) and demand management. More recently an updated system wide improvement plan is being tracked through with weekly cycles of PMO meetings with key leads and reporting back to the programme board for assurance.

The Trust along with CCG support is concentrating on the long waiters on the admitted and non-admitted pathways and progress of contacting these patients to offer choice is being reviewed at weekly NHSE meetings.

The Trust has assured Commissioners and the External Harm Panel on processes in place to review patients. A review of the process has been requested by the CCG and the Chair of the External Harm Review.

Risks to Delivery

The key risks to recovery of this standard are:

The Recovery and Improvement Plan has three main streams of action – Outsourcing, Internal Productivity and Demand Management. The key risks to delivery of the action plans are:

Internal Productivity

• Ability to recruit additional consultants (substantive & locum)
• Levels of clinical engagement required to drive changes
• High levels of bed occupancy and potential cancellation of operations due to winter pressures
• Capacity and technology to implement virtual clinics

Outsourcing

• Patient choice – patients offered an alternative provider may choose to remain on the BHRUT waiting list
• Clinical appropriateness of patients to transfer
• Sufficient capacity available at local alternative providers
### Demand Management
- Referrals require secondary care
- Ability to move at speed to implement alternative pathways
- Clinical engagement and capacity to engage
- Financial resources

### Mitigating Actions

#### Governance and reporting
Weekly escalation meetings are continuing with NHS England for RTT and a weekly reporting dashboard across the major programmes has been developed. Weekly PTL reporting from unvalidated data is continuing with a focus on prioritisation of long waiters.

A proposal for a revised PMO structure has been developed with weekly reporting to the RTT Programme Board. Additional capacity has been secured by the Trust to support validation of data and tracking of pathways for long waiters (14wte) and 11 are due to be in post by end of April.

The review of data quality, data processes, governance and demand and capacity led by Ernst and Young commenced at the beginning of April and is expected to report to the joint programme in early May.

#### Internal Productivity
The Trust advertised posts for additional consultants (substantive and locum) in key specialties in late 2015 and continues to implement additional weekend and evening surgical lists. An analysis of theatre utilisation has been undertaken and a full productivity plan is being completed.

#### Outsourcing
Commissioners continue to support the Trust in ensuring clear and robust links with NHSE’s Outsourcing PMO work. The Trust is updating commissioners on the impact on backlog reduction and is progressing work on an admitted backlog reduction trajectory. Weekly monitoring of outsourced activity against target is in place. Contracts for the provision of additional admitted capacity have been agreed with suppliers, further work is ongoing to agree capacity to outsource full pathways.

#### Demand Management
Actions continue to be progressed on the establishment of a BHR CCGs’ demand management plan that will better support the recovery of the standard at BHRUT. Each of the top 9 highest risk specialities have an appointed Clinical Director lead to provide focussed clinical leadership and assure the delivery of Demand Management plans. A quarter one redirection programme for referrals has been established with additional capacity secured at alternative providers. A communication plan to cascade information to primary care has been developed to maximise redirection. A target and monitoring plan is in place to monitor monthly.

A Contract Performance Notice was issued in July for non-delivery of the RTT Incomplete pathway standard. Whilst commissioners are closely monitoring performance with the Trust, (and NHSE and the TDA), assurance is still required that actions taken will reduce the backlog to a steady state and deliver the standard on a sustainable basis.
3.3 Diagnostics

<table>
<thead>
<tr>
<th>Current Position</th>
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<tbody>
<tr>
<td>BHRUT continue to breach the 6 week standard for diagnostics in February with reported performance of 92.8%; provisional data for March continues to show standard not achieved (95.54%) but with mitigating actions now addressing the issues. The Trust has shared capacity modelling and a recovery plan for regaining the target and a revised trajectory to achieve by July 2016. This requires significant insourcing and outsourcing of endoscopy to support internal capacity shortfall.</td>
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</table>

The achievement of the 6 week standard for diagnostics has been affected by significant capacity issues in endoscopy, maternity leave in neurophysiology and capacity in audiology assessment.

Weekly monitoring of activity undertaken and the number of patients waiting greater than 6 weeks for diagnostics demonstrates an improving trajectory in March and April with a significant reduction in the number of six week breaches reported in endoscopy.

<table>
<thead>
<tr>
<th>Risks to Delivery</th>
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<tbody>
<tr>
<td>The key risks to delivery of this standard are:</td>
</tr>
<tr>
<td>• Capacity gaps in Endoscopy result in ongoing failure to reach standard</td>
</tr>
<tr>
<td>• Independent providers’ rate of completing diagnostic tests</td>
</tr>
<tr>
<td>• Diagnostics failure has negative impact on Cancer and RTT standards</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Mitigating Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional capacity has been sourced through outsourcing and insourcing at BHRUT. An external provider is undertaking weekend lists at the BHRUT hospital sites for endoscopy and locum Gastroenterologist is in place.</td>
</tr>
</tbody>
</table>

Actions in place for addressing audiology assessment breaches in March and April have included additional clinics to see patients who have breached; recruitment of staff in Quarter one to triage GP direct referrals; investigation of outsourcing to an outside provider to commence May and review of working practices to increase to 6 day provision – this is being considered as a business case.
### 3.4 Cancer Waits

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</thead>
<tbody>
<tr>
<td>2 Week Cancer Wait:</td>
<td>BHRUT</td>
<td></td>
<td>93.4%</td>
<td>95.6%</td>
<td>95.2%</td>
<td>96.1%</td>
<td>97.5%</td>
<td>95.9%</td>
<td>96.1%</td>
<td>95.8%</td>
<td>92.2%</td>
<td>91.6%</td>
<td>89.5%</td>
<td>94.5%</td>
<td>93%</td>
</tr>
<tr>
<td>2 Week Cancer Wait: Breast Symptoms</td>
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<td></td>
<td>83.3%</td>
<td>83.8%</td>
<td>87.5%</td>
<td>93.7%</td>
<td>94.7%</td>
<td>97.1%</td>
<td>99.6%</td>
<td>93.2%</td>
<td>91.5%</td>
<td>92.2%</td>
<td>97.8%</td>
<td>83.3%</td>
<td>93%</td>
</tr>
<tr>
<td>31 day Cancer Wait:</td>
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<td>93.9%</td>
<td>96.7%</td>
<td>97.5%</td>
<td>98.2%</td>
<td>96.5%</td>
<td>97.8%</td>
<td>94.2%</td>
<td>95.8%</td>
<td>93.0%</td>
<td>95.4%</td>
<td>96.1%</td>
<td>90%</td>
<td>96%</td>
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<tr>
<td>31 Day Cancer Wait:</td>
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<td>93.3%</td>
<td>100.0%</td>
<td>96.7%</td>
<td>100.0%</td>
<td>95.7%</td>
<td>87.0%</td>
<td>88.9%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>96.1%</td>
<td>94%</td>
<td>88%</td>
<td>94%</td>
</tr>
<tr>
<td>31 Day Cancer Wait: Subsequent treatment (Surgery)</td>
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<td>100.0%</td>
<td>100.0%</td>
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<td>98.8%</td>
<td>94%</td>
<td>95%</td>
<td>94%</td>
</tr>
<tr>
<td>31 Day Cancer Wait:</td>
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<td></td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>97.8%</td>
<td>100.0%</td>
<td>98.4%</td>
<td>100.0%</td>
<td>91.5%</td>
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<td>100.0%</td>
<td>96.1%</td>
<td>99%</td>
<td>96%</td>
</tr>
<tr>
<td>62 Day Cancer Wait: GP Referral</td>
<td>BHRUT</td>
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<td>73.1%</td>
<td>76.5%</td>
<td>75.3%</td>
<td>74.0%</td>
<td>69.0%</td>
<td>89.0%</td>
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<td>76.2%</td>
<td>70.7%</td>
<td>64.9%</td>
<td>72.9%</td>
<td>85%</td>
</tr>
<tr>
<td>62 Day Cancer Wait:</td>
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<td></td>
<td>77.6%</td>
<td>95.2%</td>
<td>100.0%</td>
<td>95.8%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>93.8%</td>
<td>95.0%</td>
<td>97.3%</td>
<td>91.2%</td>
<td>96.2%</td>
<td>94.0%</td>
<td>90%</td>
</tr>
<tr>
<td>62 Day Cancer Wait: Consultant Upgrade</td>
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<td></td>
<td>84.8%</td>
<td>83.3%</td>
<td>69.2%</td>
<td>81.5%</td>
<td>84.6%</td>
<td>77.8%</td>
<td>86.2%</td>
<td>80.0%</td>
<td>83.0%</td>
<td>81.0%</td>
<td>74.6%</td>
<td>80.4%</td>
<td>THRESHOLD</td>
</tr>
</tbody>
</table>

### Current Position

Reported validated performance against the national cancer access standards showed BHRUT not delivering 3 of the 8 cancer standards in February including the 2 week wait standard and 31 day first definitive treatment. Unvalidated data for March has confirmed that these standards have been recovered but 62 day wait standard remains not achieved.

The trajectory for the Trust is to recover the 62 day standard by May 2016; weekly monitoring of activity delivered (total and number of breach patients treated) and waiting list of patients who have not been treated who have already waited longer than 62 days for a decision to treat or treatment.

The number of patients waiting greater than 62 days for a decision to treat is off trajectory and not reducing to the levels required; review of patient pathways demonstrate the main causes are wait for diagnostics/repeat investigations (urology), timeliness of review of notes and confirmation of pathway position, and access to histology and reporting of results.

The sustainable backlog for patients waiting greater than 62 days with a decision to treat is 13, the Trust has consistently in March had a backlog of 30. Review of patient pathways show that at a point in time 10 patients within the backlog will have dates for treatment, 10 will have a further outpatient appointment booked, circa 8 will be waiting for treatment at a tertiary centre and a small number will not be medically fit for treatment.

Analysis of the pathway shows that the key issue is the delay in decision to treat which is particularly an issue for urology. The forecast risk for the 2ww and 62d standard remains high with further assurance on capacity plans for 2ww slots, and diagnostics within 2w required in particular in GI, Urology and Gynaecology.

### Risks to Delivery

The key risks to delivery of this standard are:

- Insufficient diagnostic capacity to manage lung, gynaecology and urology cancer referrals
- Levels of clinical leadership required to bring about necessary change
- Sustainability of recovery plan for long term
- Increase in demand
- Unexpected reduction in theatre capacity
- Management of clinical pathways not complying with the 62 day cancer wait standard
- Data quality and flow that delay confirmation of pathway statuses
**Mitigating Actions**

Actions in place to regain the standard include:

- Additional template biopsy capacity created for urology pathway
- Recruitment to Histology
- Support given to specialties to increase timeliness of notes review
- Clinical engagement programme in liaison with the Royal Free started February

**3.5 Quality**

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</thead>
<tbody>
<tr>
<td>MRSA reported infections</td>
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<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>5</td>
<td>1</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>C. Difficile reported infections</td>
<td>BHRUT</td>
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<td>5</td>
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<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>5</td>
<td>6</td>
<td>4</td>
<td>2</td>
<td>37</td>
</tr>
<tr>
<td>Mixed Sex Accommodation (MSA) (Number of breaches)</td>
<td>BHRUT</td>
<td>20</td>
<td>22</td>
<td>18</td>
<td>3</td>
<td>10</td>
<td>14</td>
<td>8</td>
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<td>2</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>104</td>
</tr>
<tr>
<td>VTE (% admitted patients assessed for VTE risk)</td>
<td>BHRUT</td>
<td>82.1%</td>
<td>88.6%</td>
<td>93.1%</td>
<td>95.1%</td>
<td>95.2%</td>
<td>98.1%</td>
<td>95.0%</td>
<td>98.7%</td>
<td>98.3%</td>
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<td></td>
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<td>93.2%</td>
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</tbody>
</table>

**Current Position**

**MRSA**

The target set by NHS England for all Trusts is zero tolerance, i.e. any case will be classed as a breach of the target. In December and January, there have been no reported MRSA bacteraemia breaches.

The Trust has already breached by Five cases of MRSA bacteraemia within 2015-16.

**Mixed Sex Accommodation (MSA)**

BHRUT performance had improved with zero reported breaches in January but deterioration in performance with 1 breach in February and Two in March against the MSA zero tolerance standard.

Between April and March, BHRUT has reported 104 MSA breaches, which now exceeds the total number of MSA breaches in 2014-15 (94) and is a 9.62% increase in breaches.

The contractual monthly target is zero tolerance and the Trust is exceeding this on a monthly basis with the exception of January 2016. The key issue is that patients are being identified for step down from ITU/HDU in the evening (post 6pm) when they would not actually be stepped down/transferred until the following morning, which has resulted in an over-reporting of the position. National policy for safe transfer of patients from ITU/HDU stipulates that patients should not be transferred to a ward post 9pm.

**C-DIFF**

The Trust reported position on C-diff for January was 4 cases and 2 cases for February, which is a marginal improvement on November and December performance, giving a year to date position of 37 which has exceeded the annual threshold of 30. Commissioners have requested that remedial actions are taken to address performance and a paper was submitted to the Trust Executive Committee asking for approval of an improvement plan which should include resource costs to manage this service. This remains on the Quality Team Risk Register.

**Venous thromboembolism (VTE)**

The Trust reported that VTE recording has been changed and will have an impact on the reported national figure. Not all patients were being assessed within 24hrs, as per the standard and the reporting of data was not being captured and a Contract Performance Notice was issued in July 2015. Trust performance has been improving throughout the reported period; Q2 and Q3 data shows 6 consecutive
months of meeting the standard. However, BHRUT were meeting VTE 95% targets until February 2016, which has seen a dip to 93%. This is unvalidated data but is cause for concern.

**Risks to Delivery**

The key risks to delivery of this standard are:

- Step down process from ITU/HDU not compliant with MSA standards.
- Data capturing of VTE assessment and continual over-reporting.

**Mitigating Actions**

All MRSA infections are subject to Post Infection Reviews at BHRUT and the actions from these are monitored at the Joint Infection Prevention Committee (IPC) meeting. BHRUT has put actions in place to minimise MRSA infections. These include: reinforcement to all clinical staff of the importance of full patient assessments on admission and during inter-ward transfers and for ensuring compliance with IPC practice in clinical areas. However, these do not necessarily extend to intra-hospital discharge.

Infection prevention and control standards will not have been met for 2015/16 and a risk assessment will be carried out to consider whether the risks have been adequately mitigated for 2016/17.

A Contract Query Notice was issued to BHRUT in September and a remedial action plan put in place to prevent further MRSA infections. The Trust presents a detailed report at each CQRM and this is closely monitored.

A Contract Performance Notice was issued for MSA Breaches and this has now been closed as BHRUT reported zero MSA breaches in January 2016 and 1 in February 2016. It was agreed at the CRQM in April 2016 that the CPN would be closed, but that this would continue to be monitored at CQRM.

VTE performance is monitored weekly at the Trust Access Board. There is now a daily review of all new patients by ward staff to ensure they have been assessed within 24 hours. Spot audits have also provided assurance that VTE assessments are occurring. This has improved performance in Q2 and Q3 was demonstrating improvement and sustainability against this standard until the unvalidated deterioration in performance in February 2016.

BHR CCGs is formulating new KPIs for the 2016/17 contracts, which will include more robust measurement of VTE prevention and prophylaxis, linking this with hospital mortality indicators for VTE/PE.

### 3.6 Friends and Family Test (FFT)

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<tbody>
<tr>
<td><strong>Accident and Emergency</strong></td>
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<tr>
<td>% Recommended</td>
<td>82.93%</td>
<td>83.74%</td>
<td>85.42%</td>
<td>85.29%</td>
<td>87.95%</td>
<td>85.62%</td>
<td>81.34%</td>
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<td>81.11%</td>
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<tr>
<td>% Not Recommended</td>
<td>8.32%</td>
<td>10.06%</td>
<td>7.58%</td>
<td>7.22%</td>
<td>6.59%</td>
<td>6.90%</td>
<td>8.98%</td>
<td>10.98%</td>
<td>11.69%</td>
<td>8.43%</td>
<td>12.74%</td>
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<tr>
<td><strong>Inpatient</strong></td>
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</tr>
<tr>
<td>% Recommended</td>
<td>95.93%</td>
<td>95.84%</td>
<td>96.22%</td>
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<td>92.86%</td>
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<tr>
<td>% Not Recommended</td>
<td>1.25%</td>
<td>1.39%</td>
<td>1.22%</td>
<td>1.23%</td>
<td>1.84%</td>
<td>1.94%</td>
<td>2.16%</td>
<td>1.94%</td>
<td>2.54%</td>
<td>2.21%</td>
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</table>
Current Position

The Trust performance for A&E had been improving with the December (81.11%) and January (83.07%) performance but there has been a significant deterioration in February (75.48%) performance.

The Trust performance for inpatients has been maintained with the performance in December (92.86%), January (92.77%) and February (93.10%) but is below the national target and the Trust is in the bottom quartile of Trusts when benchmarked nationally.

Uptake in A&E remains very low compared to the uptake for inpatients. Underperforming wards are Paediatrics/Majors Lite; Queens Medicine in the top quartile, Queens Surgery is below median and KGH Medicine is in lower quartile. Patient actuals against uptake is still low. A review is being undertaken of all the patient experience surveys, triangulation of all patient surveys and any other survey that is being undertaken in order to identify the reasons for low uptake. The response rate for inpatients against total eligibility remains consistently low. The Trust is to identify the reasons why the uptake is low.

Risks to Delivery

The key risks to delivery of this standard are:

- Response rates
- Trust capacity

Mitigating Actions

The trust has plans in place to benchmark their performance against other indicators of patient satisfaction such as the inpatient National Survey to identify the main areas of focus and learning, review questions and the FFT guidance.

FFT performance is now scrutinised at Divisional Performance Reviews, which are chaired by the Chief Operating Officer. During Q2, the FFT surveys were adapted to reflect latest Department of Health guidelines in requesting demographic information from patients.

The Quality Team Assurance Report for April indicates that BHRUT has advised that they are outsourcing FFT which will be managed by the Deputy Director of Nursing. BHRUT have stated that they will send an invitation to BHR CCGs to engage with the new process.
### Current Position

The key message on SHIMI is that the Trust is not an outlier on this when compared to national data. Local more frequent produced data from the Trust is showing slightly different data and this issue has been picked up by CQRM to be reviewed at the next meeting.

The weekend HSMR – non-elective indicator is higher than the weekday HMSR, which reflects the National picture. However, SHMI scores related to Sepsis remains adversely higher than the national benchmark although has improved in February.

According to the SHMI data there has not been an improvement in the sepsis data since the CQUIN was implemented. BHRUT agreed to discuss the data with the Mortality Assurance Review Group Lead.

### Risks to Delivery

The key risks to delivery of this standard are:

- Accurate reporting of data
- Staff recruitment, retention and training

### Mitigating Actions

Marked progress continues following the rebuild of the Trust’s internal mortality review procedures.

The mortality review checklist process is now embedded with the Bereavement Office and every death undergoes a first review, using the Hogan Scoring System for Avoidable Deaths at the same time as the death notification certificate is completed.

The findings from these reviews are collated into a mortality score card, which is a key agenda item at the Mortality Assurance Group. The mortality team are working in collaboration with our colleagues in Public Health to produce and disseminate tailored monthly mortality reports to the Divisional Teams.

The scorecard is also used by the Mortality Assurance Group to target ‘deep dives’ into areas of concern.

All headline measures of mortality remain within expected levels and there are no CCS groups where excess deaths are outside of confidence levels. The SHMI for elective care is above 100, although within confidence intervals and warrants further review by the Mortality Assurance Groups.
### A&E

#### Current Position

The Whipps Cross site has underperformed against the A&E All Types standard throughout 2015/16. Barts Health did not achieve the 4 hour wait standard for February. The Trust is not currently meeting the agreed trajectories for each site. For Whipps Cross, the revised RAP trajectory agreed for Quarter 4 is 88.5%. Quarter 4 trajectories are now out of reach for Barts Health as a whole and the Whipps Cross site.

As at week ending 3 April 2016, predicted performance (based on NHSE methodology) for the full year is as follows;

- Barts Health - 87.99%
- Whipps Cross - 84.38%

#### Risks to Delivery

Sites have seen significant increase in attendances in January and February, with circa 15% increase across all sites, with more than a 10% at the Whipps Cross site. The largest increase has been seen in Type 1 attendances. This reflects but also exceeds the growth that is being seen in A&E attendances across London and nationally.

Patient discharge remains a significant challenge across all sites.

Other key risks:
- Staffing
- Paediatric bed availability

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<td>A&amp;E Type I Performance</td>
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<td>% Ambulance Handovers within 15 mins KPI 1</td>
<td>Royal London Hospital</td>
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<td>54.3%</td>
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<td>42.1%</td>
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<td>% Ambulance Handovers within 30 mins KPI 2</td>
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<td>Number of Ambulance Handover-30 minute breaches</td>
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<td>58.8%</td>
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Mitigating Actions

The Barts Health Emergency Care Improvement Programme has established the following key themes of work for each site:

- Site Leadership
- Aligning Capacity to Demand
- Helping our patients to avoid admission
- Paediatric Emergency Care
- Accelerating Discharge
- Revolutionising our Operational Process
- Building Better Business Intelligence

The Programme Board is chaired by the Chief Operating Officer and attended by medical, nursing and management leadership team representatives from each site, together with the trust Deputy Chief Executive.

The Programme Director is supporting each site to reach its identified Four Hour Operating Standard trajectory with additional support from ECIP targeted at specific initiatives, for example, Red day/green day, clinical challenge, MADE, concordat.

In partnership with commissioners and other providers in the three local health systems, an overall plan is being confirmed that will see the Four Hour operating Standard sustainably delivered from Quarter 3 2016-17.

Following the ‘Managing Urgent and Emergency Care pathways’ work undertaken with the support of McKinsey, it has been agreed to revise the SRG governance structure. The role of UCWG will be strengthened and will report into a senior level weekly System Cabinet. A whole system dashboard has been developed and is in the process of being implemented.

3.9 Referral to Treatment (RTT)

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<td></td>
<td>18 Weeks RTT</td>
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<td>Non-Admitted</td>
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<td>Non-Admitted &gt; 52 weeks</td>
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<td>Incomplete Pathways</td>
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<td>Incomplete &gt;52 week waits</td>
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<td>6 Weeks Diagnostic Waits</td>
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<td>99.1%</td>
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<td>Cancelled operations (Breaches of 28 day standard over number of cancelled operations)</td>
<td>Barts Health</td>
<td>77.2%</td>
<td>79.2%</td>
<td>81.9%</td>
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<td>Urgent Operations Cancelled for the 2nd or more time</td>
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Current Position

Barts 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.
The Trust has met the trajectory for backlog and total waitlist clearance of ‘known’ patients until the end of November 2015; December 2015 has seen an increase in backlog as expected at mainly Whipps Cross and the Royal London sites due to the cancellations that took place in the month. January and February again had cancellations due to a doctor’s strike but the Trust is moving towards reducing the backlog again. The overall waiting list has particularly increased in the month of February as the patients from the contact exercise have filtered through.

In January, the Trust reported performance of 84.37% (81.90% for Whipps Cross), a small decrease on the previous month, and a continuing decrease in overall pathways and a small decrease in patients waiting over 18 weeks.

The 52+ week position as at end of February is 59 with a further 46 pop-ons. Of the 59 patients, 17 are patient choices and another 10 due to patient cancellations/DNAs/unfit leading to greater delays in the pathway. In addition, 3 patients have been delayed due to being cancelled as a result of the strike and non-elective pressures.

**Risks to Delivery**

December 2015 had increased winter pressures leading to elective inpatient cancellations in the last two weeks of December; additionally, a proposed junior doctors strike day also led to c1000 elective patient cancellations on both admitted and non-admitted pathways. January 2016 again saw a similar number of cancellations due to the junior doctor strike day (12 January). February has also had circa 1,086 patients cancelled due to a junior doctor strike.

With regard to 52+ week waiters, until the exclusion rules are applied to the raw PTL, the Trust is likely to continue to see ‘pop-ons’ on the PTL.

The key areas which continue to be challenged in terms of capacity are Colorectal Surgery due to cancers and HDU/ITU capacity, Trauma and Orthopaedics - Spinal and Lower limb capacity issues and Plastic surgery due to cancers and hand surgery capacity.

**Mitigating Actions**

The CCGs issued a Contract Performance Notice on 01 June after failure to meet agreed trajectories. The Remedial Action Plan (RAP) submitted by the Trust (signed off by Commissioners) is in the process of being updated, however circa 350 actions from the RAP have been completed, leaving 18 outstanding.

Actions by the Trust currently underway include:

- All sites have set up site based Access meetings led by site leadership teams to ensure ownership and the Recovery Action Plans are regularly monitored through these. The Access policy has been redrafted and has been shared for consultation internally as well as with NHS IST and NHS Elect.
- A dedicated improvement plan for scheduling, theatres and diagnostic processes has been put into motion - the forecasting tools and KPI reports are now available and being reviewed at the RLH site access meetings as they are developed on other sites. Whipps Cross has improved scheduling processes in order to support better theatre utilisation and increased booking horizons. Standard Operating Procedures have been finalised for scheduling teams and validation teams.
- A workforce strategy has been discussed and agreed at the internal RTT and Cancer board in order to put in place a permanent structure of workforce to manage the management and delivery of access standards in the Trust. The recruitment cycle has also commenced as of February for a team of circa 31 validation staff. A new Gynaecology post is currently out to advert to improve capacity at RLH. Cardiology are also pursuing recruitment of an additional consultant Cardiologist.
• The training material for new starters is being rewritten with the support of a dedicated RTT and Cerner expert consultant. The first newly drafted RTT and Cerner training materials were launched in January. This work will feed into a more comprehensive training strategy for the Trust.
• The e-learning packages for Junior Doctors have been updated to include RTT guidance and will be launched in April to ensure the new intake receive appropriate training. The Trust is currently reviewing e-learning packages for all staff to cover key elective access standards.
• Outsourcing continues and 340 patients were treated in the Independent Sector in February, which is an increase on previous months. The Trust has advised that it is now outsourcing whole pathways, from referral as well as engaging with the national out-sourcing initiative. In addition, internal capacity is being enhanced in all areas to reduce backlogs – especially in surgical specialties and through the Newham Gateway. The Trust is currently in the midst of a tender exercise to ensure all providers are under a single framework to ensure standardised KPIs and costs can be applied.

A deep dive into 52+ week waiters in the 3 most challenged specialities, Colorectal/General Surgery, Urology and T&O, took place on 29 February between key staff at the Trust, the CCC and the CSU. The purpose of this was to review demand and capacity planning and plans to increase capacity and any blockages to meeting trajectories. This identified key challenges at speciality level by site and the actions being taken to address these.

Phase 2 of the data quality plan has resulted in a further 18,000 patients requiring direct contact to confirm the status of their pathway. The remaining Letters were sent out in February, with a view to completion of the process by the end of March. As at 1 April, circa 6,000 responses have been received to date – these are going through a validation and a harm review process. Further validation will be carried out on these to confirm the waiting time and RTT status. An additional 800 patients were not able to be traced due to missing NHS numbers – half of these (400) have been corrected and will receive a letter shortly. The remaining 400 are being re-reviewed by the Trust’s RTT Data Quality team to establish other methods of contact.

3.10 Cancer Waits

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<td>Cancer Waits</td>
<td>2 Week Cancer Wait</td>
<td>Barts Health</td>
<td>90.7%</td>
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<td>93.9%</td>
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<td>93%</td>
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<td>Cancer Waits</td>
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<td>Barts Health</td>
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<tr>
<td>Cancer Waits</td>
<td>31 Day Cancer Wait: 1st definitive treatment</td>
<td>Barts Health</td>
<td>97.5%</td>
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<td>96%</td>
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<tr>
<td>Cancer Waits</td>
<td>31 Day Cancer Wait: Subsequent treatment (Surgery)</td>
<td>Barts Health</td>
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<td>95.7%</td>
<td>100.0%</td>
<td>98.2%</td>
<td>98.2%</td>
<td>97.9%</td>
<td>94%</td>
</tr>
<tr>
<td>Cancer Waits</td>
<td>31 Day Cancer Wait: Subsequent treatment (Chemotherapy)</td>
<td>Barts Health</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>99.4%</td>
<td>100.0%</td>
<td>99.9%</td>
<td>99%</td>
<td>96%</td>
<td></td>
</tr>
<tr>
<td>Cancer Waits</td>
<td>31 Day Cancer Wait: Subsequent treatment (Radiotherapy)</td>
<td>Barts Health</td>
<td>96.5%</td>
<td>96.5%</td>
<td>97.6%</td>
<td>99.1%</td>
<td>94.3%</td>
<td>96.3%</td>
<td>100.0%</td>
<td>98.1%</td>
<td>100.0%</td>
<td>96.0%</td>
<td>98.6%</td>
<td>97.8%</td>
<td>94%</td>
</tr>
<tr>
<td>Cancer Waits</td>
<td>62 Day Cancer Wait: GP Referral</td>
<td>Barts Health</td>
<td>78.9%</td>
<td>74.2%</td>
<td>77.2%</td>
<td>78.1%</td>
<td>77.2%</td>
<td>75.1%</td>
<td>86.2%</td>
<td>84.3%</td>
<td>87.1%</td>
<td>81.2%</td>
<td>80.3%</td>
<td>80.1%</td>
<td>85%</td>
</tr>
<tr>
<td>Cancer Waits</td>
<td>62 Day Cancer Wait: Screening service</td>
<td>Barts Health</td>
<td>87.2%</td>
<td>81.0%</td>
<td>82.2%</td>
<td>90.9%</td>
<td>100.0%</td>
<td>95.5%</td>
<td>90.5%</td>
<td>100.0%</td>
<td>91.3%</td>
<td>92.0%</td>
<td>94.4%</td>
<td>90.0%</td>
<td>90%</td>
</tr>
<tr>
<td>Cancer Waits</td>
<td>62 Day Cancer Wait: Consultant Upgrade</td>
<td>Barts Health</td>
<td>75.0%</td>
<td>65.5%</td>
<td>79.2%</td>
<td>90.9%</td>
<td>87.9%</td>
<td>81.8%</td>
<td>85.3%</td>
<td>88.2%</td>
<td>87.2%</td>
<td>88.7%</td>
<td>92.2%</td>
<td>85.2%</td>
<td>90%</td>
</tr>
</tbody>
</table>
## Current Position

The Trust has shown significant progress in all aspects of cancer performance in Quarter 2 and Quarter 3 of 2015/16. The Trust achieved all nine cancer standards during the month of October 2015 and December and Quarter 3, which is the first time the Trust has achieved all cancer targets in over two years. However, the Trust failed to achieve the 62 Day Standard in January with 81.2% against the 85% threshold (21 breaches) and February with 80.1% (20 breaches).

At Whipps Cross site:
The Trust has consistently achieved the cancer 2 week wait National Operational Standard over the past 11 months at Whipps Cross. February performance was 97.4% against a 93% threshold.

The 62 day Operational Standard achievement remains inconsistent but was achieved in January (86.7%) and February (86.7%).

The tripartite (TDA, Monitor and NHS England) have instigated a number of measures including weekly reporting and more recently daily SitRep reporting of the 62 day Cancer PTL.

## Risks to Delivery

Poor performance on Cancer Waiting Times at regional and national levels has led the tripartite (TDA, Monitor and NHS England) to establish a system of weekly reporting of the 62 day Cancer standard.

A number of breaches of the 62 Day Standard were due to late tertiary referrals (including from Queens) and complex pathways. The Trust has acknowledged that there are capacity issues, including at Whipps Cross.

## Mitigating Actions

The Trust has developed a detailed Remedial Action Plan (RAP) which was signed off by Commissioners in September 2015.

Actions taken by the Trust include:
- Actioned 167 actions from the Cancer Remedial Plan (RAP).
- Training for the MDT Co-ordinators now complete
- A centralised patient level cancer access meeting at each site, which focus on the key issues within all tumour groups
- The Cancer Performance Team have recruited a General Manager and two Data Analysts who are now in post
- Continuation of backlog tracking – as at 14 April 2016, the Trust has 74 patients in the backlog
- Centralised patient level cancer access meetings at each site, which focus on the key issues within all tumour groups
- The Intensive Support Team (IST) stocktake has been finalised and signed off. Capacity and Demand modelling for Endoscopy is complete for all sites.

## Penalties

A year-end agreement has been reached with the Trust. Contract sanctions are included within this position.
North East London Foundation Trust (NELFT)

3.11 Community Health Services (CHS) – Contract Value for Barking and Dagenham CCG £28.6m

<table>
<thead>
<tr>
<th>Current Position</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Performance Management (Q3)</strong></td>
</tr>
</tbody>
</table>
Q3 was presented to SPR and closed down on 10 March 2016. The highlights are set out below:

**KPIs:**
- CTT numbers of new patients referred and conversion rate targets met. 42% above the required target for new patients referred with a 24% increase across BHR when compared to quarter 2.
- Community bed transfer rates within the 72 hour target across BHR (average 1.43 day across 3 sites) – Grays Court 1.45 days
- IRS numbers of patients referred continues to over-perform across BHR, in Barking and Dagenham this represents 24% above target. 98% achievement in improvement in TUGT (timed up and go test)
- ICM care plans agreed by patient/carer above target at 100% in the quarter.
- No reported cases of MRSA or Clostridium difficile

**CQUINs:**
- Dedicated Community Matron Inreach into adults’ wards at BHRUT achieved its 35% target increase from quarter 2 with 123 contributed patient discharges achieved in the quarter. The number of bed days saved as part of the In-reach is calculated as 174 days.
- Patient Satisfaction based on 5x5 survey is Q3- CTT 93%, IRS 100% and Community Beds 92%
- Dementia – (National) 91.2% proportion of patients over 75 where case finding is applied against 90% target, 100% identified appropriately assessed and have a written care plan on discharge and 97% of staff receiving appropriate training
- Frequent Attenders – 49% reduction in the total number of High Intensity Users (HIU) attendances during the quarter from 6,193 in quarter to 3,032 in quarter 3

**Other:**
- Community Rehab ALoS remains within the benchmark position of 21 days 2 (Foxglove 16, H&G 19, Grays Court 18, IRS 11 days).
- Stroke beds ALoS has seen a reduction compared previous quarters at 22 days and below benchmark of 28 days
- Occupancy rates for stroke beds have increased during the quarter with and average over the quarter at c.85% (14 / 17)

**RTT:**
- No reported breaches of the 18 week Referral to Treatment (RTT) incomplete pathways across NELFT consultant led Paediatric and audiology services.

Concerns have been raised by both CCG and NELFT within their MSK Physio service which included increased demand and direct referral waiting times. The CCG/CSU has recently discussed the possibility of service redesign across the NELFT MSK Physio and MCATS pathways. The CSU has begun negotiations with NELFT around service redesign with a view to implementing the above in early 2016. This is still currently being discussed with further meetings continuing to take place in April.
North East London Foundation Trust (NELFT)

3.12 Mental Health Services (MHS) - Contract Value for Barking and Dagenham CCG £24.7m

**Current Position**

Q3 performance data was presented to SPR on 10 March and was presented for closedown at SPR on 14 April. Q3 KPI highlights are set out below. It should be noted that the B&D IAPT service has achieved the quarterly IAPT target for the first time this year.

<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>IAPT Access</td>
<td>B&amp;D</td>
<td>3.75%</td>
<td>4.1%</td>
<td>NIL</td>
</tr>
<tr>
<td>IAPT Recovery</td>
<td>B&amp;D</td>
<td>50%</td>
<td>48.1%</td>
<td>NIL*</td>
</tr>
</tbody>
</table>

* Although the IAPT Recovery national and contractual targets have been missed, NELFT’s performance is above the 45% threshold below which a penalty would apply.

All other Q3 KPIs and mental health Q3 CQUIN requirements were met.

**Other highlights:**

- Child and Adolescent Mental Health Services (CAMHS) ‘did not attend’ (DNAs): Since the start of the year, NELFT has implemented an action plan to address historically high levels of DNAs in CAMHS services. NELFT has been undertaking, at the request of commissioners at SPR, further analysis to diagnose the causes of high DNA rates and reported to SPR on 10 March. Although NELFT’s actions appear to be having a positive effect on DNA rates in community health children’s services, B&D’s CAMHS service has still not been able to improve their DNA rates consistently. NELFT is undertaking further audit work to report fully at the SPR on 12 May. It is likely that the actions within NELFT’s recovery plan will take some months to take effect.

**Risks to Delivery**

The key risk has been in relation to the Improving Access to Psychological Therapies (IAPT) Access and Recovery Targets, however as stated this had improved.

**Mitigating Actions**

The CCG has an action plan to address under-performance on IAPT Access. The single most important factor to achievement of this target is increasing referrals initiated by GPs. A BHR IAPT project manager has been appointed to lead the work, together with the B&D GP mental health lead, engaging local GPs to increase referrals. M11 IAPT data indicates that the number of patients entering treatment is at a level very marginally below the rate required for achieving the Access target.

Although the mitigating actions continue to focus on GP referrals, NELFT is being required to play a greater part in marketing their IAPT service.

The NELFT IAPT service’s poor telephone response to referrals has been addressed at SPR. The SPR chair and CCG contract lead has written to NELFT requiring a remedial action plan to be delivered setting out a comprehensive diagnostic analysis of the systemic problems and a plan for recovery with timescales and systems’ testing to verify and demonstrate recovery. This will form part of the 2016-2017 contract’s Service Development and Improvement Plan.
### 3.13 PELC Performance

#### Current Position

<table>
<thead>
<tr>
<th>The PELC contract covers, GP Out-of- Hours (OOH), 111 and UCC</th>
</tr>
</thead>
<tbody>
<tr>
<td>The 111 contract is closely monitored by commissioners with key KPIs being reviewed by commissioners and NHSE on a weekly basis.</td>
</tr>
<tr>
<td>The contract negotiation for 2016-17 started in January. Since the scheduled meeting on 12 February, there have been a number of meetings and contacts between PELC DoF and CCG finance lead. The close liaison between commissioners and PELC has enabled the drafting by commissioners and provider of a Heads of Terms (HoTs) for a two year contract with certain conditions and caveats.</td>
</tr>
</tbody>
</table>

#### 111

The call volume has decreased by just -4% in February compared to same time last year. Year to date variance is around -11%. All KPIs except 'time taken for call back <10min' have met the target in February 2016. The priority indicators (60 second call answering and call abandonment rates) have been met.

The percentage of Green Ambulance re- triage is increasing gradually and has attained 60% in last few weeks and it continues to support LAS and prevent non-essential attendances to ED.

Following an instance of call outage on January 25 2016 commissioners issued a Contract Performance Notice due to the inadequacy of the provider’s business continuity and SI response. A Remedial Action Plan has been agreed and implemented, including the requirement for a ‘Well led Review’.

#### Out of Hours (OOH)

The OOH activity in February 2016 has increased across all CCGs. It has increased by 8.11% in Barking and Dagenham compared to same period in 2014-15. Year to date activity across three CCGs has decreased by -1.71%. (note; whilst OOH calls are routed through 111 they are only a proportion of 111 calls and changes in overall 111 activity can occur and trend differentially from OOH)

The KPI performance continues to sustain the improvement and in February only one KPI was reported Red and one other as Amber. PELC has confirmed that they continue to strive to meet targets and sustain the improvement achieved so far.

Commissioners have again been reassured that KPIs underperformance did not create a risk to patients or materially adversely affected PELC service delivery. The rigorous monitoring of contracts is continuing. SRG monitors the Urgent Care Pathway to ensure that there are no adverse impacts on other services, such as A&E, from reducing numbers of patients accessing PELC services.

#### UCC

The activity at KGH has increased by 13.33% in February compared to same period in 2014-15 and the year to date the overall decrease in activity is -5.60% compared to same time in 14/15. The fluctuation in demand experienced during 2014-15 appears to continue in 2015-16. All KPIs were on target in February.

Overall utilisation at King George Hospital (KGH) UCC has been increasing and has risen to 32.32% in February, indicating that proportion of patients seen within A&E is slightly reducing.
Significantly streaming data at both Whipps Cross (WX) and KGH shows a fluctuating position from start of 15/16. Patients attending UCC are streamed by PELC at point of entry. Data from both sites shows a reduction in those streamed to UCC and an increase in those streamed to Minors and Paediatrics. Since April 2015 streaming into UCC GPs has fluctuated between 34% and 44%. It dropped to 34% in September, whereas it went up to 42% in February. Staffing rotas and cover are unchanged and PELC maintain streaming protocols and decision making also remains unchanged. It should be noted that streaming trends have been variable over recent years but the current trend is particularly low in terms of those streamed to GP (PELC UCC). PELC and WX have started a joint streaming project and its impact on streaming will be known when evaluation is completed. Further joint work between PELC and BHRUT at KGH and Barts at WX is ongoing.

### Risks to Delivery

- PELC’s financial situation
- Departure of key staff and transition to new staff
- Recruitment and retention of high quality staff
- Operational management failure to invoke escalation and business continuity processes

### Mitigating Actions

- HoT for a two year contract have been agreed to ensure sustainability of the provider.
- Contractual action through the CPN is in place. A Remedial Action Plan has been agreed and implemented
- A ‘Well led Review’ has started focusing on governance and management systems.

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**London Ambulance Service (LAS)**  
**Contract Value for Barking and Dagenham CCG – £7.37m**  

### 3.14 LAS performance

**LAS Performance for Barking and Dagenham CCG**

Please note that in previous reports, LAS were reporting against a local 8min45sec target. This has now been updated to reflect the national Cat A standard of 8mins.
Current Position

LAS Performance for Barking and Dagenham CCG (see graph)
Year to date, the Barking and Dagenham CCG performance stands at 62.7% of Category A calls responded to within 8 minutes (against the 75%) target. In the latest reported month, March 2016, Cat A performance is 54.3% which is 20.7 percentage points below the standard and down by 4.5 percentage points from the previous month. There has been a 6.7% increase in demand in March 2016 (inclusive of incidents, Hear & Treat and Surge) when compared to the same period last year. Year to date, the overall demand has increased by 6.2%. Cat A activity for Barking and Dagenham CCG for the year to date is 13,703, which is above the plan of 13,440. Green activity is also above the plan of 14,650 with activity reported at 13,806.

LAS Performance Pan-London
LAS have been consistently failing the Cat A performance in 2015/16. During 2015-16 performance against the 75% national standard for Cat A has been predominantly static although January and February has seen a significant dip in performance, with March 2016 performance of 58.2% only a slight improvement on the previous month. This is below the revised recovery trajectory of 71.3%. Year to date performance at the Trust stands at 63.8%. The most recent pan London weekly performance (4th – 10th) is reported at 60.9%.

15/16 Contract Update
LAS were placed in Special Measures by the NTDA on 27 November 2015.

The LAS CQC improvement plan was submitted to the CQC on 15 January. The plan was discussed in detail at the Clinical Quality Review Group (CQRG) on 27 January, and it was noted that the plan does not address a number of the key points, or include tangible actions and timeframes, including culture and learning particularly relating to SI reporting, bullying and harassment. At the CQRG on 24 February, the LAS stated that they are focusing on the 140 projects linked to getting the Trust out of special measures, with innovative work to be progressed via CQUIN schemes. Further to this, the Trust have now sent through a business case for additional funding in 16/17 and 17/18 on the back of the CQC report, which is currently being considered.

An audit of the £32.2m funding spent by the Trust in 15/16 has been shared. The report is being considered by London COs/CFOs.

A response to the letter sent on behalf of the 12 NEL CCGs expressing concerns regarding the robustness of the recovery plan / delivery of schemes that sit behind the revised trajectory; the release of Q2 and Q3 investment funding; and the outcome of the CQC report has been received. However, the response was not deemed to be satisfactory and does not answer a number of points in the letter, including the wider concerns raised regarding the existing governance arrangements, the request for 2016/17 trajectories and the monitoring of tail times (tail times relate to the time taken for ambulances to respond to call outs) to be at CCG level. As such, a further letter has been sent to Lead Commissioners to request a meeting between Wendy Tankard, Director of Commissioning, Newham CCG (on behalf of the 12 CCG NEL Wide LAS Contract Management Forum) and Rob Larkman, Lead Commissioner, Brent CCG.

The LAS contract is funded on a block basis, as part of that arrangement the Trust has received 7.4% uplift for Cat A. Although there is a Risk Share arrangement in place in relation to Green Activity (Cat C), the pan-London Chief Officers have agreed that for financial year 15/16, no funds will be clawed back in the case of underperformance. Year to date to March 2016, the Trust is 3,728 responses under plan for Green activity.

It has been confirmed NHSE will fund £2.3m for CBRN (chemical, biological, radiological, nuclear and explosives) this year, which leaves LAS with a circa £2m shortfall. The LAS have been advised that they will need to provide a bid / business case for CBRN funding in 2016/17.

16/17 Contract Update
A baseline proposal for 16/17 has been shared with Commissioners and is currently under review for approval.

All contract schedules with the exception of CQUIN and Quality Schedules have been approved by Commissioners, subject to final CCG contract signature. A business case has been put forward by the LAS for 2016/17 to request additional funding to support the LAS improvement programme. However, a formal proposal for circulation to CCGs via the LAS Commissioning team has not yet been received. However, while this was originally being dealt with outside of SLA negotiations there is a significant risk the LAS will not sign the 2016/17 contract until the business case is agreed. As such, there is risk of arbitration in line with NHSE directive if the business case is not agreed by 25 April, which is unlikely.

Risks to Delivery

The key risks to delivery of this standard are:-

- 111 conversions to 999 across London
- Staff recruitment and training
- Demand profile
- CBRN funding shortfall
- Ambulance handover times (project underway to identify which Trusts are underperforming in ambulance handovers)
- Use of different protocols

Mitigating Actions

There are currently 361 active applications in the overall recruitment pipeline. The Trust anticipates having 2,932 (93%) operational staff on the front line by the end of March 2016.

A NEL-wide LAS contract management forum has been established. The purpose of this forum is for the day to day contract management of LAS with senior representation from the commissioners. These meetings take place monthly in advance of strategic commissioning board (SCB) going forward.

NHSE held an Ambulance Handover workshop on 26 February involving representatives of the LAS, TDA, Monitor and Commissioners, with a number of recommendations made to improve handover times. These recommendations include: providers, ambulance services and commissioners to form work groups to identify specific causes of handover delays in their area, to agree and adhere to understood definitions for the handover process, for providers and acute Trusts to develop common KPIs, to develop a common escalation plan and all regions to implement a regional capacity management system.
4.0 **Resources/investment**

4.1 Resources/investments in each service/provider are highlighted for each individual provider, under the relevant section of item 3 of this report.

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

4.3 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/mitigations for each service are highlighted for each individual provider, under the relevant section of item 3 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: 22 April 2016
### Appendix 1

**BHR CCGs Contractual Actions taken for 2015/16 Contracts**

<table>
<thead>
<tr>
<th>Provider</th>
<th>CPN’s/AQN’s/Exception notice</th>
<th>Issue</th>
<th>Current Status as at 30.03.16 - Commissioner</th>
</tr>
</thead>
<tbody>
<tr>
<td>BHRUT</td>
<td>1. VTE - CPN</td>
<td>Trust not achieving 95% national target.</td>
<td>VTE CPN issued July 2015. Trust provided summary of actions taken to recover their position. This was outlined in letter to commissioners 07.10.15. Trust has achieved VTE 95% target in Q2 and Q3. <strong>Recommendation:</strong> CPN to be closed. Trust has demonstrated improvement and sustainability against the National Target over a 6 month period.</td>
</tr>
<tr>
<td>BHRUT</td>
<td>2. 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 CPN issued July 2015. CMM held on 12 August 15. RTT recovery plan was signed off at OEG on 16 October 15. This was agreed to be used as the RAP which will be monitored through PAG and OEG, where a summary of actions and timelines are reviewed. <strong>Recommendation:</strong> CPN remains open and Trust to provide summary for RAP monitoring purposes.</td>
</tr>
<tr>
<td>BHRUT</td>
<td>3. A&amp;E - CPN</td>
<td>Trust non-achievement of the national target</td>
<td>A&amp;E CPN issued July 2015. CMM held on 12 August 15 and it was agreed Trust would provide terms of reference for a joint investigation into how to achieve the standard on a sustainable basis. <strong>Recommendation:</strong> TOR for joint investigation remains outstanding and the investigation has not taken place. Contractual action to be taken and issue Exception Notice.</td>
</tr>
<tr>
<td>BHRUT</td>
<td>4. Cancer 62 day – Exception Notice</td>
<td>Trust continued failure to achieve the 62 day standard within agreed timescales</td>
<td>Exception notice issued 4 September 2015. Achievement of standard agreed for January 2016. <strong>Note:</strong> Exception notice closed at 8 October 2015 SPR meeting, however if performance does not meet trajectory contractual action will be taken and the Exception Notice reopened. Weekly monitoring of the Trust trajectory, action plan and PTL will continue in PAG.</td>
</tr>
<tr>
<td>BHRUT</td>
<td>5. 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>CPN issued 16 September 2015. Trust provided response to commissioners on 07.10.15 requesting that the cancelled operations be rolled into the wider updated RAP for RTT. The Trust continues to report underperformance against a zero tolerance threshold with deterioration in performance in Q3. <strong>Recommendation:</strong> Commissioners have advised the trust that the CPN will remain open until the trust is in a position to sustain a zero tolerance threshold for 3 consecutive months. To be reviewed when Q4 performance data has been</td>
</tr>
<tr>
<td>BHRUT</td>
<td>6. MRSA (Methicillin-Resistant Staphylococcus Aureus) - CPN</td>
<td>Trust has breached the zero tolerance thresholds for incidences of MRSA. CPN issued 16 September 2015. Trust provided response to commissioners on 07 October 15 requested for MRSA CPN to be closed and moved to CQRM for monitoring on an on-going basis. Trust has reported no breaches in December and January with an YTD position of 4 breaches against a Zero tolerance threshold. <strong>Recommendation:</strong> Commissioners will continue to monitor MRSA through CQRM. The CPN is to remain open and will be reviewed after February data has been received. Potential for CPN to be closed should 3 months of zero breaches be achieved.</td>
<td></td>
</tr>
<tr>
<td>BHRUT</td>
<td>7. Ambulance handover 30mins</td>
<td>Trust have not achieved 30 minutes handover standard for Q1 and non-achievement is continuing SPR was asked consider non-achievement of ambulance handover standard should form part of the A&amp;E joint investigation review (item number 4). The investigation has not taken place and the trust has not met this standard in 2015-16. <strong>Recommendation:</strong> Contractual Action to be taken</td>
<td></td>
</tr>
<tr>
<td>BHRUT</td>
<td>8. Mandatory Training - CPN</td>
<td>Provider failing monthly targets for Mandatory Training in the following areas; Safeguarding (Adults and Children), Information Governance, Appraisals, Resus CPN issued on 13 January 2016 with a Contract Management Meeting taking place on 25 January 2016. Trust has provided a plan to meet the minimum Mandatory Training Requirements by 31/03/2016. <strong>Recommendation:</strong> CPN to remain open and to be review in one month when Mandatory Training performance has been received from the Trust.</td>
<td></td>
</tr>
</tbody>
</table>
To: Meeting of the NHS Barking and Dagenham Clinical Commissioning Group Governing Body

From: Jacqui Himbury, Nurse Director

Date: 24 May 2016

Subject: Quality in Commissioning Report

Executive summary

The Clinical Commissioning Group (CCG) is committed to improving the quality of care for all services we commission and to driving improvements in the quality and outcomes of all our commissioned services. We do this in a number of ways and across all our activities, as quality underpins all that we do.

Within our operating plan we have described our priorities for 2015/16 and confirmed our continued commitment to delivering the recommendations from the Francis, Berwick and Winterbourne View Reports. We have also confirmed that we will deliver the statutory functions that we are required to as part of the CCG Assurance Framework along with responding to new national policies, for example, the ‘Freedom to Speak Up’ publication. This paper provides assurance to the governing body on delivery of these functions.

The report also provides assurance to the governing body that the CCG continues to implement our quality strategy, the recommendations and requirements of our quality and safeguarding improvement plans such as Safeguarding Adult Reviews, actions to reduce health inequalities along with initiatives for compliance with Francis. The report takes a risk-based approach on our commissioned services, and actions taken to mitigate these risks.

In addition this paper provides assurance that we implement recent legislative and policy developments with regard to quality and safety.

This paper has been written to advise the governing body on the progress made since the last report.

Recommendations

The governing body is asked to:
- Review progress and improvement actions being taken to date
- Suggest any further actions required to provide further assurance.

1.0 Purpose of the Report

1.1 The purpose of the report is to provide assurance to the governing body that the CCG continues to implement our quality strategy, actions and recommendations from quality and safeguarding
improvement plans, actions to reduce health inequalities, such as strengthening safeguarding arrangements along with new initiatives around compliance with Francis.

2.0 Community Acquired Infections – Clostridium Difficile

2.1 The CCG has an annual target that it must remain within for community acquired Clostridium Difficile (C.Diff) infections which is set by NHS England. The target for 2015/16 was a maximum of 37 community acquired C.Diff infections. The CCG achieved this target and reported 34 community acquired infections.

2.2 Our annual target for 2016/17 remains the same as it was for 2015/16 and we will continue to implement the actions below to ensure we achieve the target and sustain our performance:

- Establish closer working relationships between public health, medicines management and primary care colleagues to strengthen and standardise antimicrobial stewardship across the system to include how we work more effectively with all providers
- To deliver infection prevention control sessions at all primary care training forums
- To monitor the place of residence for all people who have a C.Diff infection and to start a mapping process to identify any clusters early on so that immediate preventative action can be taken
- To undertake a full root cause analysis on 10% of all registered C.Diff infections to identify both direct and indirect contributory factors that caused the infection and to then develop a specific action plan; and
- To continue with the system wide joint infection prevention committee that is chaired by the CCG and attended by BHRUT and NELFT.

3.0 Francis Report Freedom to speak update as of 1 April 2016

3.1 Further to the report that was presented at the November 2015 meeting on the “Freedom to Speak Up” under the recommendations from the Francis Report, new measures are to be set to support whistle-blowers in primary care

3.2 From 1 April 2016 NHS England took significant steps to make it easier for primary care staff to raise their concerns so that immediate action can be taken and improvements made.

3.3 When Sir Robert Francis published “Freedom to Speak Up”, he recommended primary care be reviewed separately. NHS England with contributions from stakeholders has drafted whistleblowing policy guidance specifically for primary care. This was available for consultation until 6 May 2016 and the responses will help inform the final policy expected later this year.

3.4 The guidance comes after Sir Robert Francis recommended that the principles outlined in his Freedom to Speak Up report be adapted for primary care, where smaller work settings can present challenges around anonymity and conflicts with employers.

3.5 The intention is that the guidance should be used by primary care organisations to review their policies and procedures on staff raising concerns about safety. The policy guidance sets out:

- Who can raise a concern
- The process for raising a concern
- How the concern will be investigated; and
- What will be done with the findings of the investigation.
3.6 The proposals, developed after working with partners and stakeholders, include:

- Each provider should name an individual, who is independent of the line management chain and is not the direct employer, as the Freedom to Speak Up Guardian. They can offer support and listen to staff raising a concern.
- NHS primary care providers should be proactive in preventing any inappropriate behaviour, like bullying or harassment, or discrimination towards staff who raise a concern; and
- All NHS primary care providers should review and update their local policies and procedures by March 2017, to align with the agreed guidance.

3.7 From 1 April NHS England became a ‘Prescribed Person’ under the Public Interest Disclosure Order 1999, meaning primary care service staff working at GP surgeries, opticians, pharmacies and dental practices, can raise concerns about inappropriate activity directly to NHS England.

3.8 The new status will provide another source for NHS employees across England to raise concerns and disclosures about their workplace in circumstances where a direct approach to their employer is not favoured, suitable or appropriate. It is anticipated that this will lead to a direct improvement in the quality of care for our patients.

3.9 The action that we need to take now is to ensure any provider delivering primary care services such as the urgent care hubs, is made aware that the new policy guidance is being published and seeks assurance that they have plans to review their policies to be able to meet the March 2017 deadline.

3.10 If we do not take anticipatory action now there is a risk that our primary care providers will not meet the March 2017 deadline and this could have a negative impact on any Care Quality Commission inspections as well as compromising patient safety.

3.11 As a delegated commissioner for primary care we have established arrangements with NHS England to be notified of any whistleblowing arrangements and a forum to discuss how this is managed. If the whistleblowing concerns have any safeguarding issues, concerns or risks accountability and responsibility for managing the whistleblowing is with NHS England as we have not yet accepted any safeguarding responsibilities for primary care from NHS England. We will support NHS England and work collaboratively to ensure that patient safety is not compromised and that all risks are identified and mitigating actions agreed.

4.0 BHRUT Clinical Review Days

4.1 In preparation for the CQC re-inspection, BHRUT conducted two pre CQC inspection clinical review days with attendees from various stakeholders and partners: CCG, Primary Care, NHS Improvement (NHSI), patient partners and various employees from across the Trust on 14 and 15 April 2016. Teams of stakeholders and partners were created and dispatched to various department and ward areas across both sites including both emergency departments.

4.2 The purpose of the review was to identify any examples of good practice and excellent care as well as poor care, as yet unidentified quality risks and key quality concerns prior to the anticipated CQC inspection, the date of which is yet to be confirmed. The outcome and findings of the review will inform the CQC inspection preparation plans that BHRUT have in place and will be used to identify priority areas as well as enabling immediate corrective action to be taken.
4.3 The CCG were represented on both clinical review days and found the exercise useful and informative. The CCG identified a number of CQC domain concerns which were fed back to the BHRUT team through the agreed feedback process. The concerns that we identified were mainly related to the quality of care being delivered to patients using both emergency departments.

4.4 To seek assurance that our findings were acted upon and that any quality risks for patients are fully mitigated, the Clinical Quality Review Meeting (CQRM) received a clinical presentation at the May meeting that focused on:
- How does the Trust assure that care is: safe, effective and that patients have a positive experience?
- How are clinical risks identified?
- How are clinical risks managed?
- A review of three different case studies following the patient pathway

4.5 Following the presentation the CCG were assured that the Trust could evidence an improvement in the urgent/emergency care that patients were receiving compared to an unannounced CCG quality assurance visit twelve months ago, that there was an emerging process for managing and mitigating clinical risks and that patients were receiving the clinical care they required once the decision to admit had been made. However, patients are still waiting excessive lengths of time in the emergency departments which compromised their privacy and dignity and the Trust confirmed this to be the case. The CQRM were not fully assured that all patient safety and quality risks were accurately identified by the Trust and have requested a clinical quality risk assessment with mitigating actions for the June meeting. To triangulate the findings from the clinical review days, the clinical presentation and the quality risk assessment and to ensure that the Trust have made improvements an unannounced CCG quality assurance visit has been planned within the next three months.

4.6 The main risk is that unless the internal systems within the Trust to monitor and manage patient safety are consistently implemented and constantly reviewed patients may be a risk of receiving poor care. The Trust have assured commissioners that their processes are robust and fit for purpose, and to monitor the level of patient care we will continue to review all serious incidents, incidents, complaint data and themes and patient comments from the Friends and Family Test.

5.0 Adult Safeguarding

5.1 The Designated Nurse Adult Safeguarding position has been filled on an interim basis, confirming the CCG’s continued commitment to the safeguarding adults agenda including Mental Capacity Act (MCA)/Deprivation of Liberty (DOLS) and PREVENT. Following the introduction of this post, work has commenced to further strengthen and develop partnership working, internally across all our directorates and CSU contracting teams to ensure that adult safeguarding is fully embedded in all our commissioning functions and activities.

5.2 The CCG has also replicated the strengthening of our adult safeguarding arrangements externally, by formalising representation with local Safeguarding Adults Boards (SABs) and sub-groups with a consistent presence, developing more effective working relationships with providers and local authority colleagues.

5.3 The PREVENT agenda and BHR CCGs responsibilities regarding training and compliance has been enhanced with the development of a PREVENT awareness training session and related summary, with plans to reintroduce Health WRAP training commencing in quarter 2. WRAP training is advanced PREVENT training which specialist children and safeguarding roles require.
Plans are being developed to refocus the development of our Nursing Home Strategy, with a draft strategy to be produced at the end of quarter 2. The Nursing Home Strategy will describe our approach to continuing to improve the quality of care provided by care homes with nursing.

5.4 Processes for the collection, storage, analysis and translation of data obtained from safeguarding concerns, Serious Incidents (SI), Safeguarding Adult Reviews (SAR) and Domestic Homicide Reviews (DHR) is currently under review. This coupled with the collection of soft-intelligence will enhance our overall view of providers whilst also allowing BHR CCGs a greater level of assurance in local safeguarding adults practice and development.

5.5 Over the past eighteen months we have seen a steady increase in the numbers of Safeguarding Adult Reviews (SAR) and Domestic Homicide Reviews (DHR) that are being commissioned by SABs and Crime Prevention Partnerships. Recent reviews across BHR CCGs have included a number of suicides of people known to mental health services, a possible ‘euthanasia’ type death, a death related to possible failures in discharge planning and one relating to a patient with learning difficulties and dysphagia (difficulty swallowing).

5.6 The SAB has responsibility for monitoring the completion of the reviews, disseminating the learning through a summarised process that is shared with relevant partners, providers and all third sector organisations. Once a review is completed there is a requirement for related action plans to be developed to provide assurance to the SAB that recommendations and changes in practice are embedded into practice, policy and commissioning processes. For BHR CCGs this will include our own related action plans, and in addition, a written paper outlining themes and trends that is presented to our Safeguarding Assurance Committee.

5.7 We do not have any specific risks related to either SARs or DHRs and responsibility for monitoring the implementation of our plans is through the Safeguarding Assurance Committee.

6.0 Resources/Investment

6.1 There are no resource investment implications arising from this report.

7.0 Equalities

7.1 There are no equalities implications arising from this report.

8.0 Risk

8.1 The risks arising from this report have been described in the relevant sections of the report along with the mitigating actions.

8.2 There are still issues with the GP alert system which is not working as effectively as it needs to be and which are a missed opportunity in terms of early warnings. We are reviewing the process once more and using best practice from a neighbouring CCG where it is working well. Recommendations will be made to the Quality and Safety Committee.

9.0 Managing conflicts of interest

9.1 There are not any conflict of interest implications for this report.

Author: Jacqui Himbury and the Quality and Safeguarding Team
Date: 28th April 2016
To: Meeting of the NHS Barking and Dagenham Clinical Commissioning Group Governing Body

From: Kash Pandya, lay member and Chair of Remuneration & Workforce Committee

Date: 24 May 2016

Subject: Feedback report from the 8 March 2016 Remuneration and workforce Committee meeting

Summary
Below is a summary of items considered and approved by the Remuneration & workforce committee at its meeting held on 8 March 2016.

Key items discussed and approved
The Committee considered a number of key items:

- **Organisational development and capacity update**
  The committee noted an update on progress to date and the actions proposed to address capacity issues.

- **Management Information – workforce data**
  The committee noted a report on workforce information and Chairs and directors would address non-compliance issues with mandatory training.

- **HR Policies – agreement and update**
  The committee approved the disciplinary policy and absence management policies and agreed to circulate all outstanding policies before the next meeting which will ratify these.

- **Changes to terms of reference**
  The committee approved the proposed change to the terms of reference to remove the secondary care consultant as a member of the committee as there have not been issues with quoracy.

Recommendation
The Governing Body is asked to note this report.

10 May 2016
To: Barking & Dagenham CCG Governing Body

From: Kash Pandya, Vice Chair of the Finance & Delivery Committee and Lay Member, Governance

Date: 24 March 2016

Subject: Feedback report from the April 2016 Finance & Delivery Committee meeting

Summary

The Barking & Dagenham CCG Finance & Delivery Committee provides the minutes of each meeting to the Governing Body. To provide additional assurance to the Governing Body, this brief feedback report provides key highlights from the last meeting.

Key challenges discussed and risks addressed:

Finance
The CCG faces an enormous financial challenge in 2016/17. Concern was expressed about the imbalance in the 2016/17 draft budget and the need to prepare plans to address the likely budget shortfall and meet statutory targets through review of activity levels, a line by line budget review and risk pooling. Committee members were assured that this is all in hand and that NHS England are aware of the current difficulties in striking a balanced budget for 2016/17.

QIPP 16/17
Committee members were advised that QIPP plans for each of the three CCGs will be brought together as part of the transformation programme and members agreed that input from clinical directors is crucial.

Choose & Book (C&B) System
Committee members were advised by CSU colleagues that the issues that have been raised at previous meetings about C&B are due to the size of waiting lists and are being addressed as part of the RTT recovery.

Borough risk register:
Concerns were raised about the format of the risk register and it was greed that it needs to be completely refreshed.

Contracts/deep dives
The CSU presented data on Trauma & Orthopaedic procedures which demonstrated an increase in the numbers of procedures carried out in 15/16 compared to 14/15. A further analysis report will be undertaken for the next meeting.

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.

10 May 2016
1.0 Welcome and apologies

The Chair welcomed those present and apologies for absence were noted.

The meeting was not quorate and so the Chair explained that the Committee would only be able to make recommendations and if any decisions were required, agreement would need to be sought outside of the meeting.

1.1 Declarations of interests

There were no additional declarations of interest.

1.2 Minutes of the last meeting

The minutes of the meeting held on 16 February 2016 were agreed as an accurate record.

1.3 Matters arising/actions log

Choose & Book System (C&B)
AJ reported that the issues that had been reported by CDs at this meeting and the other two F&D Committee meetings are being caused by waiting list sizes. There are 1300 appointments per month at both BHRUT and Barts Health and the system automatically blocks the appointments when the waiting lists are too big. The appointment slots are there but the system cannot display them until the waiting list size is reduced. The matter will be picked up as part of the RTT work stream. The three CCGs and the Trusts need to agree how this can be resolved. A possible solution is to use a different system and discussions about this are taking place. KP asked for C&B to be a standing agenda item until the Committee is assured that the issues have been resolved. He said he would also welcome an update on RTT at each meeting. SM reported on the risk that B&D has in regard to dermatology and explained that a paper had been taken to the April Investment Committee to seek agreement to allow the dermatology service in Havering to accept patients from B&D and this was
Shared Electronic Care Records Risk
An updated report was provided to the Committee, however, it was not clear if the letter about the data sharing agreement that was given to LMCs has been sent to practices and if it has, how many have signed up to the agreement. AM to find out from Rob Meaker and send an update to members outside of the meeting.

All other actions were reviewed and updated.

2.0 Finance reports / risks

2.1 Financial risks report
TT explained that he would be giving a verbal update as it was ‘year-end’. The annual accounts have been completed in draft and have been presented to the Audit & Governance Committee. They are now with the Auditors. The CCG has achieved its revised surplus but faces an enormous financial challenge in 2016/17 with an un-identified QIPP of circa £3m. The cost pressure in regard to BHRUT is circa £20m before RTT is included. The report that Ernst & Young are producing regarding RTT is expected at the end of the month. The likely cost of RTT for 16/17 is £9-10m. In regard to Barts Health, the cost pressure is circa £3m across the 3 CCGs. KP asked on behalf of WM, how much is going to be invested into primary care and TT responded, saying we know what the budgets are and a paper will be going to the May Governing Body. RA added that the total QIPP across the 3 CCGs is £28m.

KP expressed concern about the imbalance in the 2016/17 draft budget and the need to prepare plans to address the likely budget shortfall and meet statutory targets through review of activity levels, line by line budget reviews and risk pooling. TT and SM explained that this was in hand and that NHS England are aware of the current difficulties in striking a balanced budget for 2016/17.

KP took the opportunity to thank TT and his team for their hard work and for producing the draft accounts in a timely manner.

2.2 Line by line budget review
SM explained that this is now being taken forward across the 3 CCGs in the form of a ‘star chamber’ which is being co-ordinated by the Project Management Office (PMO). The work is expected to be completed by the end of May. Discretionary spend will be one of the things considered and recommendations will be taken to the ‘star panel’. KP asked who would be on the panel and SM explained it will be the CCG Chair, Chief Operating Officer (COO), Chief Finance Officer (CFO), and the Contracts Senior Responsible Officer (SRO). KP said it would be good to have an independent person involved as well.

2.3 Borough risk register review
SM advised that the register was in the process of being updated therefore the version available wasn’t the most up to date. In terms of IAPT which had been escalated to the Governing Body (GB), SM reported that it looks like the target will be exceeded quite significantly and therefore the risk will soon be able to be reduced. In regard to LAS, SM advised members about the CQC report they have received There is an improvement plan in place which is being managed by the lead commissioners. SM to circulate it to members outside of the
meeting. KP said he felt that the risk register needs to be completely refreshed. He said the information in the ‘mitigating actions’ column doesn’t explain what progress has been achieved. He added that outcomes are also needed and that we need to pool the risks so that the key risks can be concentrated on. TT advised the Committee that discussions are taking place about developing the risk registers going forward.

2.4 QIPP delivery 15/16 and QIPP development 16/17
For 15/16 a year to date saving of £7.69M against a plan of £7.09M was reported. KP asked about the 15/16 QIPP schemes where activity is still very high and how they will be picked up in 16/17. SM advised that their full year effect is being looked at. KP said he would speak to WM about the CDs attending the Committee to hear from them about what they have been doing about the schemes that still show high levels of activity. SM reported that for 16/17 the CCG has a QIPP target of £7.93m and as at 21 April £4.63m has been identified. A review of the discretionary spend managed through the ‘star chamber’ process and development of further QIPP opportunities through the ‘Right Care’ process will be used to close the QIPP gap which is £ 3.5m.

2.4.1 QIPP plans 16/17
RA advised members that it is possible that the QIPP amounts for each CCG could be increased. SM added that a new system-wide approach to delivery will be taken for this year. There will be a lead CD acting on behalf of the three CCGs instead of just their own CCG. The ‘Right Care’ methodology is being incorporated into the QIPP work and a proposal will be taken to the Joint Management Team (JMT) meeting on 28 April. TT confirmed that the proposed QIPP plan will be presented at the GB meeting in May.

3.0 Voids & spaces
TT advised that there is still a lot of retained estate that is surplus to requirement and how we appropriately rationalise the estate will be looked at. TT also advised the Committee that a strategic estates plan is being developed.

4.0 Contracts position and deep dive reports

4.1 Contracts position
It was acknowledged that the report was for 15/16. GM advised that the biggest cost pressure continues to be Barts Health. KP asked if the contract for 16/17 has been signed and GM said it was being finalised by the lead commissioner but he has not seen the detail yet. The content of the report was noted.

4.2 Updated schedule of contracts
KP said the report was helpful but added that in its current format it is too detailed. He added that he was concerned about the number of single tender waivers and was very keen to know about contracts that are coming up for renewal and asked for the summary cover report to include the following:-

- contracts coming up for renewal
- contracts that are un-signed
- contracts that are not performing
- an explanation on what the nursing home assessments involve and how they are monitored
SM said it would be helpful to have a summary of the new procurement guidance at the next meeting. GM agreed and assured the Committee that the summary cover report for the schedule with the schedule attached as an appendix will be provided at each meeting going forward.

4.3 Deep dive – Trauma & Orthopaedics (T&O)
AJ tabled data showing an increase in the number of T&O procedures carried out in 15/16 compared with 14/15. The independent sector has seen the highest percentage increase. The movement of the referrals to the independent sector and away from BHRUT, together with the higher ratio of follow-up appointments has increased the cost pressure on the CCG. KP thanked the CSU for providing the helpful report and said it confirms what was expected. SM added that the feedback from CDs is that GPs have no choice but to refer patients to the independent sector because they cannot refer to BHRUT or Barts Health. It was agreed that this is all linked to the C&B system issues mentioned at the start of the meeting. The Committee agreed that the concern is the referral figures for BHRUT are still increasing. SM added that MSK and Orthopaedics have been identified as a priority for Right Care and the RTT recovery plan. SM asked the CSU to drill down further so that the Committee could look at the data in even more detail at the next meeting. GM agreed to raise the increase in follow-ups at the contracts management meetings.

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<th>5.0</th>
<th>Items for noting</th>
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<tr>
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<td>The Committee noted the following:-</td>
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<td>• Committee work plan 16/17</td>
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<td>• F&amp;D Committee’s annual report/committee effectiveness</td>
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<td>• BHR Health Economy Finance &amp; Estates Group minutes</td>
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<tr>
<th>6.0</th>
<th>Date of the next meeting</th>
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<tr>
<td></td>
<td>28 June 2016</td>
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<td></td>
<td>1.30pm – 3.30pm</td>
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<td>Maritime House, Barking</td>
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To: Barking & Dagenham, Havering and Redbridge CCGs
From: Kash Pandya, Chair of Audit & Governance Committee
Date: May Governing Body meetings
Subject: Feedback from the 19 April 2016 Audit & Governance Committee meeting

Summary

The BHR Audit & Governance Committee provides the minutes of each meeting to the three BHR Governing Bodies. To provide additional assurance, this Committee Chair’s report provides the key matters arising from the last meeting on 19 April 2016 to be drawn to the attention of the Governing bodies.

- The draft Annual Accounts and Annual Reports for 2015/16, which are subject to audit, were considered. The Committee were impressed by the overall quality and timeliness of the documents presented to them. The Committee noted that all three BHR CCGs have met the statutory targets for 2015/16.
- The Committee were advised by internal audit that, based on the work done to date, they would be minded to issue an unqualified Head of Internal Audit Opinion.
- The Committee were advised by external audit that they would be considering the financial resilience and RTT issues at the BHR CCGs in formulating their value for money conclusion for 2015/16.
- The Committee approved the internal audit plan for 2016/17. The plan addresses the key risks facing the CCGs.
- The Committee remain concerned about the risks facing the CCGs in managing the budgets for 2016/17, given the size of QIPP savings that needs to be delivered and the size of the unfunded RTTs. The Committee intend to monitor the progress in achieving financial balance on an ongoing basis.
- The Committee approved its annual report for 2016/17. This will be reported to the Governing Bodies within the CCG’s own Annual Reports.
- As part of its work plan 2016/17, the Committee has decided to invite CCG Directors and Chief Operating Officers to its meetings on a rotation basis to explore risk management processes within their areas of remit.

Kash Pandya, Audit & Governance Committee Chair
11 May 2016
Draft Minutes of the Joint Barking & Dagenham, Havering and Redbridge CCGs Audit & Governance Committee held on 19 April 2016 2016 at Becketts House 9.00-12.00pm.

Present – Members

Kash Pandya (KP) BHR Audit Chair, Lay Member for Audit & Governance
Khalil Ali (KA) Lay Member PPI Redbridge CCG
Charles Beaumont (CB) BHR Co-opted Member for Audit & Governance
Richard Coleman (RC) Lay Member PPI Havering
Sahdia Warraich (SW) Lay Member PPI Barking & Dagenham

In attendance – Officers

Marie Price (MP) BHR Director of Corporate Services
Tom Travers (TT) BHR Chief Financial Officer (CFO)
Rob Adcock (RA) BHR Deputy CFO
Paul Hunt (PH) NELCSU, Senior Financial Control Manager
Angela Ward (AW) BHR Company Secretary
Sarah See (SS) part Director of Primary Care Transformation

In attendance – auditors

Kevin Suter (KS) External Auditors Ernst & Young
Stephen Bladen (SB) External Auditors, Ernst & Young
John Elbake (JE) Internal Auditor, RSM
Kevin Suter (KS) External Auditors Ernst & Young

| Action |

9.00-9.30 Committee Members held a short private meeting and a further brief meeting with the External Auditors (EAs).

31/16 Welcome and Apologies for absence

There were no apologies for absence.

A letter of thanks from Members would be sent to Dr Ah-Fee Chan for her past contribution to the Audit & Governance Committee.

AW

32/16 Declaration of Interests (DOI)

In addition to noting the declarations on the registers provided, SW requested a new form to update the change around Healthwatch and Kash Pandya would advise of a minor change around one of his interests.

AW

33/16 Minutes of meeting held on 19 January 2016 and Chairs summary report

The minutes of the previous meeting were agreed and would be signed by the Chair as a correct record. Members noted the content of the key highlights cover report that accompanied the minutes to the last Governing Bodies.
<table>
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<tr>
<th>34/16</th>
<th>Matters Arising</th>
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<td>The three Matters Arising Actions had been completed.</td>
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<th>35/16</th>
<th>Internal Audit (IA)</th>
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<tr>
<td><strong>BHR Progress report</strong></td>
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<td>Following some minor changes agreed with management, IA had issued the IG Toolkit Review final audit report and this could be found in the Boardpad Reading Room. The Chair thanked the auditors for their input at very short notice into the final IG Toolkit. Fortunately, as a result, the BHR CCGs had met the mandatory deadline. The Chair requested the SIRO to ensure that arrangements were better next year between completing the final draft in early February to sign off and submission in March.</td>
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<td>A further final report had been issued on the GBAF-Deep Dive Review which was positive and a draft issued on QIPP. Drafts would shortly be issued on CHC-Management Review and the BCF and Collaborative arrangements-management review. Good progress had been made on management action in response to IA recommendations in-year. The Chair in noting management actions around PCC, advised that interviews were imminent for the PCC Independent GP and some action had been deferred by agreement with the auditors. JE was asked to check on the issue arising from B&amp;D CHC review involving liability for Learning Disabilities (LD) between CCG and Borough.</td>
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<td>There had been no changes to the positive draft Head Of Internal Audit Opinions (HOIOAs) as seen previously by the Committee.</td>
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<td>Some changes had been made to the IA Plan following discussion with KP/TT, in particular around the timings of reviews.</td>
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<td>Attention was drawn to a number of information briefings. It was noted that the list of IA reports 20125/16 contained some that did not warrant a formal opinion as they were advisory pieces.</td>
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<td>The Chair enquired of IA if there was any current work that could impact on the final HOIOAs. JE confirmed that though none were expected, in-year changes in process such as for QIPP had yet to be responded to by officers. In response to the Chair’s question on whether the auditors were satisfied with recommendations made being implemented to in a timely way, JE added that this was satisfactory.</td>
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<td>The Chair referred to new guidance on management of Conflicts of Interest. He was planning on meeting with the Governance team and in-house solicitor to work through the next steps that would include training in due course.</td>
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<td><strong>CSU Assurance Work - Progress report</strong></td>
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<td>Three finalised reports with ratings of amber/green had been issued on Data Quality and Performance Management, Information Governance Toolkit and Accredited Safe Haven Compliance Review and also Acute &amp; Non-Acute Contracting review. Reference was also made to follow up of 26 outstanding actions in response to IA report rec were in progress. A draft assurance plan for 2016/17 had been prepared and was being submitted to the CFO's Assurance Group.</td>
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<td>The Phase1 Service Auditor Report (SAR) had highlighted 13 exceptions across the 12 CCGs which had been addressed by the CSU and details were provided of progress made on each. These areas were not subject to additional</td>
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IA review. It was noted the report to date covered matters arising up until February 2016 and a bridging letter would follow to cover through to the year end. The Chair was encouraged by actions taken but under the Data Quality and Performance Management report he had noted delays in SI reporting on the WELC side and JE confirmed this was covered under the Clinical Governance report. KA questioned patient engagement arrangements under the Procurement report and MP confirmed it was the CCG responsibility mainly as CSU were involved in the technical side of procurement. This could be reviewed further under the new Engagement Strategy.

**Head of Internal Audit Opinions**
JE confirmed there were no changes to the drafts received at the last meeting. IA would inform the Chair directly if there were any changes before sign-off was required.

**Internal Audit Plans & Strategy**
There had been some minor amendments since the last meeting and Members were able to now approve the documents.

### 36/16 External Audit (EA)
KS confirmed good progress in preparations for the year-end auditing. Members had been advised of risks at the last meeting on the Value For Money Conclusion (VFM) and an update would follow at the May meeting. The key risks were around delegated co-commissioning and governance and the BHRUT RTT position. Members noted the significant risks round RTT and the Chair requested early advice on the outcome of this review.

An accounting issue was noted around IT equipment purchased but not yet in use due to a landlord issue, that meant that capital charges do not yet apply.

The Chair was asked to respond to an EA letter on arrangements for handling fraud in BHR CCGs and SB would provide a template that would be of assistance. TT would complete this by the end of the month.

The EA’s progress was noted.

### 37/16 Committee Draft Annual Report
Members considered the draft annual report of the Committee, a required section of the three Annual Reports. The Chair had considered other CCG reports and had expanded this year’s report. Attention was drawn to the proposal to invite all Chief Operating Officers (COOs) and Directors to at least one meeting in year to discuss their own risk areas and this was supported.

Some minor amendments to the draft were made and the draft was agreed by the Committee.

### 38/16 Governance-Draft BHR Annual Reports
MP presented the three draft Annual Reports, which were on track and had some additional areas this year e.g. performance and there were still some further text to be inserted. MP explained that some of the wording responded to national requirements. She suggested that Members read their own Borough reports and feedback directly to her by 2 May. She suggested cross reading with the draft Annual Accounts and requested that only significant queries be raised.

MP was asked to share the draft with the CCG Chairs. She said that this was in
hand. She added that there would be user-friendly summaries provided during the summer for the public AGM meetings.

The External Auditor was impressed with the progress made at this date and MP was asked to thank those furthering the production of his reports.

The drafts were noted and Member feedback would follow by 2 May.

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<th>39/16</th>
<th>Finance Updates</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>39.1 Tender Waivers</strong></td>
<td></td>
</tr>
<tr>
<td><strong>39.1.1 Resilience and mindfulness training for schools-part of CAMHS transformation programme.</strong> This waiver related to specialist training and was required to ensure CAMHS funds were utilised in year. Only one quotation was received from the Special Yoga Foundation and Members noted the single tender action that had been taken.</td>
<td></td>
</tr>
<tr>
<td><strong>39.1.2 Deloittes support to the Vanguard</strong>-The tender waiver related to support of the development of the BHR Vanguard model and Deloittes had been selected as having experience in this field. Also national funds had been received fairly late in year to support the financial modelling and there was need for expediency.</td>
<td></td>
</tr>
<tr>
<td><strong>39.1.3 Funds for operational delivery of integrated care model- service provided by Age UK Redbridge</strong>-Given the success of an Integrated Care, Care Navigator project, Age UK were seeking bids for funds to establish a significant cohort of projects to provide a useful evaluation. Age UK part funded this pilot and a single tender waiver was applied to engage BHR Age UK. The CCG funds were received from PMCF NHSE funds. Members noted the action that had been taken.</td>
<td></td>
</tr>
<tr>
<td><strong>39.1.4 PWC Finance modelling support for ACO business case</strong>-Having initially worked on the CCG’s Accountable Care Organisation (ACO) programme, PWC were asked to provide a further phase of work and a single tender waiver. It was noted Redbridge were hosting the funds for this BHR area of work. The cost of the work would be provided with the minutes of the meeting.* The Chair questioned the preparedness for procurement and contracting and noted the schedules provided to the Finance &amp; Delivery Committees with the contract expiry dates and proposed this Committee took a view on timeliness at a subsequent meeting. This would be added to the Work-plan. The Committee noted the action taken.</td>
<td></td>
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<tr>
<td>(* The cost was £279.5k plus VAT.)</td>
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</tbody>
</table>

**39.2 Draft Annual Accounts**

**39.2.1 Barking & Dagenham, Havering & Redbridge**
TT confirmed that all CCGs would meet their amended control totals, and each CCG achieved surplus was noted and running cost targets were also met.

Cross-charging within London or WIC work was assisted by a London-wide agreement and RA added that a new payment mechanism was accelerating change. TT thanked his team for producing good work to date within challenging deadlines. CB noted that budgeting would be extremely challenged in 2016/17 and the Committee would be reviewing the quarterly position. The Chair questioned if balances with Trusts were being agreed. RA confirmed a
reasonably good position with a prudent approach being taken. Similarly a
prudent approach was being taken to Provisions.

The Chair raised concern at any repetition of the last minute changes required
last year just prior to submission, which were made but this was not good
practice. CB queried a Life Study project in B&D and TT explained this
BHRUT/NELFT collaborative research project commenced in 2014 and liability
was being checked at present.

The Chair requested all present provide any comments back to TT and c.c. KP
but that the focus should be on significant issues. CB and KP would review all
Accounts and RC, KA and SW would review and comment on their own only.

<table>
<thead>
<tr>
<th>40/16</th>
<th>Delegated Commissioning-Qtr. 4 Self Certification</th>
</tr>
</thead>
<tbody>
<tr>
<td>SS attended to present the draft returns ahead of the Primary Care Committee (PCC) this time as meeting dates had allowed this. Two key highlights across all submissions were-Managing Conflicts of Interest (COI) and the impact of the Personal Medical Services (PMS) review with practice sustainability issues varying by CCG. SS was asked to emphasise the PMS Review risks in the report. Individual CCG risks such as the Abbey Medical Centre in B&amp;D CCG were discussed. Feedback was that IA quarterly reviews of the self-assessment would not be required. A final update would be provided for the next PCC meeting prior to submission.</td>
<td></td>
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<table>
<thead>
<tr>
<th>41/16</th>
<th>Committee Work Plan</th>
</tr>
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<tbody>
<tr>
<td>Additions included regular reporting on RTT progress, monitoring Constitutional targets and involving COOs (first) and Directors to understand their risks in a supportive way. LCFS would bring an Annual Report to the May meeting. The Work-plan would be updated.</td>
<td></td>
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<table>
<thead>
<tr>
<th>42/16</th>
<th>Any Other Business</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Business Continuity</strong></td>
<td></td>
</tr>
<tr>
<td>MP advised that the test exercise ‘Kanical’ had just taken place and there were a few issues to address on CCG or CSU responsibility. A report would be provided next time on the outcome and also address risk around IT change-over. The Chair requested a mapping of IT systems from RM.</td>
<td></td>
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</tbody>
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<table>
<thead>
<tr>
<th>43/16</th>
<th>Messages for the Governing Bodies</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Chair would discuss the key issues for the GBs with the secretary.</td>
<td></td>
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<table>
<thead>
<tr>
<th>44/16</th>
<th>Next Meeting</th>
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<tbody>
<tr>
<td>The next meeting was confirmed as Friday 20 May 2016.</td>
<td></td>
</tr>
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</table>

Signed............................................................Date........................................
Barking and Dagenham Clinical Commissioning Group
Patient Engagement Forum (PEF)

Thursday, 17 March 2016
Barking Community Hospital

Present:
Miriam Greenwood  PEF Chair
Nicholas Hurst  PEF Vice-Chair
Dorothy Stokes  PEF member
Val Shaw  PEF member
Wendy Garton  PEF member
Christine Brand  PEF member
Mary Parish  PEF member
Dorothy Stokes  PEF member
Sahdia Warraich  Lay member B&D CCG
Ron Wright  PEF member
Gemma Hughes  Deputy COO B&D CCG
Boba Rangelov  PPE Advisor BHR CCGs

In Attendance:
Sarah See  Director Primary Care Transformation programme

Apologies
Barbara Soyer  PEF member
Azka Sohail  PEF member
Dave Elliott  PEF member
Elaine Clark  PEF member
Sharon Morrow  Chief Operating Officer, B&D CCG
Manisha Modhvadia  B&D Healthwatch

<table>
<thead>
<tr>
<th>Item</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Welcome and apologies</td>
</tr>
<tr>
<td>1.1</td>
<td>The Chair welcomed everyone and apologies were accepted. MG invited interested PEF members to stay after the meeting to complete the annual 360 degree survey of CCG stakeholders.</td>
</tr>
<tr>
<td>2</td>
<td>Minutes of the 21 January 2016 meeting and matters arising</td>
</tr>
<tr>
<td>2.1</td>
<td>BR to amend 7.1 paragraph and to add Val Shaw, as she also met with Jess Cunnett. Subject to this the minutes were agreed.</td>
</tr>
<tr>
<td>2.2</td>
<td>Matters arising-actions taken</td>
</tr>
<tr>
<td>2.2.1</td>
<td>All actions were completed.</td>
</tr>
<tr>
<td>2.2.2</td>
<td>Ledged rooms for cancer patients at BHRUT: GH had a conversation with Dr Jane Stevens from BHRUT about ledged rooms. Dr Stevens was not in a post when decision was made about this at BHRUT so not sure if there will be any plans to reinstate those rooms, but BHRUT has no plans at present. They have in place a robust cancer strategy and this was presented to PEF at one of the recent meetings.</td>
</tr>
<tr>
<td>2.2.3</td>
<td>The IAPT update would be in July instead of June as there was no planned PEF meeting in June.</td>
</tr>
</tbody>
</table>
2.2.4 MG drew attention to the notes of the PEF extra meeting which was held on 25 February in Barking Learning Centre about plans for stroke rehabilitation services. MP referred to the importance of prevention and suggested that this should be an agenda item; prevention in relation to cancer and diabetes had been previously discussed by the group but not specifically in relation to stroke so this would be considered for the forward planner. As stated in the notes of the extra meeting it was agreed that there was no need for a joint PEF response to the consultation and it was left to PEF members to respond individually to the consultation. WG suggested Asda in Whalebone Lane, as they have already accommodated Diabetes UK and it was good location.

**ACTION:** GH to suggest this to our Communications team.

VS also suggested shopping centres in B&D.

**ACTION:** BR to check with Zoe Anderson if they approached shopping centres in B&D.

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<tr>
<th>3</th>
<th>Primary Care transformation programme (update)-Sarah See, Director Primary Care Transformation Programme</th>
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</table>
| 3.1 | MG welcomed SS to the meeting. SS provided an update on the draft primary care strategy. SS reminded everyone about the NHS Strategic Commissioning Framework (SCF) for Primary Care Transformation in London and the 17 indicators underpinning accessible care, proactive care and co-ordinated care that that CCG’s have committed to implement so that all Londoners have access to the same service offer from general practice. The draft strategy will outline how we plan to implement the SCF in Barking and Dagenham, including improving patient access and experience and addressing variable GP practice performance through a quality improvement approach. Another key issue to address with colleagues from across London, BHR and more locally is workforce recruitment and retention; B&D has one of the lowest percentage of GPs WTE per 1000 patients; this applies to practice nurses too. We will have to work differently, developing solutions on how to overcome the £400 million gap in funding across BHR health and care organisations in the coming years. In terms of the strategy, the focus was on developing productive practices, supporting collaborative working between practices and developing a GP-led locality model working with other providers. IT systems and good health and care estate would be essential. For example, we need to continue to promote the usage of the patient on-line system by patients and practices, as this would enable booking appointments, ordering repeat prescriptions and accessing one’s own GP health record. The GP records would soon be available at the GP hubs which provide out of hours GP appointments weekday nights and evenings (this was currently being piloted in Havering) to provide good continuity of care between professionals.

In B&D GPs were already working in 6 clusters; further work would be on how to reorganise into localities or networks of practices with a combined registered population of 50,000-70,000 working alongside colleagues from NELFT, the LA and other providers in a more joined joined-up way developing the integrated care model further to ensure better outcomes for our residents.

Q1: How long this work had been going on and what PPE activities were involved?

A1: SS responded that she had engaged quite widely as part of the development of the strategy. As part of locality working, the expectation...
was to work more closely with the patient groups, voluntary sector organisations and engage more widely with residents. GH added that idea of clusters in not new and it has been going for ages; the LA had organised around clusters long time ago. SS confirmed that a survey had been distributed to the voluntary organisations and she had spoken with Age UK and other organisations. The CCG was currently developing a PPE strategy which would support a more in-depth approach to working with local residents as the detail of the workstreams in the strategy were developed with patients.

Q2: What difference would the programme make for the patient?  
A2: It will be more accessible service that does not just focus on treating patients but enabling self-care and more proactive care. Achieving better patient access and satisfaction results would be key as well as how a patient feels empowered to manage their condition; localities were likely to develop more local outcomes relevant to their populations.

Q3: Have you been in touch with the residents’ associations groups?  
A3: No, this is a helpful suggestion. In Redbridge one practice has used its patients’ group to design a new way of accessing the practice – via telephone and an online triage service.

Q4: CB suggested to SS that this sounds similar to the Nuka care model whereby they support patients in lifestyle choices which frees GP time.  
A4: SS said the CCG has reviewed best national and international models, and in some ways was producing a hybrid of many of these models to make locality working most appropriate for B&D.  
**ACTION:** BR to send the Nuka presentation to SS

Q5: In my own surgery there is only one GP, so they rely on locums. Such small surgeries are not able to work 8 am to 8 pm and will not be able to cope.  
A5: Clusters already exist as a commissioner but not provider model. Some practices may decide to merge in the future but this was not the aim of the strategy rather it was about enabling practices to work collaboratively to provide good, safe quality care which meets the needs of patients. The size of the practice was not as important as the quality of service provided. Some smaller practices performed better compared with larger practices; it could all be quite variable depending on different factors. Relying on locums was not good unless a long-term locum which could bring some continuity to the practice. However, attracting primary care workers and developing new roles must be one of our key priorities.

Q6: GPs work well throughout the year and then when they come towards the end of the year, they have problems with the QOF (Quality Outcome Framework). Could they have a consultant or a person who would go around practices to look what each practice is doing?  
A6: Most practices work on QOF throughout the year, although there can sometimes be a rush towards the end of the year.

Q7: Health 1000: have more patients been persuaded to join this clinic even if they have good GP?  
A7: More patients had now registered with the practice but it was not yet at capacity; those receiving services reported very high satisfaction. The Nuffield Trust will be evaluating this pilot later in the year. Continued
support with promoting the service would be appreciated.

Q8: SW raised the issue of the PMS (Personal Medical Services) review. This was a national exercise about, bringing everyone to the same level, resulting in dramatic reduction in B&D practices’ incomes as B&D was the second highest paid area in London.
A8: SS confirmed that they were reviewing the contract to ensure equity in funding between all GP practices; currently the PMS premium was £2.4million in B&D, the second highest in London. For example, one PMS practice received an additional £63 per weighted patient. Commissioners needed to review the funding to ensure the same level of funding for all practices over a 4-5 year period. SS however recognised the impact that this will have on all PMS practices and said that the CCG will have to work with providers to ensure practices do not close or staff are lost; locality working was one of the solutions which may address this situation. MG expressed concern that with a major GP recruitment problem locally these changes could make things worse. SS confirmed that funding would stay within the borough but shared equally between all providers so that all patients had access to the same service offer.

Q9: What our GPs think about this?
A9: SS said she has spoken with the London Medical Council (LMC). The level of reduction and impact was of course a concern to all parties and more discussion at a practice level would be necessary.

Q10: You should have someone to go around practices; it is very busy in my practice.
A10: SW stated that lot of CCG staff (Practice Improvement Leads) visit GP practices and work with them.

PEF members’ additional comments: On line appointments booking was available but reception staff held back too many appointments so that those available went very quickly; further people did not know about it so did not use it. SS said they are putting some funding to support the implementation of the scheme with practices and patients.

MG thanked SS for her presentation.

4 Transforming urgent and emergency care services in BHR-update

4.1 A written update had been sent to members prior to the meeting. RW and CB had attended the workshop on the subject earlier in the day and provided feedback about the event. The whole focus was to stop unnecessary visits to A&E. Patients did not understand what service they should access when they had an emergency. Current work was to understand different routes and how to change people’s behaviour and to have a consistent approach.
BR stated this was the first workshop and that more opportunities would arise to get involved in this important project. RW said that the 111 service must be something that people will have confidence in. GH stated that they will try to design the system that it is accessible for everyone and easy for everyone to use it.
BR had spoken with Melissa Hoskins, who is leading this work from the Communications team who would like to come to PEF to give an update. This was agreed for the May meeting providing there would be some specific progress to report.
<table>
<thead>
<tr>
<th>5</th>
<th><strong>Governing body papers</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1</td>
<td>SW summarized the chosen reports. Reports were as follow:</td>
</tr>
<tr>
<td>5.2</td>
<td>BHRUT performance report: The Trust was still failing to meet the key targets being monitored.</td>
</tr>
<tr>
<td>5.3</td>
<td>PMS review report: This had already been discussed during the primary care strategy item.</td>
</tr>
<tr>
<td>5.4</td>
<td>Continuing funding for the Improving Patient Flow and Response Care initiatives: This was supported in both cases. It was explained that LAS have a small car which provides an immediate response, avoiding many A&amp;E attendances.</td>
</tr>
<tr>
<td>5.5</td>
<td>Patient experience report: The PPE strategy was being developed at present and MG referred to the workshop about it that took place in February. SW suggested that Marie Price discuss the strategy with the PEF. BR reported that the draft strategy should be ready in next few weeks. It was agreed that the PPE strategy should be discussed at the May PEF meeting.</td>
</tr>
<tr>
<td><strong>ACTION:</strong></td>
<td>BR to discuss this further with Marie Price.</td>
</tr>
<tr>
<td>5.6</td>
<td>BR updated members about the International Day of Disabled People event which took place in December last year. We would be participating this year again in organising this important event.</td>
</tr>
<tr>
<td></td>
<td>SW wanted to see patient engagement in the Primary Care Transformation Programme by having a patient representative in one of the project groups. BR stated that there would be lot of engagement opportunities regarding this programme.</td>
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<tr>
<td><strong>ACTION:</strong></td>
<td>PEF and BR</td>
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<thead>
<tr>
<th>6.0</th>
<th><strong>B&amp;D Healthwatch update</strong></th>
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<tbody>
<tr>
<td>6.1</td>
<td>In MM's absence it was noted that she had sent the Healthwatch report on St Francis' hospice and it was recognised to be a useful investigation. The report had already been emailed but BR would provide hard copies on request. Any feedback from members about the report was to be sent to BR to pass on to MM.</td>
</tr>
<tr>
<td><strong>ACTION:</strong></td>
<td>PEF and BR</td>
</tr>
<tr>
<td>6.2</td>
<td>MP mentioned difficulties accessing the wound dressing service (tissue viability service) and questioned whether district nurses refer appropriately. GH said there is a gap in this service, as some patients found difficult to access it.</td>
</tr>
<tr>
<td></td>
<td>There is a report on the Healthwatch website.</td>
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<tr>
<td><strong>ACTION:</strong></td>
<td>BR to send this report to PEF.</td>
</tr>
<tr>
<td></td>
<td>NELFT provides this service, so GH will check and feedback to PEF.</td>
</tr>
<tr>
<td><strong>ACTION:</strong></td>
<td>GH</td>
</tr>
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<tr>
<th>7.0</th>
<th><strong>PEF members report-feedback</strong></th>
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<tbody>
<tr>
<td>7.1</td>
<td>The PPE event feedback had been noted earlier on the agenda from MG, RW and CB.</td>
</tr>
<tr>
<td>7.2</td>
<td>NH reported on his visit to Japonica ward. Three members attended and it was a two hours visit. They met staff and patients on the day and undertook various activities.</td>
</tr>
<tr>
<td>7.3</td>
<td>MP reminded everyone that there would be an Open Day next Wednesday; a flyer had already been sent to members. This Open Day was organised by Carers &amp; Dagenham at the Memory Lane Resource Centre to promote their services at Memory Lane, and in particular their new pilot project. For three months, they are piloting a scheme whereby carers, where their cared for is unable to use the centre, can have respite at home where their sessional workers can come into the home to provide respite, so that the carer can go out. This should be included in patient’s</td>
</tr>
<tr>
<td>7.4</td>
<td>CCG Stakeholders’ event (Barking Learning Centre): BR thanked several members who help out on the day, which was excellent event. GH said they wanted to have something different this year. Healthwatch is writing up the report. Next year they may organise the event in Dagenham. BR expressed her high appreciation for the PEF contribution.</td>
</tr>
<tr>
<td>7.5</td>
<td>The Carers’ Conference would take place on 14th July at the Ripple Centre. <strong>ACTION:</strong> MP to send information about this conference.</td>
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| 8.0 | **Forward planner** |
| 8.1 | It was agreed that the PPE strategy and transforming emergency services project should be items for the May meeting and that sepsis should be postponed. The IAPT progress report should be in July, as mental health, dementia and IAPT all link up, so GH suggested having the whole meeting dedicated to mental health. SW suggested having an update about PMS contract in July. MG mentioned having PEF extra meeting regarding the CCG’s commissioning intentions. GH said usually it was in September. |

| 9.0 | **AOB** |
| 9.1 | GH informed everyone that the CCG would be relocating its offices soon, moving in April to Maritime House. They will have meeting rooms there for PEF meetings and also smaller rooms which could be used for the pre-meetings. The downside would be car parking as members would have to pay for it but this would be reimbursed. Public transport is central and very close to the venue. SW suggested finding out if we can keep access to Barking Hospital for meetings. **ACTION:** BR to find out about reimbursing travel expenses and feedback. MG noted that there are advantages and disadvantages with any place of meeting. PEF agreed to try the new venue and then consider which venue is preferred. |
| 9.2 | SW asked who owns the building. GH said NELFT are main users. MG brought members’ attention to the proposed BHR Accountable Care Organisation which she understood was about bringing commissioners and providers together. GH proposed sending a briefing about it first possibly to be followed by a presentation to a PEF meeting. |
| 9.3 | Young people’s representation on the PEF: BR will be approaching the Adult College of Barking and Dagenham to find out if some health care students are interested. GH supported maintenance of the relationship with the Youth Forum. BR suggested having in future topics that related to young people such as sexual health to attract them more to attend the meetings. This was agreed. |
| 9.4 | NH pointed out that NELFT staff are overstretched because of current shortages. NELFT won the Diversity award recently for their excellent work on diversity. NH recommended the LAS report “Moving forward together”, the improvement plan for LAS. **ACTION:** BR to send the report to PEF members. |
| 10.0 | **Close and date of the next meeting** |
| 10.1 | Next meeting is on Thursday, 19 May 2016, 5pm-7pm. Venue TBC (Barking hospital, boardroom 1&2 for now). |
### Action log summary

<table>
<thead>
<tr>
<th>Action</th>
<th>Who</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 BR to amend PEF’s January’s PEF minutes</td>
<td>BR</td>
<td>Immediate</td>
</tr>
<tr>
<td>2.2.4 To suggest ASDA to our Comms team as one of the venues for stroke consultation</td>
<td>GH</td>
<td>Immediate</td>
</tr>
<tr>
<td>2.2.4 To check if shopping centres have been used as a venue to promote stroke consultation</td>
<td>BR</td>
<td>Immediate</td>
</tr>
<tr>
<td>3.1 To send NUKA presentation to Sarah See</td>
<td>BR</td>
<td>Immediate</td>
</tr>
<tr>
<td>5.5 and 9.1 To clarify CCG’s travel expenses reimbursement policy for PEF members and feedback to PEF</td>
<td>BR and MP</td>
<td>By April 2016</td>
</tr>
<tr>
<td>6.1 B&amp;D Healthwatch report-PEF to inform BR if they wish to receive hard copies of the report</td>
<td>PEF and BR</td>
<td>By May 2016</td>
</tr>
<tr>
<td>6.2 To check referral processes to Tissue viability team and feedback at the next PEF meeting and BR to send the Healthwatch report to PEF</td>
<td>GH and BR</td>
<td>By May 2016</td>
</tr>
<tr>
<td>7.5 Mary Parish to send information to BR about the Carers’ Conference which will take place on 14th July</td>
<td>MP</td>
<td>By May 2016</td>
</tr>
<tr>
<td>9.5 LAS improvement report “Moving forward together” to send to PEF</td>
<td>BR</td>
<td>Immediate</td>
</tr>
<tr>
<td>10.1 To confirm a new venue information for future PEF meetings</td>
<td>BR</td>
<td>By May 2016</td>
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</tbody>
</table>
# 1st Draft Minutes of the BHR CCGs Quality & Safety Committees held on 5 April 2016 at the Ceme Centre 1.00-3.30pm.

<table>
<thead>
<tr>
<th>B&amp;D CCG</th>
<th>Havering CCGG</th>
<th>Redbridge CCG</th>
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<tbody>
<tr>
<td>Dr Steve Ryan (SR)</td>
<td>Dr Steve Ryan (SR)</td>
<td>Dr Ah–Fee Chan (AFC)Chair</td>
</tr>
<tr>
<td>Dr Ravi Goripathi (RG) 1.40 to 3.00</td>
<td>Dr Ann Baldwin (AB) 1.00 to 3.00.</td>
<td>Dr Sarah Heyes (SH)</td>
</tr>
<tr>
<td>Jacqui Himbury (JH)</td>
<td>Jacqui Himbury (JH)</td>
<td>Jacqui Himbury (JH)</td>
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<tr>
<td>Sharon Morrow (SM) 1.00 to 2.45</td>
<td>Quorate</td>
<td>Quorate</td>
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## Apologies/DNA
- Dr TC Mohan - apologies
- Dr Maurice Sanomi - apologies
- CD Vacancy
- Alan Steward - apologies
- Louise Mitchell - apologies

### In Attendance:
- Christine Kane (CK)  BHR Interim Deputy Director Quality Assurance
- Vicky Pemberton (VP)  BHR Interim Deputy Director Quality Assurance
- Angela Ward (AW)  BHR Company Secretary

<table>
<thead>
<tr>
<th>Item</th>
<th>Action</th>
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<tbody>
<tr>
<td><strong>24/16 Apologies for absence</strong></td>
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<tr>
<td>It was noted that Dr Ah–Fee Chan had been appointed by recent GB meetings to act as Chair of the Committee for 2016/17. Apologies for absence were received from Dr Mohan, Dr Sanomi, Alan Steward and Louise Mitchell. It was noted there was a Committee CD Member vacancy in Redbridge and there would be a B&amp; D CD Member vacancy from 18 May.</td>
<td></td>
</tr>
<tr>
<td><strong>25/16 Declarations of conflicts of interest</strong></td>
<td></td>
</tr>
<tr>
<td>There were no additional conflicts of interests to those in the registers provided.</td>
<td></td>
</tr>
<tr>
<td><strong>26/16 Minutes of the meeting held on 9 February 2016</strong></td>
<td></td>
</tr>
<tr>
<td>The Minutes of the previous meeting were agreed and would be signed by the Chair as a correct record.</td>
<td></td>
</tr>
<tr>
<td><strong>27/16 Actions/Matters arising log</strong></td>
<td></td>
</tr>
<tr>
<td>Several actions were covered by new reports at the meeting. Updates were given on other matters, including;</td>
<td></td>
</tr>
<tr>
<td><strong>22/15 PELC Clinical Audit Plan</strong>- The Plan was attached to the action log. It was noted further detail had been requested on the 8 cases considered inappropriately streamed following a 44% case audit. This would enable action to prevent recurrence. Action Closed.</td>
<td>SE</td>
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<tr>
<td><strong>64/15 BH Maternity data</strong>- JH would ask SE to chase for a breakdown of data by site as requested in future maternity reports. Action open.</td>
<td>SE</td>
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<tr>
<td><strong>56/15 Revised Service spec for LAC</strong>- It was noted that the Executive Committees</td>
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</table>
would shortly receive the business case on commissioning services for Redbridge and Havering. An update would be provided at the next meeting. **Action open.**

**63/15 Revised POLVE policy**- The CSU lead had updated that a number of review meetings with GPs and consultants were being held on various sections of the policy. As soon as this work was complete the policy would be updated and circulated to all practices. **Action Open.**

**Safeguarding Adults & Children Strategies**- It was reported that these were being promoted at PTI/PLE events. **Action Closed.**

**Reg. 28 reports**-The NELFT response was not yet due and the BHRUT report was being chased (see agenda item below). Further updates to follow. **Action open.**

**Recesses For Southern FT Commissioners**- Deferred to June meeting. **Action open.**

**Oversight of SIs**-NELFT case-see agenda item below for update. It had not yet been possible to obtain the Coroners psychological assessor’s report. **Action open.**

**BH Never Events Action Plan**-since circulated to Members. **Action closed.**

**Risk Register**- JH had responded at the CQRM that she was not assured by the discussion of the Radiology action plan at the last CQRM (see minutes) and would discuss a briefing with AB to share with GPs as an interim measure. Concern was expressed around knock on effects of diagnostic backlogs that could impact 2 week cancer referral targets. Also that that the reference group had not met for several weeks and whilst there was evidence of training and retraining plus a new post, there appeared to be slippage and issue with identified leads and no impact yet on the backlog. It was understood an external agency was being engaged to do an external review. The Committee would receive the recovery plan at their next meeting.

**Discharge Summaries**- Agenda item-see below.

**CHC & Pupoc update**-to be scheduled for next Committee meeting, noting split by Borough requested.

**28/16 Committee Forward Planner 2016/17**
A draft planner was provided for comment and particularly for Committee support for a 30 minute deep dive at each meeting to allow for more in depth discussion of the highest risk area at that time. This was supported and the Planner would be brought to each meeting.

**29/16 Feedback from Members on local risks**
Due to some high priority discussions by Members this was not covered on an individual basis this time.

**30/16 GP Alert System and process across BHR**
VP’s report outlined a review of the GP alerting process that had been operational for two years, which had led to recommendations for improvement. The report provided detail of 49 alerts received over a six month period from April to September and it was noted a similar number were received in the following 5 month period. It was noted that Redbridge had the highest number of alerts relating
to Barts Health with main issues relating to referrals, discharges or commissioning gaps. 

The report acknowledged that feedback to GPs had been sporadic and required strengthening. Risks identified were of a GP alert being made instead of a Serious Incident being reported, a Safeguarding concern raised or dealt with through the complaints process. Definitions for GPs would be re-provided. A new process and pathway was proposed to be launched from the 1st May and a flow chart of the process provided.

Members raised the importance of thematic reviews as alerts were often of the same issue from the same provider and the importance of triangulation including contract management. Also questioned was whether primary care involvement would assist and the benefit of centralised recording, action and feedback supported. Clinical input in the process was questioned and an example was given of the difference if an A & E consultant carried out the triaging. Members supported a single point of access and proposed considering the effective Waltham Forest arrangements. The Chair added that the workload related to 40% of practices raising alerts and there was potential for growth to be accounted for when considering the co-ordinators role.

The Committee supported JH providing an options paper to the Executive Committees to progress the next steps.

### 31/16 Discharge Summaries-clinical risk update

The Committee had previously discussed feedback from some GPs on whether there were issues with the new contractual obligation for all providers to send patient discharge information electronically (effective since October 2015) to reach the correct GP and in a timely manner. A number of checks had been done through PILS and COOs and IT had confirmed that there were unaware of any issues raised about receipt or lack of capacity on GP system. All practices had been set up to receive these reports. BHRUT CQRM had confirmed the system was operational.

It was requested that the PILS liaise with practice managers to ensure the system was functioning and to raise any problems. SR questioned if IT could send a test email to confirm a proxy discharge letter had been received and read.

AB added that not all information was provided, such as ward discharges. AB would provide JH with the detail of what was and was not being received and she would raise this shortly at the CQRM, having checked with MS also. SH confirmed the service from Barts Health was excellent.

### 32/16 Infection Prevention Control-CCG Performance against trajectory

The report referred to Havering and Redbridge breaching C.Diff infection targets and Barking & Dagenham not breaching, but only just achieving target. Although the NELCSU were commissioned to provide post-infection reviews of MRSA in the community they were not required to carry out RCA or track patients who may transfer into secondary care. A case had been raised where tracking from primary to secondary care was important to respond to a legal claim. It was noted that RCA was mandatory for hospital Trusts but not the community. JH added that on studying trajectories there had been spikes in May of each of the last two years and the Committee were asked for a view on risk.

The proposal for medicines management to provide a GP PLE session referring to
a cause of death, covering C.Diff and prescribing was proposed and **supported**. It was further **agreed** that JH would provide a detail report next time with recommendations for gaining further control and assurance that trajectory targets would be met this year.

**33/16 Quality Strategy Implementation**

Discussion was deferred to the next meeting.

**34/16 Reg. 28 Provider responses**

The Committee noted that the NELFT report was not yet due but the BHRUT response to the Coroner was due on the 24 March. A copy of this was awaited and the Committee tasked the quality team with requesting assurance that the Trust response had met the important Coroners Court deadline and that the CCG copy delay was an oversight. JH was asked to raise this at the next CQRM.

JH advised that there was a new local Coroner with a legal background and summarised the Coroners powers and requirement for a timely response. Preventing recurrence was key, with learning and sharing lessons learnt a vital component. A Reg.28 was being issued to both the CCG and NELFT on a joint response basis and SM was leading for the CCG on agreeing actions with the Trust, noting a joint task and finish group had already been established. It was noted this was a very complex case. Members discussed behaviour disorders referred to and questioned mental health co-morbidity.

JH updated on the current position on the highly complex NELFT case where the 8 day Coroners hearing in June had been deferred whilst awaiting the outcome of whether the police considered there was any criminal activity. Further updates would follow.

**35/16 CCG oversight of 6 SI cases**

The report highlighted the main risks being managed currently by the quality team under the CQC Safe Domain. There were six areas under close review and risk reports emanating from the KLOE tracker were provided. Updates were given on the following areas;

**BH-ophthalmology** the current update was an amber rating now that all patients had been validated and no clinical harm found. The case remained open at the CQRM and was also reviewed at the SI Panel.

**BH-Never Events** currently at 14, with a further very recently reported case that CK would discuss further with JH. JH would provide further detail to SH as this related to her Locality. Noting a Rapid Action Plan had been developed Members were not assured that recurrence will be prevented and found the level of Never Events reports (against zero tolerance) to be quite unacceptable. They requested LM write to Steve Gilvin with the Committee’s view and request an external review of the dental cases.

**Death of a learning disability patient placed outside of the area** JH reported that investigations and analysis was continuing and provider, coroner and police investigations were involved. A Regulation 28 report from the Coroner was likely.

Strong focus on these 6 key cases would continue and updates would be provided to the next Committee meeting.
36/16 Provider SI Trend Reports Qtr.3
Discussion was deferred to the next meeting.

37/16 Maternity Commissioning
Kate Brintworth, Head of Maternity Commissioning in NEL, attended to provide information on a number of maternity matters including the effectiveness of the clinical network; MBRRACE recommendations and implementation and also the Homerton Quality Improvement Plan.

**Homerton QIP** - the report referred to maternal deaths over a two year period at the Homerton and the CQC inadequate rating in respect of safety and improvements required in relation to be well led and effective. In the autumn the CQC continued with the rating of requiring improvement on Safe and Well Led. Various summits had been held between March 2015 and February 2016 when a number of actions were closed. The CQC had more recently acknowledged large improvements in the services.

**The NEL Maternity Network (NELMN)** - had been relaunched in January 2016 and covered all CCGs and Providers in that area. The work-plan had been revised and linkages clarified and all 7 CCGs in NEL had to respond to the Sustainable Transformation Plan by mid-April leading to a detailed plan being submitted in June.

**National Maternity Review** - a summary was provided of this 5 year forward view of maternity services and Transforming Services Together working in alignment. The top areas of focus were personalised care, continuity of care, safer care, postnatal and perinatal mental health, multi-professional working, working across boundaries and reform of the payment system (this being national work). There was a maternity vanguard on offer to CCGs with pilots commencing in June 2016 to run for 18 months.

**Demand for maternity services** - tables indicating capacity and demand for maternity services and place of birth across NEL units was noted and forecasts discussed. Queens was currently over the expected capacity this year by 200 births and potential for shifts questioned. Feedback from the maternity surveys showed little change and perinatal death rates were the lowest at Queens by comparison. Also considered was a briefing from Priscilla Young, the local specialist clinical expertise lead, responded with a number of recommendations to MBRRACE -saving lives, improving mother’s care.

JH stressed the key issue of demand and capacity and noted a generalised pressure on the system when a bed was urgently required. She referred to previous capping of numbers at Queens following earlier Health For NEL mapping and planning work. Significant population growth had been forecast, particularly affected by new builds in Barking & Dagenham, which needed to be kept pace with to ensure safety. Members were reminded of the current closure of the Barkantine Birthing Centre and agreed it was important to work together to manage the future and receive regular monitoring data on demand, noting the clinical network only meets bi-monthly.

It was **agreed** that demand and capacity should be added to the risk register and note should be taken of patient flows. VP added that a review of outcomes could assist in calculating the numbers that could have been accommodated safely in the midwife led units. JH also proposed a maternity summit at the next Clinical Network.
meeting, with the right attendees from all service providers that could affect change. Also that maternity deliveries should be monitored at the BHRUT monthly CQRM. RG also asked for consideration on capacity to go beyond the footprint and ensure a safe high quality service.

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<tr>
<th>38/16 LAS Quality Improvement Plan</th>
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| The report described the special measures set in December and the requirements of a QIP for the year with key performance indicators and an end date of December 2016. There had been a risk summit where issues such as staffing levels and culture were raised. The target offered by LAS to the CCG of 75% had not been met and in February they achieved 53%.

Concerns have been raised by the quality team around the logistics process where vehicles and personnel may not be fully equipped to deal with life-threatening conditions which could lead to SIs around preventable deaths. Members noted an incident where adrenaline was not immediately available and this had recently been flagged for urgent attention with the LAS CQRM and an update would be provided at the next meeting. |

<table>
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<tr>
<th>39/16 Deep Dives into Safeguarding</th>
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<td>Discussion was deferred to the next meeting.</td>
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<tr>
<th>40/16 Updated Quality Team Risk Register</th>
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| SM proposed focus on 5 highest risks and to request assurance on systems and processes.

Members discussed BHRUT RTT and forthcoming Member briefings and referred to past processes such as demand management work and the clinical reference group. CCG support and additional finance had been provided and the GB had received reports and an action plan. Recent media attention was noted. JH stressed the role of this Committee in seeking assurance on the process to identify any potential risk of clinical harm to patients with waits over 18 weeks. The External Harm Review Panel are assured that the Trust have an agreed process for reviewing potential clinical harm to patients on the admitted list, however the CCGs are not assured how the Trust are implementing this process operationally. JH has escalated these concerns to Angela Lennox (AL), Associate Medical Director at NHSE and Chair of the External Harm Review Panel. These concerns will be addressed with the Trust at the next meeting on 28th April 2016. The committee noted these concerns and requested that a formal paper be brought to the next QSC meeting that clearly identifies any clinical patient safety risks.

JH had requested the numbers/scale of the issue at CQRM but the figures had not been available. Also requested was waiting times on the cancer clinical pathway but that information was not provided either. Following the meeting JH had formally written to the Trust Executive leads expressing concern that the numbers had not been provided. JH had discussed with MS, TDA and AL that monthly clinical harm review meetings must take place and more robust engagement was required from the Trust.

AB added that data quality underpinned everything and a deep dive at the next meeting was proposed. CK added that there was an external review into the cancer pathway underway and TOR had been issued to cover this work. Two related SIs in December and January were noted. JH would send out briefings updating on the process and timelines. SH had received assurance that there were no 52 week
waiting breaches at BH. JH was not assured of this and will follow this up with the lead commissioners.

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<th>41/16</th>
<th>Any Other Business</th>
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<td>Noting that the Remuneration Committee had already raised the issue of Committee effectiveness due to poor attendance and engagement, it was agreed that the Chair would write to the CCG Chair and copy the AO, again requesting improved attendance at these very important meetings that consider high risks. Also, two additional CDs were to be appointed to fill Member vacancies to be able to attend the next meeting in June. Given the number of high risk issues raised at the Committee JH would liaise with MP on whether she provide a report to the Executive Committees or to Part 2 GB meetings.</td>
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<td>AFC JH</td>
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<tr>
<th>42/16</th>
<th>Minutes for Noting</th>
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<tr>
<td>22.1</td>
<td>Safeguarding Assurance Committee (SAC)- The minutes of the meeting held on 9 March were noted.</td>
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<td>22.2</td>
<td>SI Panel meeting- The minutes of the meeting held on 17 February 2016 and 21 March were noted.</td>
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<td>22.3</td>
<td>BHRUT CQRM- The minutes of the meeting held on 14 December 2015.</td>
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<td>22.4</td>
<td>NELFT CQRM- The minutes of the meeting held on 17 February 2016 were noted.</td>
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<tr>
<td>22/5</td>
<td>WX CQRM- The minutes of the meeting held on 21 January were noted.</td>
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<tr>
<th>43/16</th>
<th>Next Meeting</th>
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<td>The next meeting had initially been arranged for 7 June. The June date would be confirmed as soon as the two replacement CD Members were appointed and a quorum could be confirmed. Confirmation would be sent to Members.</td>
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Signed………………………………………………..Date………………………….
# Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups

**Draft Minutes of the Primary Care Commissioning Committee (Committee in common) held on 9 March 2016 at Becketts House 1.00pm**

## Members

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
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<tbody>
<tr>
<td>Richard Coleman (RC) Chair</td>
<td>Lay Member, Havering CCG</td>
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<tr>
<td>Khalil Ali (KA)</td>
<td>Lay Member, Redbridge CCG</td>
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<tr>
<td>Kash Pandya (KP)</td>
<td>Lay Member, BHR Audit &amp; Governance</td>
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<tr>
<td>Sarah See (SS)</td>
<td>Director of Primary Care Transformation, BHR CCGs</td>
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<tr>
<td>Tom Travers (TT)</td>
<td>Chief Finance Officer, BHR CCGs</td>
</tr>
<tr>
<td>Dr Adedayo Adedeji (AAd)</td>
<td>GP, Barking &amp; Dagenham CCG</td>
</tr>
<tr>
<td>Sahdia Warraich (SW)</td>
<td>Lay Member, Barking &amp; Dagenham CCG</td>
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<tr>
<td>Conor Burke (CB)</td>
<td>Chief Officer, BHR CCGs</td>
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<tr>
<td>Jacquie Himbury (JH)</td>
<td>Nurse Director, BHR CCGs</td>
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<tr>
<td>Steve Ryan (SR)</td>
<td>Secondary Care Consultant, B&amp;D and Havering CCG</td>
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<tr>
<td>Dr Kalkat (GK)</td>
<td>Clinical Director, Barking &amp; Dagenham CCG</td>
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<tr>
<td>Dr Alex Tran (AT)</td>
<td>Clinical Director, Havering CCG</td>
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<tr>
<td>Frances Carroll (FC)</td>
<td>Chair, Healthwatch B&amp;D</td>
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<tr>
<td>Alison Goodlad</td>
<td>Head of Primary Care Commissioning, NHSE</td>
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<tr>
<td>Dr Anil Mehta (AM)</td>
<td>Chair, Redbridge CCG</td>
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<tr>
<td>Dr Waseem Mohi (WM)</td>
<td>Chair, Barking &amp; Dagenham CCG</td>
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<tr>
<td>Dr Atul Aggarwal (AAg)</td>
<td>Chair, Havering CCG</td>
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<tr>
<td>Cathy Turland (CT)</td>
<td>Chief Executive, Healthwatch Redbridge</td>
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<tr>
<td>Terilla Bernard (TB)</td>
<td>Barking, Dagenham and Havering LMC</td>
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<tr>
<td>Ian Buckmaster (IB)</td>
<td>Director Healthwatch Havering</td>
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<tr>
<td>Gladys Xavier (GX)</td>
<td>Deputy director of public health, LBR</td>
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<tr>
<td>Matthew Cole (MC)</td>
<td>Director of Public Health, LBBD</td>
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<tr>
<td>Terilla Bernard (TB)</td>
<td>Barking, Dagenham &amp; Havering LMC</td>
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## In attendance

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<tr>
<th>Name</th>
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<tr>
<td>Anne-Marie Keliris (AMK)</td>
<td>Company Secretary, BHR</td>
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<tr>
<td>Lorna Hutchinson (LH)</td>
<td>Assistant Head of Primary Care Commissioning, NHSE</td>
</tr>
<tr>
<td>Natalie Keefe (NK)</td>
<td>Head of Primary Care Transformation, BHR CCGs</td>
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## Apologies

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<tr>
<th>Name</th>
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<tr>
<td>Anne-Marie Dean</td>
<td>Chair, Healthwatch Havering</td>
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<tr>
<td>Cllr Wendy Brice Thompson</td>
<td>Chairm, Havering Health &amp; Wellbeing Board</td>
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<tr>
<td>Dr David Derby</td>
<td>Haverig GP member</td>
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<tr>
<td>Liz Wise</td>
<td>Director, Primary Care Commissioning, NHSE</td>
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<tr>
<td>Vicky Hobart</td>
<td>Director of Public Health, Redbridge</td>
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## Action

1. **Welcome and Apologies for absence**

   The Chair welcomed those present and apologies were noted.
2. **Declaration of Interests**

Members noted the Committee’s Declaration of Interest Register and no further interests were declared relating to agenda items.

3. **3.1 Minutes of meeting held on 10 February 2015**

The minutes of the previous meeting were agreed.

**3.2 Actions log/matters arising**

Committee members noted the actions that had been taken and the following updates were noted:

**ACT54 delegated self certificate** – It was noted that this had been approved by CB/KP and sent to NHS England.

**ACT55 quality report** – It was reported that a meeting date has been agreed to meet with NHS England to progress this issue.

4. **Budget update**

TT presented the month 9 primary care commissioning budget update.

The current overspend position at month 10 for each CCG’s primary care commissioning budget is as follows:

- Barking & Dagenham CCG  £349k
- Havering CCG  £238k
- Redbridge CCG  £168k

It was reported that a budget transfer of £240k was actioned between Barking & Dagenham and Havering CCGs to reflect the merger of the Lawns and North Street practices.

The Redbridge CCG cost pressure around the Loxford Polyclinic is still to be resolved. TT added that he was confident that the CCG would achieve breakeven position at year end. KA questioned how this would be achieved, TT responded there will be a set of adjustments in month 11.

The committee noted the report.

1.15pm WM and FC arrived.

5. **Introduction STP primary care chapter**

SS presented a report which briefed the committee on the purpose of the Sustainability and Transformation Plan (STP) and recently released guidance from Healthy London Partnership on the proposed template structure for the primary care chapter.

MC questioned if there is enough appropriate engagement captured. SS responded that engagement will be managed as part of the overall STP process across NEL (and within BHR specifically); in terms of primary care the PCC Committee and Primary Care Transformation Programme Board will be kept in the loop.

1.20pm SW arrived.

AAD questioned if the focus was planned or unplanned care. SS responded that the focus was on both planned and unplanned care in primary care across the NEL
WM highlighted the importance of local priorities and was concerned that the STP was moving away from this. CB responded that the planning process for the STP is a nationally mandated process which had been engaged on locally for the best footprint and it was decided that this would be NEL. He added that the ACO business case is a local process which was agreed on before the STP process began. The STP was purely a planning exercise and any changes to CCGs would require legislation changes.

AM was concerned that this process could lose CCG membership interest and understanding. MC commented that localities will be key in the delivery of the STP and placed based needs to be critically described.

The Chair shared the concerns raised around engagement and welcomed further information on this. SS will request the engagement plan from the CCG’s STP lead, Tara-Lee Baohm.

SS reported that these are high level intentions that will need to reflect on the transformation strategy.

The committee noted the report and agreed to receive a progress report at the next meeting.

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<th>6.</th>
<th>APMS procurement update</th>
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<td>The Practice Loxford</td>
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AG presented a report which updated on the emerging themes and issues raised by patients following a consultation session and an online survey.

The main issues raised by patients were:
- Telephone access
- Availability of appointments
- Core hours within the new specification
- Staff attitude and behaviour

SW expressed surprise at the low number of responses and questioned what process was used. LH responded that a letter was sent to all registered patients over 16 years of age and 2 engagement events were also held at the practice.

CT commented that it was difficult to understand the low number of responses and reported on the engagement Healthwatch had been undertaking with Barking and Havering on emergency care.

SS reported that there had been a higher response rate at the Kings Park surgery even though the same process had been followed.

AAg welcomed the survey responses which highlighted the areas that the new bidders will need to address.

The committee noted the report.

| 6.2 | Orchard Village |
AG presented a report which detailed the revised contract price for the Orchard Village practice.
AT questioned if capacity can be utilised until the list size increases. CB responded that as we develop the locality model a demand/capacity review will be undertaken.

AAg questioned if the CCG would pay for the practice manager post if there is no manager when the practice opens. LH responded that this was part of the start-up business fee and recognises that support will be needed. SS added that there will be a check and balance process, close monitoring of mobilisation and contract management of the practice.

AAAd questioned why this was not procured as a GMS contract. AG responded that APMS was a more flexible and normal route for a zero list procurement.

The committee noted the rationale for taking the action for the revised contract price.

6.3 Kings Park
AG presented a report which updated on the position to defer the procurement of the GP list to coincide with the expiry of the walk in services in March 2017.

The committee noted the report.

7. Havering PCC Committee

7.1 Spring Farm Surgery – branch closure (Rainham Health Centre)
LH presented an application from Spring Farm Surgery to close their branch site at Rainham Health Centre on 31 May 2016, which will result in the surgery operating from the main site on Upminster Road.

It was noted that further work was required on patient engagement / local stakeholder engagement on the proposed changes including Health Overview and Scrutiny and therefore, SS suggested that the application was deferred until further information was received.

The committee agreed to defer the application for closure.

7.2 Berwick Surgery – list closure application
SS presented an application for list closure and reported that the CCG would like the practice to work with practices in the cluster area to manage overall capacity. SS noted that Berwick Surgery was in the same locality as Spring Farm Surgery, and any decision should take into account overall access issues in the locality.

Discussion ensued on the greater number of registrations in other practices in the cluster and the opportunity of developing the locality to review the capacity in the area. SS reported on exploring opportunities with local authority colleagues to do this.

KP questioned if there are any quality issues that the committee should be aware of. SS confirmed that the Berwick surgery was performing very well but the other two practices in the cluster have variable performance so additional pressure from a list closure could impact their performance.

The committee refused the request to the list closure application and requested a locality plan for the cluster area.

8. Vulnerable practices update
AG reported that letters will be sent to those practices identified in the scheme and a matching process will follow. It was noted that this was tranche one of the
process and tranche two would continue in 2017 following evaluation of tranche one.

AA questioned which organisations are providing the support. AG responded that there were a mix of providers, including local federations who had submitted applications as a part of the procurement process.

AM highlighted that some practices he deemed as “good” had received letters and questioned what the definition of a vulnerable practice was. AG agreed to send AM a copy of the indicators and methodology.

KP questioned if the committee will see a list of the practices identified. SS gave assurance to the committee on the methodology applied and agreed to circulate the final list in confidence (a draft list had been tabled previously.)

The committee noted the update.

<table>
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<tr>
<th>9. Contract variations and discretionary payments (locum reimbursements)</th>
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<td>SS presented a report which detailed contract variations and discretionary payments which included cost of funding.</td>
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<td>The committee noted the report.</td>
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<th>10. Risk Register</th>
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<td>SS presented the risk register.</td>
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<td>The committee approved the risk register.</td>
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<th>11. Questions from Public</th>
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<td>There were no questions from the public.</td>
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<th>12. Any Other Business</th>
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<td>There was no other business.</td>
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<th>13. Date of Next Meeting</th>
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<td>The next meeting was confirmed as 13 April 2016.</td>
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Signed..............................................Date..............................................
Draft Minutes – BHR CCGs Investment Committee

Tuesday 12 April 2016

B&D CCG	Havering CCG	Redbridge CCG

Tom Travers, Chief Finance Officer, BHR CCGs (TT)	Richard Coleman – Chair, Lay Member PPI Havering (RC)	Tom Travers, Chief Finance Officer, BHR CCGs (TT)

Steve Ryan, Secondary Care Consultant (SR)	Tom Travers, Chief Finance Officer, BHR CCGs (TT)	Ah-fee Chan, Secondary Care Consultant (AFC)

Dr Waseem Mohi, Chair B&D CCG (WM)	Steve Ryan, Secondary Care Consultant (SR)	Steve Ryan, Secondary Care Consultant (SR)

Ah-fee Chan, Secondary Care Consultant (AFC)

Apologies/DNA

Kash Pandya, Lay Member, Governance, BHR CCGs (KP)	Kash Pandya, Lay Member, Governance, BHR CCGs (KP)	Kash Pandya, Lay Member, Governance, BHR CCGs (KP)

Sahdia Warraich, Lay Member PPI (SW)	Dr Atul Aggarwal, Chair, Havering CCG (AA)	Dr Anil Mehta, Chair, Redbridge CCG (AM)

Khalil Ali, Lay Member PPI (KA)

Attendees:

Clare Burns (CB) - Deputy Chief Operating Officer, Havering CCG
Natalie Keefe (NK) - Head of Primary care Transformation, BHR CCGs
Anna McDonald (AMc) - Business Manager, BHR CCGs

1.0 Welcome and apologies

The Chair welcomed members to the meeting and apologies were noted. In accordance with the Terms of Reference (ToR), members of other CCGs acted as substitute members to make the meeting quorate for Redbridge CCG and for B&D CCG when Dr Mohi was excluded due to conflicts of interest where there were quoracy issues.

1.1 Declaration of interests

No additional declarations were declared.

The Chair explained that Dr Mohi would be excluded from the discussions about the GP Access Hub 2016/17 contract paper and also that there would be a change to the order of the items on the agenda due to CB having a commitment to attend another meeting.

1.2 Minutes of the last meeting

Minutes of the meeting held on 8 March 2016 were agreed as an accurate record.
1.3 | **Actions log/matters arising**
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TT advised that the mapping discussions he is having with CB and MP are ongoing.

CB fed back that the Shared Care Clinical Management and Prescribing Scheme paper had been approved at the first meeting of the Investment Committee in October 2015.

WM asked for clarification on what papers should come to this committee and TT confirmed that the committee was set up to consider papers only where there are conflicts of interest.

*Natalie Keefe joined the meeting.*

1.3.1 | **Everyone Counts Schemes – briefing paper**
The committee noted the briefing paper provided by Louise Mitchell which included a breakdown of the metrics applied to each of the top 4 schemes as agreed at Investment Committee meeting in March. The paper also referenced the current national guidance for the utilisation of ‘Everyone Counts’ money which says the funding is to be used to transform services for patients aged 75 and over. RC asked TT if the expectation was for the committee to have a further discussion at the next meeting and TT confirmed that to be the case as the financial position would be known by then. WM raised his concern that the CCGs’ could end up in the same position as last year and asked for clarity on whether the payment is definitely only for over 75s. TT said it is possible to be flexible and we don’t have to follow the same schemes as last time but he reiterated that whatever the investment decision is, it has to fit with the CCGs’ priorities. WM asked for a timeline and added that the process needs to start by July at the latest and asked for confirmation that practices would receive the agreed amount. TT said it would not be possible to confirm that until the finance position is known. WM referred to the quote from the national guidance given in the paper and said the direction given to CCGs’ is quite clear. He said a message needs to be communicated practices and stressed the need to start the process as soon as possible. TT said it was agreed that the 15/16 schemes were non-recurrent and had to stop. NK confirmed that the responsibility for the ‘Everyone Counts’ schemes would be transferring from LM to Sarah See (SS) and explained that SS is planning to meet with the CDs to seek agreement and take things forward. RC asked for a paper with a clear set of recommendations for the committee to agree to be brought to the next meeting.

*The order of the agenda was changed at this point.*

2.0 | **BHR CCGs**

2.1 | **Community Dermatology Service**
The committee noted the following conflicts of interests provided under section 10 of the report:-

*This service is currently provided in premises leased out by Dr Atul Aggarwal and Dr Ashok Deshpande who are appointed members of the Havering CCG Governing Body. The current service (Communitas Clinics) employs Dr Sood CD for Redbridge and Dr Ashok Deshpande’s daughter and could potentially be delivered by GPs with special interests.*
It was noted that an open procurement process had originally been undertaken. The paper was being presented to the committee again following a request at the March meeting for more detail to be included. CB advised the committee that B&D CCG face the same issues as Havering as noted in the paper but with the added difficulty that they do not have any alternative community provision that could reduce the demand pressures on BHRUT. CB explained that an informal meeting with the CDs at B&D CCG had taken place where a significant clinical risk was highlighted associated with the delay of treatment for patients referred to the BHRUT Dermatology service. As a result, the amended paper was being presented for both Havering CCG and B&D CCG.

Committee members were asked to agree the following recommendations for Havering CCG:

- Agree to issue a single waiver contract to the current community provider for 12 months with a 3 month break clause.
- Agree to remove all dermatology outpatient activity (excluding under 5s and cancer) from secondary care providers for Havering CCG.
- Agree to procure a new community dermatology service via an open tender process to select the new provider as per the procurement timeline for the new contract to start from the 1st February 2017.

Committee members were asked to agree the following recommendations for B&D CCG:

- Agree for B&D to issue a single waiver contract to the Havering or the Redbridge Community Dermatology provider on the basis of the urgent need to mitigate current clinical risks.
- To include Barking and Dagenham CCG in the joint procurement with Havering CCG of a new community provider as per the procurement timeline for the new contract to start from the 1st February 2017.

In regard to Redbridge CCG, CB advised that a paper would be going to their Executive Committee meeting on 19 April 2016 to seek approval for the CCG to be included in the procurement. RC noted that as Dr Sood had a conflict of interest, she would need to be excluded from the discussion and the decision at the Executive Committee. AMc to send an e-mail to LM.

SR highlighted that the list under 4.1 in the paper needed to be quality checked as it contained conditions that are not related to dermatology. CB said she would amend the list and circulate it to members outside of the meeting. WM said the dermatology service definitely needs to be provided in the community but said he was concerned about the sustainability of the provider at the price given in the report and asked for an external audit. CB agreed. WM also asked about the governance arrangements and CB assured the committee that the contract is measured in the same way as all the other contracts.

RC requested that the final paper be brought back to the Investment Committee for final approval and referred to the new draft guidance issued by NHS England on ‘conflicts of interest’ and said it is no longer just about the
decision making process, it is about the process as a whole and needs to be managed properly. TT said this committee could make the recommendation to the Governing Body to award the contract but it would be the Governing Body that made the final decision.

The recommendations for Havering CCG were agreed by the committee in principle but TT said he would want to carry out some background checking, adding that we need to be sure that a new level of demand is not created.

The recommendations for B&D CCG were agreed by the committee.

### 3.0 Havering CCG

#### 3.1 Community Ophthalmology & Ear Nose & Throat (ENT) service

The committee noted the following conflicts of interests provided under section 6 of the report:-

*This service is currently provided in premises leased out by Dr Atul Aggarwal who is an appointed member of the Havering CCG governing body. The service could potentially be delivered by GPs with special interests.*

It was noted that an open procurement process had originally been undertaken. CB explained that the paper contained more information as requested by the committee at the March meeting. Community ENT and Ophthalmology services demonstrate high levels of patient satisfaction measured by a patient survey. Significant improvement in patient pathways and the level of secondary care activity have reduced, for Ophthalmology by 21% and ENT by 11% between 13/14 and 14/15.

The committee members were asked to:

- Agree to issue a single waiver contract to the current community providers for Community ENT and Community Ophthalmology for 12 months with a 3 month break clause to the current provider to ensure capacity remains within the system until a longer term solution is in place.
- Undertake a market testing exercise to determining whether to go for an open tender
- Delegate responsibility to determine whether to go for an open tender following the market testing to the Chief Finance Officer.

WM said there is definitely scope for ENT to have an impact in the other two boroughs. TT said there were a number of questions about the figures contained in the paper. Members agreed that rather than go through them all at the meeting, they would consider what the consequence would be if the contract was not extended. WM added that he was disappointed that market testing hadn’t already been undertaken.

The committee agreed to the recommendations.

*Clare Burns left the meeting.*
4.0 BHR CCGs

4.1 GP Access Hubb 2016/17 contract

Dr Mohi was excluded from the meeting for this agenda item.

The committee noted the following conflicts of interests provided under section 8 of the report:-

Conflicts of interest should be managed by the decision to invest in the provision of the GP Led Access Service in 2016/17 subject to a 6 month review with the provide being taken by a non-conflicted, action group of the governing body.

NK presented the paper on behalf of SS and explained how the contract had been constructed under an ‘open book’ arrangement which had proved to be cumbersome for both commissioner and provider and did not enable the providers to develop as an independent organisation. Following negotiations, the CCGs and the GP Federations have in principle reached an agreement for a new tariff model in 2016/17 which aids the achievement of the CCGs’ financial principles of securing economy, efficiency and effectiveness in the use of the CCGs’ resources, and has moved away from the ‘open book’ arrangement previously used.

The committee members were asked to:

- Note the update on the performance of the GP-led access hubs during 2015/16;
- Comment on the key principles in developing a new tariff for pricing the hub service in 2016/17;
- Approve the budget, tariff price (per attendance and total cost per annum) and payment mechanism for 2016/17, subject to a 6 month review, to be specified within the NHS Standard Contract 2016/17; and
- Note that subject to approval of the new contract arrangements, that the PMCF Steering Group be disbanded. The contracts will be managed via quarterly contract review meetings, and performance overseen within BHR’s System Resilience Group.

AFC asked what impact the hubs have had on A&E. NK explained that due to the number of schemes currently operating to reduce attendances at A&E, it is difficult to determine which scheme is having the biggest impact and we will know more when the results of the Nuffield report are known in September 2016. TT advised that the budget has been set at £2.5m but we need to see what the Nuffield report says. The committee agreed that this fits closely with primary care transformation and the primary care strategy and TT added that it is consistent with Vanguard. AFC asked about DNAs and NK responded saying that 91% of appointments are used, the DNA rate is very low and is reported weekly by the Federation. RC asked a couple of questions on behalf of KP; if it would be possible to see the activity on Sundays and by each week day; and where does the new Federation that is being set up in Barking and Dagenham fit into this as they will be competing for business with the existing Federation. NK answered the second question saying that a review would be carried out in 6 months. NK to speak to SS about the first question and
feedback to KP.

The committee agreed the recommendations which included the recommendation to disband the PMCF steering group.

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