# AGENDA

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NB: Members of the public will be given the opportunity to ask questions. These must relate to items that are on the agenda for this meeting and should not take longer than three minutes per person.

## 2. Overview Reports

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9. Any Other Business

10. Date of Next Meeting

10.1 21 March 2013

REGISTER OF INTERESTS

A register of members’ interests is available for viewing by the public. The register will be available at the meeting or during working hours within the Executive Office, Stephenson House, 75 Hampstead Road, London NW1 2PL

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PART II MEETINGS

To resolve that as publicity on items contained in Part II of the agenda would be prejudicial to public interest by reason of their confidential nature, representatives of the press and members of the public should be excluded from the remainder of the meeting. Section 1 (2) Public Bodies (Admission to Meetings) Act 1960
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Minutes – Part I
Meeting of the Joint Boards of NHS North Central London
29 November 2012 at 2:00pm
Seminar Room 2, Resource for London, 356 Holloway Road, London N7 6PA

Present:
Paula Kahn Chair
Caroline Taylor Chief Executive
Bev Evans Interim Director of Finance
Caroline Rivett Audit Chair
David Riddle Vice Chair – Barnet, Non-Executive Director – Islington
Karen Trew Vice Chair – Enfield, Non-Executive Director – Camden
Cathy Herman Vice Chair – Haringey, Non-Executive Director – Enfield
Anne Weyman Vice Chair – Islington, Non-Executive Director – Haringey (from Item 3)
Sue Baker Non-Executive Director – Haringey and Enfield
Sorrel Brookes Non-Executive Director – Islington and Haringey (for Items 1 – 4.1)
Robert Sumerling Non-Executive Director – Camden and Barnet (for items 1-10)
Deborah Fowler Non-Executive Director – Camden and Enfield
Marek Koperski PEC Chair - Camden
Mayur Gor PEC Chair, Haringey
Gillian Greenhough PEC Chair - Islington, Clinical Commissioning Group Chair, Islington
Alison Pointu Director of Quality and Safety and PEC Nurse – Barnet

In attendance:
Siobhan Harrington Barnet, Enfield & Haringey Clinical Strategy Programme Director and Senior Responsible Officer, Primary Care
Angela Lennox Deputy Medical Director, NHS North Central London (Item 3.1)
Simon Currie Interim Director of Contracts
Helene Brown Deputy Medical Director (Primary Care)
Ellen Schroder Lay Member, Camden Clinical Commissioning Group Governing Body

Observers with speaking rights:
Helena Kania Haringey LINk Representative
Jo Wealleans Enfield LINk Representative
Ray James Enfield Local Authority Representative

Minutes:
Matt Hopkinson Board Secretary (Acting)

1. INTRODUCTION

NHS North Central London is a collaborative working arrangement between Barnet, Camden, Haringey, Enfield and Islington Primary Care Trusts.
The Joint Boards of NHS North Central London refers to the joint meeting of the Boards of Barnet, Camden, Haringey, Enfield and Islington Primary Care Trusts.
1.1 Apologies for Absence:

Members:
Bernadette Conroy  Non-Executive Director – Barnet and Islington
Shahed Ahmad  Director of Public Health – Enfield
Andrew Howe  Director of Public Health – Barnet
Jeanelle de Gruchy  Director of Public Health – Haringey
Penny Bevan  Director of Public Health – Camden and Islington
Philippa Curran  PEC Chair – Barnet
Mohammed Abedi  PEC Chair - Enfield
Helen Pelendrides  PEC Chair - Haringey
Jennie Hurley  PEC Nurse – Islington
Joanne Wickens  PEC Nurse – Camden

In attendance:
David Cryer  Chief Officer Designate – Camden Clinical Commissioning Group
Liz Wise  Chief Officer Designate – Enfield Clinical Commissioning Group
Alison Blair  Chief Officer Designate – Islington Clinical Commissioning Group
John Morton  Chief Officer Designate – Barnet Clinical Commissioning Group
Sarah Price  Chief Officer Designate - Haringey Clinical Commissioning Group
Sylvia Kennedy  Acting Director of Strategy & Performance
Nick Losseff  Medical Director, Secondary Care
Caroline Sayer  Chair, Camden Clinical Commissioning Group
Alpesh Patel  Chair, Enfield Clinical Commissioning Group
Helen Pelendrides  Chair, Haringey Clinical Commissioning Group
Sue Sumners  Chair, Barnet Clinical Commissioning Group

Observers with speaking rights:
Janet Burgess  Executive Member for Health & Wellbeing, Islington Council
Bernice Vanier  Cabinet Member for Health and Adult Services, Haringey Council
Helena Hart  Cabinet Member for Public Health, Barnet Council
Arthur Brill  Camden LINk
Gerald McMullan  Islington LINk

Declaration of interests

The following attendees made declarations of interest in relation to the agenda:

- Ellen Schroder declared that she was a lay member on the Great Ormond Street Hospital Clinical Ethics Committee
- David Riddle declared that he was a Primary Care Trust-appointed Governor of the Royal Free London NHS Foundation Trust
- Marek Koperski declared that his practice was a member of Haverstock Health
- Robert Sumerling declared that he was a Governor of Camden and Islington NHS Foundation Trust
1.2 Chair’s Introduction and Opening Remarks

1.2.1 The Chair welcomed Helene Browne, who was deputising for Henrietta Hughes, and Ellen Schroder, who was attending as an observer.

1.2.2 The Chair observed that this time of year would usually see the Joint Boards considering the commissioning strategy for the coming year; however, in view of the fact that this was now the responsibility of the Clinical Commissioning Groups (as well as the several receiving organisations for Public Health and specialised commissioning), the Boards’ responsibility was rather to seek assurance on the delivery of corporate objectives for the current year. The Chair reminded the Joint Boards of the three corporate objectives, specific progress on which was covered in agenda Item 7.3.

1.2.3 As the transition progressed, there were changes to the workforce, with some members of staff currently divided between two jobs, or leaving the organisation entirely. The Chair made mention of a number of changes in particular:

• John Carrier had been appointed Chair of the North East London Primary Care Trust cluster until 31 March 2013. He would continue as lay-member for Camden Clinical Commissioning Group Governing Body, but was no longer a non-executive director of Camden Primary Care Trust. The Chair thanked John Carrier for all his work for the Primary Care Trust.

• Helen Pettersen had been appointed Deputy Chief Executive and Director of Customer Services at the North East London Commissioning Support Unit.

• Henrietta Hughes had been appointed Medical Director for North and East London at the NHS Commissioning Board

• Simon Currie had been appointed Interim Director of Contracting for the Waltham Forest, East London and the City team at the North and East London CSU.

1.2.4 The five North Central London Clinical Commissioning Groups were progressing well towards authorisation. Barnet, Camden, Haringey and Islington had all been through the active stages of the process and had received positive feedback. Enfield was in the final wave of authorisations and was on track, with its assurance visit due on 7 January. The Commissioning Support Unit had passed the first three of five checkpoints towards validation, with very positive feedback, and was considered to be one of the national frontrunners in this area.

1.2.5 The Joint Boards noted again the importance of successful transition to the continued delivery of high quality services to patients.

1.3 Minutes of the meeting held on 27 September 2012

1.3.1 The Joint Boards APPROVED the minutes as a true and accurate record of the meeting.

1.3.2 The Joint Boards reviewed and updated the Action Log.
In relation to Action 12/09-2, the Director of Quality & Safety reported that a letter had been sent to all providers seeking assurance on their child safeguarding arrangements in response to problems identified in Rochdale, and a full and helpful response had been received from all providers.

1.4 Matters arising

1.4.1 There were no matters arising.

1.5 Questions from the public

1.5.1 Donald Smith asked raised issues relating to transport arrangements at the Chase Farm Hospital site as part of the site developments.

1.5.2 The Chief Executive noted that transport had always been a significant issue for the development of Barnet and Chase Farm Hospitals and that a previous transport working group had been reconstituted, with Mark Easton as Chair until his recent departure. The two trusts were working together to produce a joint position on transport, accounting for travel policies and issues around transition, and a number of improvements had been made. The Chief Executive assured Mr Smith that his queries would be addressed by the Transport Group.

1.5.3 The Chief Executive noted that questions had been received from the Enfield LINk representative, and that these would be responded to in writing, since there had not been time to formulate a full response in time for the meeting.

2. OVERVIEW REPORTS

2.1 Chief Executive’s Report

2.1.1 The Chief Executive presented an update on developments in the local NHS and wider policy issues. The NHS London Capital Investment Committee had approved the Strategic Outline Case proposing acquisition by the Royal Free Hospital of Barnet and Chase Farm Hospitals. The next stage would be the development of an outline business case to explore issues in detail. There would be significant engagement with commissioners, with a steering group including members from all local commissioning organisations concerned. The outline business case would go back to NHS London in March, following consideration by the Joint Boards in late February.

2.1.2 The Capital Investment Committee had also approved the Full Business Case for capital investment at Barnet and Chase Farm as part of the Barnet, Enfield and Haringey Clinical Strategy. Both trusts had been undertaking preparatory works and could now move swiftly into the building phase.

2.1.3 The North Middlesex University Hospital Business Case for capital investment was still awaiting approval from the Treasury.

2.1.4 Helena Kania asked whether there were increased risks around the delivery of the Barnet, Enfield and Haringey Clinical strategy following the departure of the Chief Executive of Barnet and Chase Farm Hospitals NHS Trust.
2.1.5 The Chief Executive replied that Dr Tim Peachy had been appointed interim Chief Executive. It was important to recognise the distinction between operational management and the process of considering the transaction; the change would not have any effect on the delivery of the strategy. It was clear that the transaction must not impede in any way the delivery of the Clinical Strategy.

2.1.6 Some concerns had been raised about the quality of services at the Barnet, Enfield and Haringey Mental Health Trust, and the Care Quality Commission had been conducting site visits. The pause in the Foundation Trust timetable would ensure that issues could be fully resolved before the Trust made any further progress towards Foundation Trust status.

2.1.7 The Joint Boards:

- **NOTED** the report
- **NOTED** the finalisation of the Individual Funding Requests Policy
- **APPROVED** the appointment of Dr Angela Lennox as Accountable Officer for Controlled Drugs
- **APPROVED** the appointment of Alison Pointu as Senior Information Risk Officer

2.2 Chair’s Action and Use of the Seal

2.2.1 The Joint Boards received the report on Chair’s Action taken and on the use of the seals of the five Primary Care Trusts between 19 September and 13 November 2012, as well as a verbal update from the Chief Executive on such matters undertaken since the report was published.

2.2.3 The Audit Chair queried whether it was appropriate for Islington Primary Care Trust to authorise a contract on behalf of 12 Primary Care Trusts. The Chief Executive responded that it was standard practice in this instance for a single body to hold the contract, but that the risk associated with the contract would be shared across all twelve bodies.

2.2.4 The Boards of **Barnet, Camden, Enfield, Haringey and Islington Primary Care Trusts**:

- **RATIFIED** the Chair’s action taken to agree and sign the Commissioning Letter of Support for the Strategic Outline Case for the acquisition of Barnet and Chase Farm Hospitals NHS Trust by the Royal Free London NHS Foundation Trust.

The Boards of **Barnet, Enfield and Haringey Primary Care Trusts**:

- **RATIFIED** the Chair’s Action taken to approve the full business cases and sign the Commissioning Letters of Support for Barnet and Chase Farm Hospitals NHS Trust and North Middlesex University Hospital.
The Board of **Barnet Primary Care Trust:**

- **RATIFIED:** The use of Chair’s action in approving the lease of premises of two rooms forming part of ground floor Finchley Memorial Hospital, Barnet, London, between Barnet Primary Care Trust and University College London Hospitals NHS Foundation Trust – Audiology

- **RATIFIED:** The use of Chair’s action in approving a contract variation to University College Hospitals NHS Foundation Trust, Barnet and Chase Farm Hospitals and award of a new contract to Royal Berkshire Hospital via the AQP vehicle, to provide Adult Hearing Services for Barnet and Enfield Primary Care Trusts.

The Board of **Camden Primary Care Trust:**

- **RATIFIED:** The use of Chair’s action in approving extra funding to procure and implement the NHS Camden Integrated Care IT system and approval of the award of contract to Insight/Orion Health based on the procurement process and evaluation report.

The Board of **Enfield Primary Care Trust:**

- **RATIFIED:** The use of Chair’s action in agreeing the settlement payment and authorising the use of signing under seal the Deed of Settlement with Dulwich Medical Centre.

- **RATIFIED:** The use of Chair’s action in approving a contract variation to University College Hospitals NHS Foundation Trust, Barnet and Chase Farm Hospitals and award of a new contract to Royal Berkshire Hospital via the AQP vehicle, to provide Adult Hearing Services for Barnet and Enfield Primary Care Trusts.

The Board of **Islington Primary Care Trust:**

- **RATIFIED:** The use of Chair’s action to approve the award of contract to Virgin Media Business Limited and authorisation for the use of seal for the contract for IT and telecommunications services on behalf of North East London Commissioning Support Unit and the 12 CCGs of NHS North Central London and East London Clusters.

- **RATIFIED:** The use of Chair’s action to approve and sign a contract variation to allow the incorporation of RNTNE activity into the main UCLH contract

**Use of Seal:**

The Board of **Barnet Primary Care Trust:**

- **NOTED:** The use of seal in respect to the lease of premises of two rooms forming part of the ground floor Finchley Memorial Hospital,
The Board of **Enfield Primary Care Trust:**

- **NOTED:** The use of seal in respect to the Deed of Settlement between Enfield Primary Care Trust and Dulwich Medical Centre Healthcare Limited.

The Board of **Islington Primary Care Trust:**

- **NOTED:** The use of seal in respect the contract between Islington Primary Care Trust on behalf of the North East London Commissioning Support Unit and Virgin Media Business Limited.

### 3. STRATEGY

#### 3.1 Primary Care Strategy 2012/15 – Update

3.1.1 The Senior Responsible Officer for Primary Care presented a quarterly update on the implementation of borough and cluster level elements of the Primary Care Strategy. All boroughs had now developed Primary Care Plans and leads for clinical networks and practice nurse development had been appointed. There had also been excellent progress with the implementation of web-based information technology, SMS texting, premises improvement grants, contractual performance management and workforce sustainability. The next step would be to refresh the strategy with the Clinical Commissioning Groups, a report on which would be brought back to the Joint Boards in March 2013.

3.1.2 Helena Kania sought assurance that the implementation of cluster-wide IT projects would not disenfranchise patients who did not have access to computers and phones. Siobhan Harrington advised that the intention of the IT projects was primarily to improve working between practices.

3.1.3 The Islington PEC Chair observed that the improved IT had proven very useful for practices where it had already been implemented, particularly SMS services for patients, which were optional, but had achieved good results and were popular with patients.

3.1.4 Members sought detail on how the positive impact and outcomes of the strategy could be clearly demonstrated, as well as assurance that milestones were fully defined. It was necessary to be clear that the implementation of the strategy was progressing according to plan, noting that the paper did not give detail on what work was still outstanding.

3.1.5 Siobhan Harrington reported that there was still work to be done on outcome measurements, but that all the business cases listed specific outcomes. Further work on milestones was needed, and the March report would include key milestones for agreement by the Joint Boards.

3.1.6 Members suggested that the milestones should include a mechanism for the identification and management of project under-spend, as this was a key risk.
to the success of the strategy.

3.1.7 The Director of Finance reported that a standard business case template had been implemented, which necessitated the inclusion of detail on milestones, and a member of the finance team was working with Clinical Commissioning Groups to support the finance content in business cases. With regards to early alerts for under-sPENDS, there were indications that there may be a Department of Health-led mechanism for carrying forward some funds into the next financial year, and Primary Care Strategy had been flagged as a particular area of focus in this respect.

3.1.8 The Deputy Medical Director for Primary Care congratulated the team on the development of the strategy and the level on engagement to date. It was clear that poor performance would not be tolerated or missed by the new commissioning organisations. The Strategy also had the positive effect of bringing inspirational GPs to the fore, which would have a significant impact on culture and the sustainability of the strategy.

3.1.9 Members asked that the report to the Joint Boards in March should address the issue of ensuring patients were not disadvantaged by their registration with particular practices that were not able to offer a full range of services, and also include feedback from the survey of premises.

3.1.10 The Joint Boards:

- **NOTED** the good progress in the delivery of the borough and cluster-wide implementation plans
- **AGREED** to champion the delivery of the Primary Care Strategy implementation at the local level
- **AGREED** to receive a progress report at the March 2013 meeting of the Joint Boards of NHS North Central London

3.2 Royal National Orthopaedic Hospital (RNOH) Foundation Trust Application: Commissioner response to the RNOH’s public consultation

3.2.1 The Chief Executive reported that as part of the development stage of their Foundation Trust application the Royal National Orthopaedic Hospital had carried out a public consultation exercise. Members were asked to consider the draft formal response to consultation and to agree the response to the Trust. Some issues had already been raised regarding the balance of local and national services and alignment with commissioner requirements

3.2.2 The Joint Boards **APPROVED** the draft response to the RNOH’s public consultation document.

4. QUALITY AND SAFETY

4.1 Mental Health and Learning Disabilities High Level Review

4.1.1 The Director of Quality and Safety presented a high level review of Mental
Health and Learning Disability services commissioned by the five Primary Care Trusts, focusing on Camden and Islington Mental Health Foundation Trust (CIFT), the Barnet, Enfield and Haringey Mental Health Foundation Trust (BEHMHT) and the Tavistock and Portman NHS Foundation Trust.

4.1.2 National data for mental health was not as robust as acute hospital data, but a substantial volume of information had nevertheless been gathered from a range of robust data sources. The key findings of the review related to problems in communications between GPs and Mental Health service providers, regularity of care programme reviews and workforce issues (highlighted by staff survey results). A series of recommendations were made about improving communication and partnership working and engaging with service users and other stakeholders.

4.1.3 There was even less national data on learning difficulties, but the London-wide self-assessments over recent years had generated a high level of robust evidence, as had a Local Enhanced Service for an annual healthcheck for patients with learning disabilities.

4.1.4 Ray James noted that the review was not as inclusive of a Local Authority perspective as it might have been and offered to contribute to any future reviews. The Director of Quality and Safety accepted the comment and noted that there was very good close working with local authorities, not least in Enfield, and that this contribution was of immense value.

4.1.5 David Riddle noted that the review did not quite fulfil the intended breadth of scope, due to the difficulty of obtaining reliable data. It was, however, somewhat disappointing that there was not a stronger equalities dimension in the report, since there were significant issues to be addressed.

4.1.6 It was noted that BEHMHT’s response was somewhat complacent, and that a majority of GPs in Barnet were of the opinion that the level of support that Barnet GPs were able to provide was not as high as it should be because there was not sufficient support from the Mental Health Trust. Members felt that the PCTs should express their concerns in terms stronger than those set out in the report.

4.1.7 **ACTION 12/11-1** – To write an assertive letter to Barnet Enfield and Haringey Mental Health Foundation Trust expressing the concerns raised and seeking a response with a full action plan to address concerns.

4.1.8 The report was not clear on the process for implementing actions across the diverse parties involved and it was **AGREED** that an action plan should be brought to the next meeting.

4.1.9 It was noted that with regards to learning difficulties, Enfield was rated ‘red’ on health checks for 2011. A very detailed action plan had subsequently been put in place, and the outcomes of the self-assessment framework in December would provide a clear picture of whether the situation had improved as a result.

4.1.10 Overall progress was monitored by the Clinical Quality Review Groups, and all findings of the review had been raised with the trusts. Efforts were also being made to focus the membership of the groups in order to improve levels of
engagement and make conversations with the trusts more meaningful.

4.1.1 The Chief Executive advised that regular meetings had been held with
BEHMHT since the beginning of the year, and in line with the findings of the Maudsley InternationalReport, work was progressing on jointly identifying improvements to quality and finance. A workshop was scheduled in early December at which engagement issues with primary care could be raised. Currently this level of collective commissioner engagement was not in place with CIFT, and the CCGs would need to consider how best to engage at a strategic level with Mental Health providers in the south of the cluster. The Camden PEC Chair assured the Joint Boards that Camden Clinical Commissioning Group was making good progress on improving joint working between CIFT and Primary Care.

4.1.1 Members noted that the ongoing dialogue with carers, family members and patients should be brought to the fore in discussions relating to this area of services.

4.1.1 Members noted that, particularly given the wider context of NHS funding, there was a wastage of resources if communications were not effective. Additionally, the contribution of GPs was essential to ensure physical health issues were properly dealt with.

4.1.1 Members expressed concern regarding the delays to discharge summaries. It was confirmed that information on delays should be escalated immediately and that any three month delays should constitute a Serious Incident from a clinical governance perspective. It was noted that a comprehensive and systematic approach to this was needed.

4.1.1 **ACTION 12/11-2** – To report to the Joint Boards at the next meeting on issues across the cluster relating to delayed discharge summaries.

4.1.1 **ACTION 12/11-3** – To notify the trusts of concerns raised by the review and in the discussion by the Joint Boards.

4.1.1 The Director of Quality and Safety thanked members for their input. A more robust action plan would be developed and shared with Board Members and Clinical Commissioning Groups for further contribution.

4.1.1 The Joint Boards:
- **CONSIDERED** the review report contents and recommendations; and
- **APPROVED** the report

4.2 Rehabilitation and Remediation of Doctors’ Performance

4.2.1 Helene Brown presented the report on the process of revalidation, due to be launched in December 2012, which was designed to provide positive affirmation that licensed doctors remained up to date and fit to practise throughout their career. It involved strengthened appraisal processes and a closer link between other clinical governance systems and appraisal.

4.2.2 Members noted that the policy was very clear and that the cluster had
produced good work on this area. It would be helpful to identify risks in relation to the transfer of accountability for Primary Care performance to the NHS Commissioning Board.

4.2.3 Helene Brown reported that the LAT Medical Directors were all now in post and performance teams were being mapped. The rest of the team was scheduled to be in place by Christmas, and detailed arrangements would be finalised prior to transfer.

4.2.4 The Joint Boards:
- AGREED to champion the delivery of Appraisal and Revalidation at the local level; and
- APPROVED the Remediation Policy

5. FINANCE AND PERFORMANCE

5.1 Month 6 and 7 Finance Report

5.1.1 The Director of Finance presented a report on the Month 6 and 7 finance positions for the five Primary Care Trusts of North Central London. All five trusts were still on target to deliver their control totals at year-end, but there had been some deterioration on run-rate delivery in month 7 due to the greater challenge of higher QIPP targets in the second half of the year. Whilst QIPP schemes were being implemented, progress was not as quick as had been predicted. Additional support had been put in to each of the Clinical Commissioning Groups to improve delivery. The Director of Finance was working closely with the Chief Finance Officers of all five Clinical Commissioning Groups to monitor capital and cash positions and to maintain focus on run-rates.

5.1.2 Members enquired how debtors would be managed through the transition. The Director of Finance reported that the team was working to resolve all debts over 60 days for the hard close, and all debts over 30 days by March. Substantial progress had been seen over the last two weeks. Management of debtors would be transferred to the Department of Health from 31 March 2013.

5.1.3 The Director of Finance advised that the format of the Finance Reports would be changing for future meetings. Members welcomed this and asked for more detail on QIPP progress.

5.1.4 The Joint Boards NOTED the Month 6 and 7 Finance Report.


5.2.1 Anne Weyman presented a report on the work to date of the Financial Recovery and QIPP Committee, which had been focusing in particular on run-rates and on issues with the ‘back-loading’ of QIPP delivery into the second half of the year, and with the under-spend on investment programmes in Camden and Islington. The Committee was working closely with Clinical Commissioning Group teams to scrutinise and provide assurance on these issues.
The Joint Boards NOTED the report.

Performance Report

The Joint Boards NOTED the report.

The Joint Boards NOTED the report.

The Joint Boards NOTED the report.

The Joint Boards NOTED the report.

The Joint Boards NOTED the report.

The Joint Boards NOTED the report.

The Joint Boards NOTED the report.
5.8 Islington Emerging Clinical Commissioning Group (CCG) Performance

5.8.1 The Board of Islington Primary Care Trust NOTED the report.

6. TRANSITION

6.1 Transition Programme Progress Update

6.1.1 The Director of Quality & Safety presented an overview of the progress made on the NHS North Central London Transition Programme. In London, 7 January had been signalled as the date of the start of the final transition period, with a core cluster team remaining in post for the delivery of core Primary Care Trust functions whilst other delivery areas would be carried out by the various inheritor organisations. A Transition Committee had been established to monitor the process and to provide additional Non-Executive oversight.

6.1.2 Public Health England and the NHS Commissioning Board had now published their organisational structures and were underway with recruitment, and the Clinical Commissioning Groups continued to develop at a good pace. The Legacy, Handover and Closedown programme was also in operation to ensure that the handover of responsibilities was conducted safely and thoroughly.

6.1.3 Members noted that it was important that the Boards be appraised of any issues in sufficient detail, and that problems in the transition could be escalated quickly. The Chief Executive advised that there was a robust process in place to monitor all potential problems identified. There was a number of ongoing issues such as the detail of the service level agreements between the Clinical Commissioning Groups and the Commissioning Support Unit, which were still being identified and would be resolved over the coming months. Members were urged to flag any issues with the Director of Quality and Safety.

6.1.4 It was noted that it would be the responsibility of the Clinical Commissioning Groups to determine the level of resourcing they required from the CSU and whether they chose to purchase services from the CSU outside those included in the core offer.

6.1.5 The Joint Boards noted risks associated with the various new organisations not developing at the same pace. The Chief Executive reported that NHS London had established a Transition Committee and that a stock-take of unresolved issues would be carried out in January 2013.

6.1.6 Members asked about the nature of audit functions in the new organisations. The Director of Finance reported that the Commissioning Support Unit would have its own internal and external audit processes, as well as an Audit Committee or equivalent body. Ernst and Young had been retained to look at standard operating procedures, and there would be a formal mechanism in place for reporting to the Clinical Commissioning Groups.

6.1.7 The Joint Boards NOTED the report.

7 GOVERNANCE AND ASSURANCE


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7.1.1 The Chief Executive presented the Board Assurance Framework and Corporate Risk Register. Key areas of risk were highlighted around the quality of nursing homes; financial year-end position and delivery of QIPP; specific issues arising from mental health placements; and property disposal and other estates issues relating to the transition.

7.1.2 There was also a national issue relating to the deadline for retrospective care claims and the Finance Pan-London Group was meeting the next day to consider a London-wide solution.

7.1.3 The Joint Boards NOTED the report.

7.2 Report of the Audit Committees of NHS North Central London

7.2.1 The Audit Chair presented the report on the work of the Audit Committee since the last meeting of the Joint Boards. The Committee had focused at the last meeting on seeking assurance on non-clinical contract transition risks as well as IT security and estates risks. The Committee would continue to focus on transition through the coming months.

7.3 2012/13 Review of Progress on Corporate Objectives

7.3.1 The Joint Boards received a report on the progress made against each of the three principal corporate objectives since they were agreed in March 2012, with references to the 2012/13 Board Assurance.

7.3.2 Members asked how the work of the multi-agency working group on the quality of nursing homes would be handed over. The Director of Quality and Safety reported that all five Clinical Commissioning Groups had nominated members to this group and were actively involved in the work, which would greatly simplify the process of handover. Clinical Commissioning Groups would lead this work in the future, in collaboration with local authorities and other stakeholders.

7.3.3 Members asked whether there was any specific data showing reductions in health inequalities. The Director of Quality and Safety advised that there was some performance data to indicate process, but there was still a long way to go on this objective. The Clinical Commissioning Groups were well aware of the importance of this objective and that they would show strong leadership in the area. It was noted that at this stage it was not likely that that hard data would be available, but there were some proxy indicators (for example, smoking cessation, immunisation and early booking in maternity) which gave good indications.

7.3.4 It was noted that health inequalities should be built into needs assessments early on and that data was collected from sources such as screening programmes and health checks.

7.3.5 The Joint Boards NOTED the report.

7.4 Standards for Members of NHS Boards and Clinical Commissioning

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Group Governing Bodies in England

7.4.1 The Chief Executive reported that the Professional Standards Authority (PSA) had published new standards for members of NHS boards and clinical commissioning group (CCG) governing bodies in England, and that all Members were asked to make a declaration of their commitment to a number of standards around personal behaviour, technical competence and business practices.

7.4.2 The Joint Boards:

- **ADOPTED** the standards published by the Professional Standards Authority;
- **AGREED** that all Members of the Boards sign up to the declaration; and
- **AGREED** that the standards should be submitted to the five North Central London Clinical Commissioning Group Governing Bodies for adoption.

7.5 Updated Terms of Reference – Transition Committee and Haringey CCG Governing Body

7.5.1 The Joint Boards received the updated terms of reference for the newly established Transition Committee and the Governing Body of Haringey Clinical Commissioning Group.

7.5.2 The Joint Boards:

- **APPROVED** the Terms of Reference for the Transition Committee

7.5.3 The Board of Haringey Primary Care Trust:

- **APPROVED** the Terms of Reference for the Haringey Clinical Commissioning Group Governing Body

8 FOR INFORMATION

8.1 Report on the London Specialised Commissioning Group Board Meeting

8.2 Haringey Professional Executive Committee (PEC) Report

8.3 Barnet Professional Executive Committee (PEC) Report

8.4 Barnet Professional Executive Committee (PEC) Minutes

8.5 Haringey Professional Executive Committee (PEC) Minutes

8.6 Audit Committee Minutes

8.7 Financial Recovery & QIPP Committee Minutes Part I

8.8 Barnet Clinical Commissioning Group Board Minutes

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8.9 Camden Clinical Commissioning Group Board Minutes
8.10 Enfield Clinical Commissioning Group Board Minutes
8.11 Haringey Clinical Commissioning Group Board Minutes
8.12 Islington Clinical Commissioning Group Board Minutes

9 ANY OTHER BUSINESS
9.1 There was none.

10 DATE OF NEXT MEETING
10.1 Thursday 31 January 2013

These minutes are agreed to be a correct record of the meeting of the Joint Boards of NHS North Central London held on 29 November 2012

Signed: Date:
<table>
<thead>
<tr>
<th>Meeting Date</th>
<th>Action No.</th>
<th>Minutes Reference</th>
<th>Action Description</th>
<th>Responsibility</th>
<th>Target Date</th>
<th>Progress Details</th>
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<tr>
<td>29/11/2012</td>
<td>1</td>
<td>4.1.7</td>
<td>To write an assertive letter to Barnet Enfield and Haringey Mental Health Foundation Trust expressing the concerns raised and seeking a response with a full action plan to address concerns.</td>
<td>Director of Quality &amp; Safety</td>
<td>Dec-12</td>
<td>The Chief Executive wrote to BEHMHT on behalf of the Joint Boards in December and there is an ongoing dialogue with the trust.</td>
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<tr>
<td>29/11/2012</td>
<td>2</td>
<td>4.1.15</td>
<td>To report to the Joint Boards at the next meeting on issues across the cluster relating to delayed discharge summaries.</td>
<td>Director of Quality &amp; Safety</td>
<td>Jan-13</td>
<td>Issues around delayed discharge summaries are being picked up via the Clinical Quality Review meetings and will continue to be a high priority in the CCG system.</td>
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<td>29/11/2012</td>
<td>3</td>
<td>4.1.16</td>
<td>To notify the trusts of concerns raised by the review and in the discussion by the Joint Boards.</td>
<td>Director of Quality &amp; Safety</td>
<td>Dec-12</td>
<td>This is being followed up through Clinical Quality Review meetings, which are in place with all provider trusts.</td>
</tr>
</tbody>
</table>
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**MEETING:** Meeting of the Joint Boards of NHS North Central London  
**DATE:** Thursday 31 January 2013  
**TITLE:** Chief Executive’s Report  
**LEAD DIRECTOR:** Caroline Taylor, Chief Executive  
**AUTHOR:** Caroline Taylor, Chief Executive  
**CONTACT DETAILS:** Caroline.Taylor@nclondon.nhs.uk

**SUMMARY:**
This is the Chief Executive’s report to the Joint Boards. This report provides an update on developments in the local NHS and wider policy issues.

**SUPPORTING PAPERS:**
None.

**RECOMMENDED ACTION:**
The Joint Boards are asked to:

- **NOTE** the report
- **NOTE** the appointment of Julie Billett as Joint Director of Public Health for Camden and Islington
- **NOTE** the appointment of Helen Pelendrides as Haringey PEC Chair

**LINKS TO NHS NORTH CENTRAL LONDON STRATEGY**
This report outlines developments in key areas since the last meeting of the Joint Boards.

Updates on work that contributes to NHS North Central London’s objectives to ensure we commission services which are safe and of increasing quality for the people we serve, and to deliver the NHS North Central London QIPP Plan are included.

**GOVERNANCE:**
Voting: Please indicate which Board(s) has voting rights on this matter (if applicable)

<table>
<thead>
<tr>
<th>Barnet</th>
<th>Camden</th>
<th>Enfield</th>
<th>Haringey</th>
<th>Islington</th>
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<tr>
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<tr>
<td>David Riddle</td>
<td>Caroline Rivett</td>
<td>Karen Trew</td>
<td>Cathy Herman</td>
<td>Anne Weyman</td>
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<td>Caroline Rivett</td>
<td>Robert Sumerling</td>
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<tr>
<td>Bernadette</td>
<td>Karen Trew</td>
<td>Deborah Fowler</td>
<td>Sue Baker</td>
<td>Sorrel Brookes</td>
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The Joint Boards of NHS North Central London refers to the joint meeting of the Boards of Barnet, Camden, Haringey, Enfield and Islington Primary Care Trusts.
Objective(s) / Plans supported by this paper:
Principal Objective 1: To ensure we commission services which are safe and of increasing quality for the people we serve.
Principal Objective 2: To deliver the NHS North Central London QIPP Plan.

Patient & Public Involvement (PPI): Patient and public involvement has been through existing channels and meetings with patients and representative groups.

Equality Impact Assessment: Not applicable.

Risks: There are no new risks to be recorded.

Resource Implications: There are no additional resources implications from these items.

Audit Trail: This report has not been presented to any Committees of the Board.

Next Steps: This is the most recent of a regular report to the Joint Boards.
1.0 ORGANISATIONAL FORM FOR BARNET AND CHASE FARM HOSPITALS

1.1 Following Barnet and Chase Farm Trust’s decision that it was not viable as a standalone Foundation Trust, a competitive selection process was undertaken which resulted in the selection of the Royal Free London NHS Foundation Trust as the Trust’s preferred partner.

1.2 The Strategic Outline Case, making the case for progressing to a detailed outline business case for the acquisition of Barnet and Chase Farm Trust by the Royal Free London NHS Foundation Trust was approved by the Capital Investment Committee of NHS London at the end of November 2012.

1.3 The Royal Free is now working with Barnet and Chase Farm Hospitals and the wider health economy to develop an innovative solution that maximises clinical synergies and delivers patient benefits in a financially sustainable way. The Outline Business Case is due to be submitted to the Trust Development Agency at the end of April 2013, with agreement for the Outline Business Care planned for the end of May 2013.

1.4 Parallel to this work the Royal Free will be undertaking the necessary due diligence to be in a position to assure their Board by the end of February 2013. The Competition and Co-operation Panel will carry out the first stage of their review between February and March, with the full review expected to continue until July 2013.

1.5 Subject to a positive outcome of these pieces of work it is anticipated that the full business case will be completed and agreed by November 2013, with the transaction expected to take place in January 2014.

2.0 WHITTINGTON HEALTH – PROGRESS TOWARDS FOUNDATION TRUST STATUS

2.1 Following Whittington Health’s decision, reported to the previous meeting, that it was to delay its foundation trust application by three months to allow for more time to strengthen aspects of its strategic and financial plans the Trust is progressing along its revised timeline. An updated integrated business plan and long term financial model have been produced and submitted to NHS London. The expectation is that consideration and challenge of these plans will take place during February, including a Trust Board to Board meeting with the Strategic Health Authority/Trust Development Agency on the 14 February.

2.2 Commissioners have been closely involved in the process to date and will continue to input as part of the review and challenge role, ensuring that the plans are aligned with the commissioner’s strategic direction and that they are best placed to deliver high quality, affordable and sustainable services.

2.3 Once the application has completed this phase submission of the application to the Secretary of State is planned for the end of March 2013. If approval is subsequently received from the Secretary of State to progress then the application will be passed to Monitor for their review. The timeline for the overall process of this should result in the Trust receiving authorisation to become a Foundation Trust status during 2013/14.
3.0 THE BARNET, ENFIELD AND HARINGEY MENTAL HEALTH TRUST (BEHMHT) - FOUNDATION TRUST APPLICATION PROGRESS

3.1 BEHMHT’s Foundation Trust application completed the development stage of the Foundation Trust pipeline process and was submitted by NHS London to the Department of Health in June 2012

3.2 Further work is on-going by the Trust to inform NHS London’s updated statement on quality for the NTDA. Following a successful assessment by Monitor the Trust would be expected to achieve Foundation Trust status during the 2013/14 financial year.

4.0 ROYAL NATIONAL ORTHOPAEDIC HOSPITAL – PROGRESS TOWARDS FOUNDATION TRUST STATUS

4.1 Following approval of the Outline Business Case to redevelop the Stanmore site, which was supported by NHS North Central London in 2011/12, the Trust has been progressing its Foundation Trust application in parallel with the Private Finance Initiative development.

4.2 The PFI development has reached the stage of the Royal National Orthopaedic Hospital (RNOH) submitting a draft Appointment Business Case, together with a refreshed long term financial model, to NHS London, which it did on 6 December. This followed assurances from the Trust advisors that they have two compliant bids.

4.3 The draft Appointment Business Case will be reviewed by NHS London in partnership with the Department of Health (including the Private Finance Unit). The next stage will be for the Appointment Business Case to be approved by the NHS London Capital Management Group and Capital Investment Committees in February. Following this RNOH will remain on target to formally close this stage of competitive dialogue in May 2013, prior to requesting and receiving final bids for evaluation by the end of that same month.

4.4 To deliver the Foundation Trust pipeline alongside this the Trust has established a clear trajectory, with submission of the application to Monitor expected to take place in December 2013. The public consultation, required as part of the application’s development, was completed at the end of November 2012 and the draft Integrated Business Plan and Financial Model were submitted to NHS London at the end of December 2012. Commissioner support for these plans will need to be agreed by June 2013 and given the Trust case mix, with approximately 80% of activity being specialist and 20% routine, consideration is being given as to how this can best be achieved to ensure both representative and effective engagement in the new environment.

5.0 NORTH WEST LONDON SERVICE RECONFIGURATION

5.1 NHS North West London completed a fourteen week public consultation on service reconfiguration across the Cluster on 8 October 2012, with 17,022
responses received. The results were fed back at a stakeholder event at the end of November 2012.

5.2 The consultation had asked for opinions on a range of issues including whether changes needed to be made and where the major hospitals with Accident & Emergency Units should be located within the Cluster.

5.3 The results showed 64% of people who responded agreed that there were convincing reasons to change the way services were provided and 61% of those who responded supported the recommendation that there should be five major hospitals in North West London.

5.4 Three options for major hospital reconfiguration were considered. Of those who responded there was 83% support for the preferred option (option A), which would see Chelsea and Westminster Hospital, Hillingdon Hospital, Northwick Park Hospital, St Mary's Hospital and West Middlesex Hospital as major hospitals, with Ealing and Charing Cross Hospitals as local hospitals, Central Middlesex as a local and elective hospital, and Hammersmith Hospital as a specialist hospital.

<table>
<thead>
<tr>
<th></th>
<th>Option A</th>
<th>Option B</th>
<th>Option C</th>
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<tbody>
<tr>
<td>St Mary's</td>
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<tr>
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<tr>
<td>Hillingdon</td>
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5.5 For the other two options there was a majority amongst those who responded who opposed both options, option B, which would see Chelsea and Westminster as a local hospital and Charing Cross as a major hospital, and option C, which would see the West Middlesex as a local hospital and elective hospital.

5.6 The final recommendations put forward by NHS North West London will be considered by the Joint Committee of the PCTs on 19 February 2013. Whatever is agreed it is expected that it will take around three years to develop the necessary out of hospital care in North West London.
communities before any changes to hospitals recommended by the ‘Shaping a healthier future’ programme could be implemented.

6.0 JOINT SERVICES CENTRE, ORDNANCE ROAD, ENFIELD

6.1 NHS North Central London is working with the London Borough of Enfield to improve the delivery of local primary care services within the Borough. A demand has been identified to provide improved premises within the locality. This has arisen from a combination of predicted population growth, the potential to improve patient registration numbers and generally to improve healthcare in the Enfield Lock area, as well as the condition of the existing Ordnance Road practice premises.

6.2 The London Borough of Enfield and NHS North Central London have investigated a number of alternative locations for delivery of the new services and after consultation have selected the Ordnance Road library site as the preferred location for development of an integrated scheme. The decision of both parties to back the integrated scheme is supported on the NHS side by completion of a Full Business Case which tests the case for change against policy requirements, value for money considerations and affordability as well as testing or re-testing any alternative options. The Full Business Case has been submitted to NHS London for review and approval. The Council has already approved the scheme and full planning permission has been obtained.

6.3 The integrated scheme when completed will comprise a purpose built new development comprising of a Library, Community Hall, GP Practice and a Dental Surgery. The proposed GP surgery will replace the practice currently operating from 171 Ordnance Road and provide enlarged practice facilities and the opportunity to deliver an increased level of local services, including out of hospital minor procedures. The Dental Surgery will allow provision of community dental services to the north of the Borough to offer greater efficiencies, service resilience and provision of local services. Opportunities to engage with local dentists to offer specialist services will also be explored.

7.0 UPDATE ON CHANGE OF HOURS IN EVERGREEN WALK-IN CENTRE

7.1 At the Joint Boards meeting of NHS North Central London in July 2012, the Board of Enfield Primary Care Trust (PCT) approved a proposal by Enfield Clinical Commissioning Group (CCG) to reduce duplication, ensure quality of care for patients and make best use of every NHS pound spent by revising the opening hours of the Evergreen Walk-In Centre.

7.2 In advance of the service change, which was introduced on 1st December 2012, a working group was established (which included Local Authority and LINKs representation) to agree an action plan, ensure appropriate communication arrangements were in place and oversee the change. As part of this work, checks were carried out with local practices to ensure that additional access was being made available by them.

7.3 On introducing the new arrangements, a review was conducted at the end of the first weekend which provided assurance that the changes were working
appropriately, with some minor issues (primarily around communication) being identified and addressed.

7.4 Initially, around 9% of patients attending were unregistered. Those living within Evergreen Surgery’s catchment area were offered registration by the surgery. Others were given a list of local GPs in the area and information on how to obtain assistance in case of difficulty registering.

7.5 A further review was undertaken at the end of December (the first month of the new arrangements), where it was noted that the change in operational hours had coincided with one the busiest weekends ever in the Walk-In Centre, with a record 310 patients seen on Sat 29th / Sun 30th. However, this may reflect the fact that there were several bank holidays and the outbreak of Norovirus and flu-like illness which have been widely reported in the press.

7.6 Some concerns were expressed in early December by North Middlesex University Hospital about an increase in the number of under 18s attending A&E during the week, with the suggestion that many of these were Evergreen patients. A review was immediately undertaken based on analysis of a sample week of data provided. This identified that over a quarter of the patients were not Evergreen patients, and a number of others had attended either out of core weekday hours or at weekends. No evidence was found that a direct link could be made between the service changes and the increased A&E attendances. However, as a trial, the surgery has introduced "under 12s only" sessions to further improve access for acutely ill children, with the intention of providing dedicated access for children who may otherwise have needed to access unscheduled care.

7.7 Although it is acknowledged that some patients were unhappy about the change in service, no formal complaints have been received, and the implementation has so far been uneventful.

8.0 HARMONI OUT OF HOURS SERVICE

8.1 Members will be aware that NHS North Central London has instigated some enquiries into Harmoni’s Out of Hours GP Service following a Serious Incident and a report in the Guardian newspaper alleging its service “puts patients at risk” and that it “manipulated performance data, masking delays in seeing patients and other missed targets”. The Serious Incident Investigation is due to report at the end of January following which an update will be provided to board members. A report into the review of performance and associated assurances is being finalised and is expected to be available shortly.

8.2 A response was submitted to the Guardian newspaper in December 2012. However, to ensure that appropriate assurances were obtained in relation to rota arrangements and cover, additional attention was paid to this over the Christmas and New Year period. In addition, meetings have been held to review current performance, management and reporting arrangements which, with learning from the recent events, will be developed into an approach that will provide enhanced levels of assurance. The matters have also been the subject of recent scrutiny committee discussions, which Harmoni
representatives attended to provide updates and responses to questions posed by committee members and others.

9.0 UPDATE ON THE FINAL REPORT INTO WINTERBOURNE VIEW

9.1 The Department of Health published the final report on Winterbourne View on 10 December 2012. The report encompasses the findings from the CQC internal review and outcomes of the 150 inspection visits to learning disabilities services, the Castlebeck Internal Review and the Serious Case Review. Alongside the report a Concordat was published, outlining the commitment to a programme of work by national organisations including the Royal Colleges, Association of Directors of Adult Social Services and the NHS Commissioning Board.

9.2 David Nicholson subsequently wrote to PCT Cluster Chief Executives, Local Authority Chief Executives and Directors of Adult Social Services on 10 December 2012, outlining a clear programme of national and local actions to transform care, to ensure that there are local high quality services that reduce the health inequalities suffered by people who have a learning disability or autism and whose behaviour is regarded as challenging.

9.3 There are key actions that organisations are now requested to do, and it will take continued joint leadership from NHS and Local Authority organisations to work in an integrated and collaborative way to make changes happen.

9.4 Key National Enablers:
- Transforming care: A national response to Winterbourne View Hospital (DH 2012)
- A mandate from the Government to the NHS Commissioning Board: April 2013 to March 2015 (DH 2012)
- Clinical Commissioning Group Authorisation: Guide for applicants (NHS CB)
- Clinical Commission Group Commissioning Guidance Everyone counts: Planning for Patients 2013/14 (NHS CB)

9.5 Action Required:
- NHS North Central London, Clinical Commissioning Groups and the Local Authority need to take account of the Concordat and key actions to ensure that people with learning disabilities and autism receive safe, appropriate high quality care.
- NHS North Central London needs to ensure that handover and transition arrangements are put into place to ensure Clinical Commissioning Groups have accurate records and clear outlines of future expectations. This should build on the existing work undertaken following Winterbourne View, which included the Safeguarding Assurance Framework and Learning Disability Health Self-Assessment Framework.

9.0 UROLOGICAL CANCER SURGICAL SERVICES
9.1 Following a 2010 pan-London cancer review which involved public engagement on a case for change and model of care for London, clinicians are considering a local model of care for urological cancer surgical services, specifically complex surgery for bladder and prostate cancer and kidney cancer. This review is being led by London Cancer, the integrated cancer system for north central and east London and west Essex. Clinicians representing all the hospitals providing urological cancer services in the area are involved, together with GPs and patient representatives.

9.2 Clinicians are finalising their case for change which sets out why they believe changes are needed to improve patient outcomes and patient experience. Clinicians recommend that complex surgery be centralised in a single centre for bladder and prostate cancer and a single centre for kidney cancer. Currently around two people a day across the London Cancer area require this type of complex surgery. Clinicians also believe we need to improve diagnosis and support for patients. Local urological units would continue to provide the vast majority of patient care. In 2010/11, four hospitals across the London Cancer area each undertook between 54 and 89 complex operations for bladder and prostate cancer (a total of 296 operations) and nine hospitals undertook between 10 and 72 complex kidney operations (a total of 292 operations). Clinicians also believe that there are up to 50 bladder and prostate patients each year who currently do not get the complex surgery that they would benefit from.

9.3 As the future commissioner of these services, the NHS Commissioning Board (NHS CB) has commissioned North and East London Commissioning Support Unit to support engagement on the proposals. As the current commissioner, NHS North Central London and NHS North East London & the City will sponsor an eight week engagement to understand the wide range of views of stakeholders across north central London, north east London & the City, west Essex and south Hertfordshire. This engagement process will be formally launched in late January and run to the end of March. The engagement will be an opportunity to consider the views of stakeholders on the proposed service model and any concerns relating to patient choice and travel. Later in the process, we will formally discuss the clinical recommendations with Clinical Commissioning Groups (as one of the key stakeholders for the four tests for reconfiguration) and the Joint Health Overview and Scrutiny Committees. The NHS CB will formally make decisions on the future configuration of urological cancer services in the new financial year, taking account of all the views received during engagement.

9.4 London Cancer has started discussions with NHS hospital trusts currently providing urological cancer surgical services about how they could work together to implement the proposed model of care. An initial expressions of interest process has been undertaken. Trusts have now submitted formal expressions of interest and discussions are continuing. London Cancer will make a recommendation to the NHS CB later in the process as to which hospitals it believes are best placed to provide a truly world class service in future. We have committed to sharing more information on the designation process during the engagement process.
10.0 NEUROSURGERY UPDATE

10.1 The transfer of non-elective neurosurgical patients, intracranial neurosurgery elective inpatient work, and complex spinal work from the Royal Free Hospital to University College London Hospital (UCLH) took place in June 2012. At the time of approval this transfer was represented as phase 1 of a 2 stage process. This process is now intended to conclude with the transfer of routine spinal surgery scheduled to move to Queen Square at the end of March 2013.

10.2 Routine spinal surgery remained at the Royal Free Hospital with 24/7 consultant support from Queen Square and day time junior doctor cover from the neurosurgical team at Queen Square. The out of hours support has been provided by the orthopaedic team at the Royal Free Hospital. Current elective work at Royal Free is approximately 20 cases per month equating to 240 inpatient cases per year plus related outpatient and diagnostic imaging services. The interim service at the Royal Free was a short term solution and the plan was to transfer the remaining services to Queen Square within the same financial year.

10.3 The rationale for this two stage approach to this transfer was based on capacity restrictions at Queen Square. Additional capacity is now in place following a capital project to create 7 extra beds and improvements to the availability of day care facilities. UCLH is able to confirm that the remaining patients can now safely be accommodated on the Queen Square site.

10.4 This transfer of services was recommended to the Commissioner and the Joint Health Overview and Scrutiny Committee (JHOSC) on the basis that the consolidation of neurosurgical services in North Central London offered significant benefits to patients including but not limited to; accelerating advances in neurosurgical practice through research, improving education to medical and nursing teams and more effective use of resources through co-location and consolidation.

10.5 The two trusts concerned are now engaged in the communication and engagement exercises required in order to conclude the transfer. There will be another stakeholder event at Queen Square in March for interested patients, GPs and patient representative groups as a follow up to last year’s event, and the JHOSC are to be contacted again. In addition the Trust intends to produce a paper for the Clinical Commissioning Group Boards within North Central London. Once this has been completed and any feedback received the transfer will be brought back to the NHS North Central London Joint Boards meeting in March 2013 for final approval.

11.0 SENIOR APPOINTMENTS

11.1 Julie Billett has been appointed Joint Director of Public Health for Camden and Islington. Julie will take over from the Interim Director, Penny Bevan, on 1 February 2013.
11.2 Henrietta Hughes has been appointed as Medical Director and Responsible Officer for Central & North East London and London Lead for Long Term Conditions, NHS Commissioning Board, Local Area Team, London.

11.3 Neil Roberts has been appointed Head of Primary Care, North & East London NHS Commissioning Board.

The Camden PCT Board is asked to:

- **NOTE** the appointment of Julie Billett has been appointed Joint Director of Public Health for Camden and Islington.

The Islington PCT Board is asked to:

- **NOTE** the appointment of Julie Billett has been appointed Joint Director of Public Health for Camden and Islington.

12.0 BOARD AND COMMITTEE ARRANGEMENTS

12.1 Dr Mayur Gor has handed over his leadership role as Chair of the Professional Executive Committee of Haringey Teaching Primary Care Trust. Dr Gor has been Chair since the PCT was established in 2001 and has been engaged in leading work on the Barnet, Enfield and Haringey Clinical Strategy and, more recently, on Haringey’s primary care strategy.

12.2 Dr Helen Pelendrides, who is already a member of the Haringey PEC, has been appointed as PEC Chair. The appointment was approved by the Chair of Haringey PCT, Paula Kahn.

The Haringey PCT Board is asked to:

- **NOTE** the appointment of Helen Pelendrides as Haringey PEC Chair.

13.0 PART II AND III OF THE MEETING OF THE JOINT BOARDS OF NHS NORTH CENTRAL LONDON

13.1 In the private session the Joint Boards will receive:

- The Part II minutes of the Board Meeting held on 29 November 2012
- An update on Whittington Health’s Foundation Trust Application
- Estates Contracts for Approval
- Ordnance Road Full Business Case
- Kings Cross Road Surgery and Brunswick Medical Centre Contract Award Reports
- Primary Medical Services Contract Review
- Barnet & Chase Farm A&E Performance Review
- Update on Transfer Schemes
- Camden and Islington GP Out of Hours Service Procurement Contract
- Report on use of Beds and Finchley Memorial Hospital
Meeting of the Joint Boards of NHS North Central London

Meeting of the Joint Boards of NHS North Central London

Thursday, 31 January 2013

Chair’s Actions and Use of Seals

Caroline Taylor, Chief Executive Officer

Joanna Georgiades, Interim Senior Board Support Co-ordinator

joanna.georgiades@nclondon.nhs.uk; 020 7685 6297

Section 5.2 of Standing Orders provides that the powers which the Boards have reserved to themselves “may in emergency or for an urgent decision be exercised by the Chief Executive and the Chairman after having consulted at least two non-officer members. The exercise of such powers by the Chief Executive and Chairman shall be reported to the next formal meeting of the PCT Board in public session for formal ratification.”

In all cases where Chair’s Action has been taken, a process is in place to ensure that the organisation is operating in line with Standing Orders and Standing Financial Instructions and that signatures of approval are received from the Lead Director, Director of Finance, Chief Executive and two non-executive Directors prior to seeking the approval of the Chair.

This report provides the Joint Boards of NHS North Central London with an update on Chair’s Action taken and on the use of the seals of the five Primary Care Trusts 13 November 2012 and 24 January 2013.

There are no supporting papers.

Chairs Action:
The Board of Barnet Primary Care Trust is asked to:

- RATIFY: The use of Chair’s action in authorising the use of seal in respect of:
  - Licence to underlet the whole between Barnet PCT, Finchley Memorial Hospital (FMH), Fund Co Limited and Gentian (Finchley) Limited – cafe/retail premises forming part of the FMH Building, Barnet.
  - Deed of Covenant, between Barnet PCT, FMH, Fund Co Limited and Gentian (Finchley) Limited relating to retail unit within FMH.
  - Licence for fitting out works between Barnet PCT, FMH, Fund Co Limited, Aramak Limited and Aramak Investments Limited relating to cafe/retail premises forming part of the FMH building, Barnet.
  - Licence to Sub-underlet the whole between Barnet PCT, FMH, Fund Co...
The Board of Camden Primary Care Trust is asked to:

- RATIFY: The use of Chair’s action to sign under seal the Alternative Provider Medical Services Contract between Camden PCT and Turning Point for the provision of services offered by the Camden Health Improvement Practice.

- RATIFY: The use of Chair’s action to authorise the use of seal in signing the NHS Camden Integrated Care IT system contract to Insight/Orion.

The Boards of Barnet, Enfield and Haringey PCT are asked to:

- RATIFY: The use of Chair's action to approve the award of a 24 month contract to Barndoc to deliver the GP Out of Hours service for Barnet, Enfield and Haringey, and authorisation for use of seal.

Use of seal:

The Board of Barnet Primary Care Trust is asked to:

- NOTE: The use of seal in respect of:
  - Licence to underlet the whole between Barnet PCT, Finchley Memorial Hospital (FMH), Fund Co Limited and Gentian (Finchley) Limited – cafe/retail premises forming part of the FMH Building, Barnet.
  - Deed of Covenant, between Barnet PCT, FMH, Fund Co Limited and Gentian (Finchley) Limited relating to retail unit within FMH.
  - Licence for fitting out works between Barnet PCT, FMH, Fund Co Limited, Aramak Limited and Aramak Investments Limited relating to cafe/retail premises forming part of the FMH building, Barnet.
  - Licence to Sub-underlet the whole between Barnet PCT, FMH, Fund Co Limited, Aramak Limited and Aramak Investments Limited relating to cafe/retail premises forming part of the FMH building, Barnet.
  - Head Lease between Barnet PCT and FMH Fund Co Limited of retail premises forming part of the FMH building, Barnet.

The Board of Enfield Primary Care Trust is asked to:

- NOTE: The use of seal in signing the collaborative working agreement relating to the establishment and management of jointly commissioned services and an associated integrated joint commissioning structure pursuant to Section 75 NHS Act 2006 and the Localism Act 2011 between the Mayor and Burgesses of the London Borough of Enfield and Enfield PCT for Children’s Services, following approval by the Board on 20 September 2012.
LINKS TO NHS NORTH CENTRAL LONDON STRATEGY

Strategic Objective 3.2: To maintain a clear focus on delivery through the effective alignment of staff and resources, and ensuring clarity over roles and robustness of governance arrangements.

GOVERNANCE:
Voting: Please indicate which Board(s) has voting rights on this matter (if applicable)

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Objective(s) / Plans supported by this paper:
Strategic Objective 3.2: To maintain a clear focus on delivery through the effective alignment of staff and resources, and ensuring clarity over roles and robustness of governance arrangements.

Patient & Public Involvement (PPI): Patient and public involvement has been through existing channels and meetings with patients and representative groups.

Equality Impact Analysis: Not applicable.

Risks: There are no new risks to be recorded.

Resource Implications: Resource implications for the individual transactions were set out in the supporting paperwork submitted in each case. Further information is available on request.

Audit Trail: All Chair’s Actions and uses of the seal are reported to the Joint Boards as a standard agenda item.

Next Steps: This is a standing Item on the agenda of the Joint Boards.
1. **CHAIR’S ACTION**

1.1 **Barnet Primary Care Trust**

**Lease, Licence to Underlet and associated documents relating to Finchley Memorial Hospital Cafe and Retail Leases.**

In line with Standing Financial Instructions for agreements and licences, and requirements for use of the seal, approval by Chair’s Action was sought to authorise the use of the seal in the signing of the lease, licence to underlet and associated documents relating to FMH cafe and retail space.

With the approval of the Chair, supported by two non-officer members from the Board of Barnet Primary Care Trust, the Lead Director, the Director of Finance, and Chief Executive Officer, the contracts for of the lease, licence to underlet and associated documents relating to FMH cafe and retail space were signed under seal on 15 January 2013.

The Board of Barnet Primary Care Trust is asked to **RATIFY** the Chair’s Action taken to sign under seal the lease, licence to underlet and associated documents relating to FMH cafe and retail space.

1.2 **Camden Primary Care Trust.**

**NHS Camden Integrated Care IT System**

Approval through Chair’s action was sought to authorise the use of seal in signing the contract awarded to Insight/Orion in line with Standing Orders relating to the signing of contracts with organisations other than the NHS where the costs exceed £100,000.

With the approval of the Chair, supported by two non-officer members from the Board of Camden Primary Care Trust, the Lead Director, the Director of Finance, and Chief Executive Officer, the Chair’s action was agreed on 17 January 2013.

The Board of Camden Primary Care Trust is asked to **RATIFY** the Chair’s action taken to authorise the signature under seal of the NHS Camden Integrated Care IT system: approved on 17 January 2013.

1.21 **Alternative Provider Medical Services (APMS) Contract between Camden PCT and Turning Point for the provision of services offered by the Camden Health Improvement Practice.**

At the 20 July 2012 meeting of the Joint Boards formal approval was given for the award of a 5 year APMS to deliver the service provided by the Camden Health Improvement Practice to Turning Point following a competitive tendering process. The contract required signature under seal in line with standing orders relating to the signing of contracts with organisations other than the NHS where the costs exceed £100,000.

With the approval of the Chair, supported by two non-officer members from the Board of Camden Primary Care Trust, the Lead Director, the Director of Finance, and Chief Executive Officer, the Chair’s action was agreed for use of the seal on 4 December 2012.
The Board of Camden Primary Care Trust is asked to **RATIFY** the Chair’s action taken to authorise the signature under seal of the APMS Contract between Camden PCT and Turning Point for the provision of services offered by the Camden Health Improvement Practice.

### 1.3 Barnet, Enfield and Haringey PCT
**GP Out of Hours service for Barnet, Enfield and Haringey**

Following agreement by Barnet, Enfield and Haringey Clinical Commissioning Groups, use of Chair’s action was requested to approve the award of a 24 month contract to Barndoc to deliver the GP Out of Hours service for Barnet, Enfield and Haringey, and authorisation for use of seal.

With the approval of the Chair, supported by six Non Executive Directors, two from each of the Boards of Barnet, Enfield and Haringey Primary Care Trusts, the Lead Director, the Director of Finance, and Chief Executive Officer, the Chair’s action was agreed on 25 January 2013.

The Boards of Barnet, Enfield and Haringey PCTs are asked to **RATIFY** the use of Chair’s action to approve the award of a 24 month contract to Barndoc to deliver the GP Out of Hours service for Barnet, Enfield and Haringey, and authorisation for use of seal.

### 2. USE OF SEAL

#### 2.1.1 Barnet Primary Care Trust

#### 2.1.2 Lease, Licence to Underlet and associated documents relating to Finchley Memorial Hospital Cafe and Retail Leases.

Use of the seal was authorised by Chair’s action on 15 January 2013 following NHS London approval. The use of the seal was enacted on 15 January 2013, signed by the NHS North Central London Chief Executive Officer and the Director of Finance.

The Board of Barnet PCT is asked to **NOTE** the use of seal in respect to the Lease, Licence to Underlet and associated documents relating to Finchley Memorial Hospital Cafe and Retail Leases.

#### 2.1.3 Camden Primary Care Trust

#### 2.1.4 Alternative Provider Medical Services (APMS) Contract between Camden PCT and Turning Point for the provision of services offered by the Camden Health Improvement Practice.

Use of seal was authorised by Chair’s action on 4 December 2012, enacted on 5 December 2012, and the contract was signed by the Chair and Chief Executive Officer.
The Board of Camden PCT is asked to **NOTE** the use of the seal in respect of the APMS contract between Camden PCT and Turning Point for the provision of services offered by the Camden Health Improvement Practice.

### 2.1.5 Enfield Primary Care Trust

### 2.1.6 Section 75 Children’s Services

Following approval by the Board of Enfield PCT at the 20 September meeting the seal was enacted on 15 November 2012 by the Chief Executive Officer and Director of Finance.

The Board of Enfield PCT is asked to **NOTE** the use of the seal in respect of the collaborative working agreement relating to the establishment and management of jointly commissioned services and an associated integrated joint commissioning structure pursuant to Section 75 NHS Act 2006 and the Localism Act 2011 between the Mayor and Burgesses of the London Borough of Enfield and Enfield PCT.

### 2.1.7 The seals of Haringey and Islington Primary Care Trusts have not been used during this period.
**MEETING:** Meeting of the Joint Boards of NHS North Central London
**DATE:** 31 January 2013
**TITLE:** Annual Report of Director of Public Health for Enfield
**LEAD DIRECTOR:** Dr Shahed Ahmad
**AUTHOR:** Dr Shahed Ahmad
**CONTACT DETAILS:** Shahed.ahmad@enfield.gov.uk

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<th><strong>SUMMARY:</strong></th>
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<td>This is the Annual Public Health Report for Enfield for 2012. Its focus is to describe the determinants of health and wellbeing, to describe the new public health system, to outline Enfield’s health needs and to showcase a small amount of the excellent public health work being done in Enfield, both by the NHS and by other partners. The Primary Care Improvement Plan in particular is highlighted. We intend the report to help the process of public health transition by building an increased awareness of public health amongst a broader range of people. Enfield has enormous health challenges with North Central London’s largest number of children living in poverty. It is pleasing to see that despite the low levels of public health funding and high health needs, Enfield has shown the largest improvement in all age all cause mortality (2008-2010) in North Central London and that the screening rates are the best in North Central London. Stakeholders are commenting positively on the report. In particular people are commenting that although the report is large, it is highly accessible and people are able to find the information they need quickly and easily. From the report, the five top area for 2013 are:</td>
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| • Tackling childhood obesity  
• Narrowing the life expectancy gap  
• Making health everybody’s business  
• Making every contact count  
• Putting health in every policy |
| Enfield has held a major public health conference. Over 100 delegates attended from a range of organisations including Chief Executives and Directors from the NHS and Local Government. The conference was positively evaluated and copies of the conference report are available on request. |

**SUPPORTING PAPERS:**

**Summary Report**

NHS North Central London is a collaborative working arrangement between Barnet, Camden, Haringey, Enfield and Islington Primary Care Trusts.
The Joint Boards of NHS North Central London refers to the joint meeting of the Boards of Barnet, Camden, Haringey, Enfield and Islington Primary Care Trusts.
RECOMMENDED ACTION:

The Board of Enfield Primary Care Trust is asked to:

- **NOTE** the Enfield 2012 Annual Public Health Report. It demonstrates the significant progress in tackling health inequalities and will serve as a useful tool for the Local Authority as it prepares to take responsibility for public health.

LINKS TO NHS NORTH CENTRAL LONDON STRATEGY

The report is informed by the Enfield Joint Strategic Needs Assessment (JSNA), which informed the NCL commissioning plan, and will serve to inform the next JSNA and Joint Health and Wellbeing Strategy.

GOVERNANCE:

Voting: Please indicate which Board(s) has voting rights on this matter (if applicable)

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Objective(s) / Plans supported by this paper: Improving health and wellbeing

Patient & Public Involvement (PPI): Whilst this is an independent report of the Director of Public Health, the thinking has been informed by a large number of stakeholders including Enfield’s Health Improvement Partnership. Key issues highlighted in the report were discussed at the Public Health Conference.

Equality Impact Analysis: Inequalities are described through the report. There has not been an equality impact assessment undertaken. However an equality impact analysis would need to be applied to any approaches agreed as a result of this work.

Resource Implications: The report will inform the future JSNA and Joint Health and Wellbeing Strategy

Next Steps: The APHR should inform the next JSNA and Joint Health and Wellbeing Strategy.
Key messages

- Health is everybody’s business. We will only build a healthier Enfield by putting health at the heart of what we do.

- Enfield Council is being given new responsibilities for improving the health of local people.

- Enfield is more deprived than other outer London boroughs.

- Enfield has marked health inequalities, with poorer people having worse health and shorter lives. The death rate for people in the most deprived areas is nearly twice that for people in the richest areas.

- Life expectancy is rising in Enfield. This reflects good progress in reducing the death rate locally, which fell by 13% for men and 9% for women between 2008 and 2010. The most important causes of death are circulatory diseases, cancers and lung diseases.

- Few adults in Enfield are physically active enough.

- More children are obese in the borough than elsewhere in London, with a quarter of children leaving primary school obese.

- Teenage pregnancy rates are falling in Enfield and are now below the London average.
Health and its determinants

Our health is influenced by the circumstances in which we are born, grow up, live, work and grow older. These include

- age, gender and constitutional factors, such as ethnicity
- individual lifestyle factors such as smoking, drinking and diet
- social and community networks, which provide us with support
- socioeconomic, cultural and environmental conditions, such as education, work and unemployment, transport and access to health services.

Because these factors are often adverse for poorer people, they have worse health and shorter lives. The Marmot Review, a government enquiry, said that these health inequalities are avoidable and unfair, and that we should put them right to make our society more just. The Review recommended how health inequalities can be tackled.

Figure 1: The determinants of health model
The new public health system

A new law means that local councils in England will now take responsibility for improving the health of local people. There are several ways that Enfield Council will set about this:

- Putting health at the heart of its decisions and policies
- The new role of Director of Public Health will lead on health improvement locally, and produce a report on the health of the population each year.
- The new Health and Wellbeing Board and other groups will make sure that everyone works together to improve services. The Board will develop the Joint Strategic Needs Assessment so that the needs of the people of Enfield are understood. The Board will also lead on the development of a Joint Health and Wellbeing Strategy to meet those needs.
- The Council will provide support to local clinical commissioning groups, which commission NHS services.
- The Council will also commission some health services, for example to help people quit smoking.

These steps are part of wider changes that the Government is making to the way the NHS works. Delivering them will depend critically on the wider public health workforce – people who make an enormous contribution to improving health even though their posts do not formally cover that responsibility. There are about 10,000 such people in Enfield.
The health of Enfield

The population of Enfield is growing, and is expected to increase by 6% by 2031. There are more young people and people of retirement age in Enfield than in London as a whole, and fewer people of working age. The number of older people is set to increase.

Enfield is ethnically diverse: just over four of every ten primary school age pupils in Enfield have a first language other than English, while school pupils in Enfield recorded themselves under 87 different ethnicities.

Enfield is more deprived than other outer London boroughs. Nearly a third of Enfield children are in a household where there is no paid work, with child poverty concentrated in the east of the borough.

Smoking is the most important threat to people’s health in Enfield. One in five local adults still smokes, about average for London and England.

Alcohol consumption in Enfield is similar to elsewhere, though rates of alcohol-related crime are higher than the England average.

Rates of physical activity are very low, with only about one in seven Enfield adults doing the recommended minimum levels of activity.

About one in four Enfield adults is obese, bringing a higher risk of many important diseases. More worryingly still, one in seven children in Enfield is already obese when they start school, and a quarter are obese by the end of primary school. These figures are among the highest in London and suggest serious health problems ahead as these children become adults, unless their weight reduces.

Housing problems in Enfield include high rates of temporary accommodation by London standards, and the highest rates of landlord repossessions in the capital.

Educational attainment in Enfield is comparable to the England average but below that for London. However, attainment for children aged between 5 and 7 years in Enfield is below national and London average levels. Unauthorised absence from school in Enfield is higher than in England or in London.
Enfield has lower rates of notifiable crime than London or national averages. However, fear of crime was the most significant risk to good health and wellbeing identified by Enfield’s Citizen’s Panel – it keeps people from going out, accessing services and maintaining social networks. Fear of crime is linked to depression, less physical functioning and lower quality of life.

Teenage pregnancy rates are falling in Enfield and are now below the London average.

Male life expectancy at birth is 79 years, better than London and England. Life expectancy for females is 83 years, higher than for England but less than for London. Life expectancy is rising in Enfield, as it is elsewhere in London and England. This reflects good progress in reducing the death rate in Enfield, which fell by 13% for men and 9% for women between 2008 and 2010 – helping people quit smoking and control blood pressure and cholesterol levels underlies this progress. The most important causes of death are circulatory diseases, cancers and lung diseases.

Enfield has a high level of health inequalities. The death rate for people in the most deprived areas, is nearly twice that for people in the richest areas.

Figure 2: Improvement in All Age All Cause Mortality for males (2008-2010)

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<th>Percentage improvement</th>
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This paper provides an update on the BEH Clinical Strategy Programme and the next steps planned.

Key programme achievements are:
- Approval of the business cases for capital investment
- Completion of Gateway 0 review
- Workstreams in place and development of detailed plans
- Clinical cabinet and assurance process in place to ensure quality and safety
- All enabling workstreams in place

Next Steps:
- A focus on delivery of improved patient care across both Trusts and Barnet, Enfield and Haringey CCGs including delivery of the primary care strategy
- Continued strengthening of the programme arrangements and governance through 2013/14
- Communicating the changes widely and effectively
- Continuing to strengthen partnership working
- Engaging more with local people and stakeholders
- Continuing the deep dives and assurance of quality and safety
- Developing our measures of success and commissioning an evaluation

The Joint Boards of NHS North Central London are asked to:
- **NOTE** the contents of this paper
GOVERNANCE:
Voting: Please indicate which Board(s) has voting rights on this matter (if applicable)

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Objective(s) / Plans supported by this paper: To implement the Barnet, Enfield and Haringey Clinical Strategy

Audit Trail: The CCGs and Joint PCT Boards agreed commissioner letters of support for the North Middlesex University Hospital NHS Trust Full Business Case and the Barnet and Chase Farm Hospitals NHS Trust Full Business Case. Final approval of both Full Business Cases was announced on 7 January 2013. These cases provide the capital investment to enable the delivery of the BEH Clinical Strategy.

Patient & Public Involvement (PPI): There has been extensive engagement with patients and the public throughout the BEH Clinical Strategy programme. The programme works with both the Trusts and CCGs processes to engage patients and the public. Within the governance of the programme, the Reference Group and Chase Farm Vision group continue to further patient and public involvement in the programme.

Equality Impact Analysis: The Equality Impact Assessment for the BEH Clinical Strategy was developed in 2007, reviewed in 2010 and is being refreshed currently.

Resource Implications: Transitional costs will need to be met from the health economy as a whole over the next 3 years.

Next Steps:
- A focus on delivery of improved patient care across both Trusts and Barnet, Enfield and Haringey CCGs including delivery of the primary care strategy
- Continued strengthening of the programme arrangements and governance through 2013/14
- Communicating the changes widely and effectively
- Continuing to strengthen partnership working
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- Developing our measures of success and commissioning an evaluation
Following the approval of both full business cases for capital investment at the North Middlesex University Hospital NHS Trust and Barnet and Chase Farm Hospitals NHS Trust the Barnet Enfield and Haringey (BEH) Clinical Strategy is now in a ‘drive for delivery’ phase.

The Clinical Strategy was developed in 2007 with the aim of delivering improvements to patient care. As further detailed plans have been developed the focus has remained on ensuring that the improvements planned will meet the latest quality and safety standards, within modern and improved buildings.

A Joint Economic Case was conducted in April 2012 which states that the proposed changes will lead to ‘123 lives saved per annum’ based on the expectation of improvement in outcomes for patients from the changes that will be delivered.

The changes being delivered in redesign of the acute pathways for patients will happen within the context of primary and community care in Barnet, Enfield and Haringey continually improving. The Boards are aware of the complementary work of implementing the Primary Care Strategy (JPCT Boards 29 November 2012). A further update will come to the Boards in March 2013.

This paper updates the Boards on progress to date and next steps to ensure successful implementation of the BEH Clinical Strategy in November of this year.

1. Progress to date

1.1. Overall the BEH Clinical Strategy is on track for implementation of the acute service changes in November 2013. Key elements of the programme are being strengthened to ensure the focus of the programme is on track for implementation and delivery.

1.2. The NHS North Central London BEH Clinical Strategy programme team is in place and works with the programme offices in both Trusts as well as colleagues from Barnet, Enfield and Haringey Clinical Commissioning Groups.

1.3. Approval of Business cases

1.3.1. Barnet and Chase Farm Hospitals NHS Trust full business case for £34.6m received approval from NHS London Capital Investment Committee on 29 November 2012. This capital investment is to develop the Barnet Hospital site and refurbish the Chase Farm Hospital site. Building works have commenced to expand capacity in both Accident and Emergency and Maternity services on the Barnet Hospital site.

1.3.2. The North Middlesex Hospital NHS Trust full business case for £80m received approval from Her Majesty’s Treasury and the Department of Health. This capital
investment will enable the modular build of the new women and children’s centre to be delivered alongside improvements to the tower block. Building works have commenced at the North Middlesex University Hospital site.

1.4. Programme Planning

1.4.1. External resource has been procured to strengthen the programme arrangements for delivering the BEH Clinical Strategy. Key to delivery is ensuring that alongside the building works the clinical workstreams are delivering at pace.

1.4.2. There has been additional work to strengthen the detail of the overall programme and critical path with key milestones over the coming months including progress on workforce issues and the development of the urgent care models. Over the next three months milestones for the programme include:

- Recruitment plan in place at North Middlesex University Hospital for consultants and midwives
- Bookings process in place for deliveries post November
- Urgent Care Centre in place at Barnet Hospital April 2013
- Reviewed models of Urgent Care in place at Chase Farm and North Middlesex Hospital sites from April 2013
- Workforce modelling complete with recruitment plan for paediatrics
- Building works to continue as planned
- Transport impact assessment and next steps agreed
- Chase Farm vision work complete by April 2013
- Communications campaign being delivered

1.5. The clinical workstreams

1.5.1. There are 5 key clinical workstreams that are meeting monthly to drive the BEH Clinical Strategy forward across both Trusts. These workstreams are the Emergency Care, Urgent Care, Maternity and Neonates, Paediatric and Planned Care workstreams.

1.5.2. The clinical workstreams all have a senior responsible officer appointed who chairs the workstream meetings and ensures that the workstreams deliver assurance of care through transition, have detailed plans on workforce and models of care post the changes, and develop joint transitional plans and individual Trust mobilisation plans. The workstreams also review risks and develop mitigations. All the workstreams will ensure that the latest quality and safety standards will be met within both Trusts. Each workstream is supported by a member of the central North Central London BEH Clinical Strategy programme team and is in the process of ensuring there is GP engagement.

1.5.3. The Emergency Care workstream is chaired by the Director of Operations from North Middlesex University Hospital NHS Trust. It involves clinicians from both Trusts and is working through the detail of the transitional plans and mobilisation plans.

1.5.4. The Urgent Care workstream is a whole system workstream and the SRO is the Chief Officer (designate) from Enfield CCG. The key milestones for this workstream are the delivery of the new urgent care centre at Barnet Hospital and the revised model of urgent care at Chase Farm Hospital and North Middlesex University Hospital by April 2013. This workstream is also focused on continuing the detailed
work on the paediatric assessment unit and older people’s assessment unit that will be located at Chase Farm Hospital. This work also has interdependency with the commissioning of the GP out of hours service across Barnet and Enfield.

1.5.5. The Maternity and Neonates workstream is chaired by the Director of Operations - Planned Care from Barnet and Chase Farm Hospitals. The current focus of this workstream is clarifying the details of the model of care and the workforce to deliver that model. Midwifery led antenatal and postnatal services will continue on the Chase Farm site. The group has key milestones over the next two months linked to communications to staff, GPs and future patients about the changes. There is also internal Trust work to ensure that the booking process is robust as women will potentially be booking from March into either the North Middlesex University Hospital or Barnet and Chase Farm Hospitals. The work with regard to neonatal services currently involves detail on workforce and recruitment issues.

1.5.6. The Paediatric workstream is chaired by the Director of Nursing at North Middlesex University Hospital. The group is focusing on ensuring quality and safety standards are met through the transition and developing the transitional plan. There is strong clinical engagement and leadership in this workstream.

1.5.7. Planned Care. The SRO for this workstream is the Director of Operations - Planned Care at Barnet and Chase Farm Hospitals. The planned care changes involve ensuring more complex planned care is delivered at the Barnet Hospital site with less complex planned care being delivered at the Chase Farm site. Issues such as clinical rotas, job planning and theatre capacity and bed planning are all part of the remit of the group. Communications with GPs and the public will also be an essential element of the mobilisation plan.

2. The work of the clinical cabinet

2.1. The Clinical Cabinet meets monthly and is chaired by Nicholas Losseff, medical director for NHS North Central London. The cabinet includes in its membership GPs from all CCGs, the medical and nursing directors from both Trusts and the central programme team. The role of the cabinet is to provide assurance through the transition on quality and safety of services and ensuring that the resulting services following the changes meet up to date quality and safety standards.

2.2. The cabinet has developed a clinical assurance framework, a clinical risk register and a scorecard that captures information on performance, workforce, serious incidents and patient experience in the key clinical areas. Each workstream is subjected to a deep dive review and presentation to the clinical cabinet on a rolling programme whereby the cabinet will review each workstream. To date deep dives have been completed on Emergency Care, Maternity and Neonates; Paediatrics and Planned Care. Members have commented that this cabinet is a very positive experience of primary and secondary care clinicians working together.

2.3. There have been recent discussions with the medical director of NHS London to add an external assurance process for the next phase of the programme.

3. The Chase Farm Vision Group

The Chase Farm Vision Group is chaired by the Chair of Enfield CCG. The group includes commissioners, providers, Enfield LINk, and local authority representation. The group is currently developing a vision for the Chase Farm site and has agreed
an engagement piece to involve local people and stakeholders in contributing to the
work.

4. **The Reference Group**

The Reference Group is chaired by the vice chair of Enfield PCT and consists of key
stakeholders from Barnet, Enfield, Haringey and Hertfordshire, alongside the Chief
Executives and Chairs of both acute Trusts. The Reference group is key to keeping
stakeholders fully informed and for stakeholders to inform the work of the
programme.

5. **The Enabling workstreams**

5.1. There are 3 key enabling workstreams to the programme. These are
Communications and Engagement, Workforce and Transport.

5.2. **The Communications workstream** has produced a communications and
engagement strategy, detailed plan and a communications grid supporting the
delivery of this strategy. As part of implementation the resource has been reviewed
and the pace and scale of the communication work will be increased. A campaign is
being developed where we will ensure that the public are aware of the changes
being implemented and what it will mean for them. There have been presentations at
local Overview and Scrutiny Committees, Health and Wellbeing Boards and the Joint
Health Overview and Scrutiny Committee.

The key communications messages aims to communicate the delivery of the
following for the people of Barnet, Enfield and Haringey:

- Safer, more effective care for patients with a medical or surgical emergency
- Concentrated clinical expertise and equipment to meet modern standards
- Higher quality, safer care for mothers and their babies
- Better, more integrated care
- Complementary improvements in primary and community care
- Improved hospital buildings
- Lower rates of infant and adult mortality

5.3. **The Workforce workstream** has the North Central London interim Director of HR
as the SRO. The role of the group is to ensure delivery of the workforce needed to
deliver the care following the changes. The process has been agreed between the
Trusts. Staff consultation and recruitment planning are key milestones in the next
two months. There will be an external assurance of the workforce detail provided by
the Trusts. The programme is working to minimise the risk of redundancies.

5.4. **The Transport workstream** is chaired by the CEO of Barnet and Chase Farm
Hospitals NHS Trust. The transport impact assessment has been reviewed and the
group, which includes representatives from both trusts, Transport for London and
local authority colleagues will be reviewing this on the 29 January 2013.

6. **Benefits realisation**

6.1. The Programme is currently reviewing its Benefits Realisation strategy. The strategy
builds on the clinical case for change by describing the benefits that are expected to
be achieved as a result of implementing the proposals set out in the BEH Clinical
Strategy Integrated Implementation Plan. The benefits include improvements to
patient outcomes and patient experience, as well as improved experiences for staff through advanced patient care, improved ways of working and opportunities to enhance skills. The benefits will be developed with inputs from existing programme documentation in addition to a Benefits Realisation Workshop which will have clinical, workstream lead and SRO representation. In addition, the Clinical Cabinet will be asked to contribute to its development. The benefits have been developed in line with the clinical standards that underpin the proposals for clinical change and the strategy will set out how progress against the benefits will be monitored as well as the set of performance indicators that the programme will focus on.

6.2. The approach used will link improvements in service delivery to the benefits the new services will be expected to deliver using three stages; the inputs (the clinical standards), the outputs (the changes) and the outcomes (the results or benefits of the service change). Benefits tables have been drafted for each of the workstreams and work is ongoing to validate and refine the tables.

7. Key risks

The risk register is closely monitored by the programme board. The top 3 risks identified for the programme are:

Table 1: Top 3 Programme Risks

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<th>Risk Description</th>
<th>Mitigation</th>
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<tbody>
<tr>
<td>1</td>
<td>There is a risk that the workforce changes will take longer to implement than planned; that the Trusts do not work closely enough together to mitigate risks around workforce changes and that the workforce is available in the right service at the right time.</td>
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<tr>
<td>2</td>
<td>There is a risk that the services currently provided at Chase Farm Hospital may not be sustainable until alternative services are in place. This risk is significantly increased if the accelerated case is not met and services are not transferred in autumn 2013.</td>
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<td>3</td>
<td>There is a risk that the building works at Barnet and NMUH will be delayed.</td>
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8. **Next steps**

The next steps for the BEH clinical strategy programme include:-

- A focus on delivery of improved patient care across both Trusts and Barnet Enfield and Haringey CCGs including delivery of the primary care strategy
- Continued strengthening of the programme arrangements and governance through 2013/14
- Communicating the changes widely and effectively
- Continuing to strengthen partnership working
- Engaging more with local people and stakeholders
- Continuing the deep dives and assurance of quality and safety
- Developing our measures and commissioning an evaluation

The Joint Boards are asked to note the update on the implementation of the BEH clinical strategy.

Siobhan Harrington
Programme Director BEH Clinical Strategy
MEETING: Meeting of the Joint Boards of NHS North Central London: Part 1
DATE: 31 January 2013
TITLE: Barnet & Chase Farm A&E Performance Review
LEAD DIRECTOR: Caroline Taylor, Chief Executive
AUTHOR: Susan Beecham, Assistant Director of Performance
CONTACT DETAILS: Susan.beecham@nclondon.nhs.uk 020 7685 6289

SUMMARY:

An independent review of A&E performance reporting arrangements at Barnet and Chase Farm Hospitals NHS Trust was undertaken in the autumn of 2012 following allegations of data misreporting. The report of that review has now been considered by the Trust’s Board and is summarised here, together with a summary of actions, for the Joint Boards’ information.

SUPPORTING PAPERS:

None.

RECOMMENDED ACTION:

The Joint Boards are asked to:

• **NOTE:** the recommendation of the review and the proposed actions going forwards.

LINKS TO NHS NORTH CENTRAL LONDON STRATEGY

A&E waiting times’ performance is a key quality standard in the delivery of health care to the population in North Central London.

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**Objective(s) / Plans supported by this paper:** Delivery of the maximum 4-hour waiting times’ standard in A&E.
Patient & Public Involvement (PPI): There has been no PPI involvement to date.

Equality Impact Analysis: The NHS Operating Framework sets out a comprehensive range of performance targets, including A&E waits, designed to measure quality and access to health services provided to local communities.

Risks: Failure to implement recommendations arising from the review would result in underachievement of the A&E quality standard and could affect quality of patient care.

Resource Implications: Funding from the national winter initiatives scheme has been allocated to Barnet and Chase Farm to support delivery of the A&E target throughout the winter period.

Audit Trail: The Verita report was considered by Barnet & Chase Farm Hospitals NHS Trust Board at its meeting on 18 January 2013.

Next Steps: The Trust has action plans in place in response to the recommendations of both reviews.
1. Executive Summary

Barnet and Chase Farm Hospitals NHS Trust (BCFH) has recently been subject to an external review conducted by Verita, an independent consultancy firm that specialises in investigations, reviews and inquiries for the public sector, and was commissioned by the Trust Chief Executive following an allegation that there had been misreporting of A&E data on the Chase Farm site.

The Verita Review concluded that the allegations of misreporting were substantiated and made a series of recommendations to address the situation. Many changes have already taken place and other actions are in hand to ensure immediate performance problems are addressed and that there is sustained improvement going forward into the new organisational model and strategic changes ahead.

It should be noted that the Verita report has been reported to Part 1 of the BCFH Board meeting on 18 January.

2. Verita Investigation into A&E Waiting Times’ Reporting at Chase Farm

2.1 In August 2012, the staff-side chair for BCFH approached the Trust chief executive with accusations about misreporting of A&E data at Chase Farm Hospital. The allegations included:

- Misreporting of patient records in A&E at Chase Farm, in particular the time of assessment and of discharge or admission
- The role of the flow co-ordinator in falsifying patient records
- The use of the observation unit to avoid breaches of the four-hour standard
- The use of the fracture clinic out of hours
- Patients being transferred to wards before a bed (or staff) are ready

2.2 The Trust Chief Executive advised the Board, NHS London and the NHS North Central London of the allegations made and commissioned Verita to conduct an investigation. Verita conducted a series of interviews with relevant staff and compared paper and electronic records for a sample of 81 patients who attended Chase Farm A&E between January and March 2013.

2.3 The final draft report was released in January 2013. Its key findings were:

- There is evidence to support the allegation that the time taken for patients to be assessed and the time they leave the department had been misreported and, as a result the Trust under-reported breaches of A&E performance targets.
- The practice of not recording patients onto the system when they are returned from the observation unit or fracture clinic) or logging them off the system when they remain in the department made it difficult for staff to keep track of patients.
- Whilst none of the flow coordinators confirmed that they were personally put under pressure to misrecord times in order to avoid breaches, Verita found that misreporting had become accepted practice because of the pressure on the department to meet targets.
- Verita found it true that patients put in the observation unit were taken off the A&E FirstNet system and that the unit was used to avoid four-hour breaches.
- On occasions the observation unit was used as an inpatient area with the recliner chairs being replaced by beds. At other times the beds are replaced with recliner chairs to avoid mixed sex breaches. Both practices were widely known and accepted within the trust.
• The fracture clinic had sometimes been used overnight and there had been occasions when it remained as an inpatient area at the weekend. The patients had then been returned to the A&E department in the morning, if no beds were available elsewhere in the hospital, and remained off the FirstNet system.
• Patients had sometimes been taken to the wards before ward staff were ready and on occasion without receiving essential first-line medication.
• Verita concluded that they had not seen or heard sufficient evidence to determine if any individual manager has broken the managerial code.

2.4 Verita made the following recommendations:
• The Trust must immediately make it clear to all managers, doctors and nurses that misreporting against the performance targets/clinical indicators is unacceptable and should stop immediately. Site and bed managers should also be told that the practice has to stop.
• Within one month of the publication of this report, the Trust should develop and implement a programme to improve record keeping. Record keeping should be audited every three months, and the results reported to the Board.
• The application of the Trust’s policies on same-sex accommodation and the use of the observation unit must support the requirements of the emergency care pathway and good patient care.
• The Trust should test every three months that the observation unit is only used for patients who meet the criteria set out in trust policy.
• The Trust should introduce a simple system for recording and monitoring the replacement of beds by chairs (and vice versa) in the observation unit – along with the reasons.
• The Trust should ensure that the fracture clinic is never used as an inpatient area with immediate effect.
• The Trust should consider developing a new bed management system that alerts A&E when a ward bed becomes available for an A&E patient in real time.
• The Trust should consider how best to ensure the timely administration of pain relief and other first-line medication to patients in A&E.

2.5 BCFH has developed an action plan in response to the Verita recommendations and took immediate steps to ensure that patients were being appropriately treated through the non-elective care pathway appropriately and that A&E data was accurately reported.

2.6 Progress against the action plan will be monitored through the BCFH Programme Board and resulting performance delivery will be tracked by NHS North Central London / North & East London Commissioning Support Unit on behalf of the CCGs.

2.7 The BCFH Board report notes that the Care Quality Commission undertook an unannounced visit to Chase Farm on 28th December 2012. No immediate concerns were raised in their informal feedback and their written report is currently awaited.

3. Allocation of Winter Funds

3.1 In December 2012, the Department of Health announced the availability of non-recurrent funds to support organisations through the winter period particularly with a view to maintaining A&E performance and sustaining the emergency care pathway. All North Central London Trusts submitted bids against this fund. The bids from Barnet and Chase Farm were aimed at ensuring that the Trust is well placed to cope with winter
pressures during the coming months and where possible to assist the Trust to improve its performance in the longer term.

3.2 Local Clinical Commissioning Groups have been actively engaged with NHS North Central London to evaluate all of the bids before onward submission to NHS London for final approval. The following bids have been approved for BCFH:

<table>
<thead>
<tr>
<th>Details of Scheme</th>
<th>Amount approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Senior Rapid Assessment in EDs on both sites at peak pressure times</td>
<td>£250,000</td>
</tr>
<tr>
<td>Enhancement of senior paediatric team in ED in evenings</td>
<td>£140,000</td>
</tr>
<tr>
<td>Junior Doctor Support in evening peaks</td>
<td>£100,000</td>
</tr>
<tr>
<td>Earlier implementation of surgical assessment unit as part of planned new Surgery/Trauma model</td>
<td>£120,000</td>
</tr>
<tr>
<td>Additional 7 emergency theatre sessions per site per week</td>
<td>£300,000</td>
</tr>
<tr>
<td>Minors see and treat at times of peak pressures supported by GPs and nurses</td>
<td>£350,000</td>
</tr>
<tr>
<td>Additional support to Clinical Decision Unit to deliver enhanced admission avoidance</td>
<td>£200,000</td>
</tr>
<tr>
<td>Additional Escalation Beds at both sites</td>
<td>£250,000</td>
</tr>
<tr>
<td><strong>BCFH winter bids sub total</strong></td>
<td><strong>£1,710,000</strong></td>
</tr>
</tbody>
</table>

3.3 Monitoring of the initiative implementation; effectiveness and resulting performance delivery will be tracked by NHS North Central London / North & East London Commissioning Support Unit on behalf of the CCGs.
MEETING: Meeting of the Joint Boards of NHS North Central London
DATE: 31 January 2013
TITLE: Public Consultation and Engagement Plan about proposed changes to the Out of Hours GP Services in Camden and Islington
LEAD DIRECTOR: Caroline Taylor, Chief Executive
AUTHOR: Eilis Kilfeather
CONTACT DETAILS: Robert.Evans@nclondon.nhs.uk

SUMMARY:

This report outlines the proposal to pilot Out of Hours GP patient consultations (face to face consultations only) at two Urgent Care Centre sites (the Whittington Hospital and Royal Free Hospital) across Camden and Islington. This is in addition to the primary site at St. Pancras Hospital and would replace the current much smaller Out of Hours service located at the Whittington Hospital. Overall this would be a service improvement, as there would be one more access point for patients living locally (Royal Free Urgent Care Centre). It will also provide a more straight forward pathway for patients to access the right care and the right professional from the start of their journey. This should also lead to better health outcomes for those patients who need more immediate access to diagnostics (blood tests, X-rays etc.). It is also an opportunity for patients and other stakeholders to provide valuable input into the new service design (specification) to improve the patient experience and quality of care delivered.

The report is coming to the Joint Board of North Central London for approval to commence the public consultation on these proposed changes to the delivery of GP Out of Hours care.

SUPPORTING PAPERS:

The following supporting papers are available on request: please contact eilis.kilfeather@NClondon.nhs.uk

- Out of Hours Business Case
- Equality Impact Assessment
- Risk Assessment
- Proposed Consultation document for the public
RECOMMENDED ACTION:
The Boards of Camden and Islington Primary Care Trusts are asked to:

- **NOTE** the proposed changes
- **AGREE** that the consultation plan should be submitted for approval of the individual Overview and Scrutiny Committees for both Camden and Islington
- Receive feedback from the Public Consultation once completed

LINKS TO NHS NORTH CENTRAL LONDON STRATEGY

<table>
<thead>
<tr>
<th>Improving the health and wellbeing of our population by reducing inequalities and maximising value in terms of outcomes, quality and efficiency from services provided to patients:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The proposed changes to the Out of Hours Service support this aspiration and fit with the strategic direction of integrated care by:</td>
</tr>
<tr>
<td>• Enhancing patient experience with better outcomes</td>
</tr>
<tr>
<td>• Addressing health inequalities</td>
</tr>
<tr>
<td>• Promoting health, wellbeing and illness prevention</td>
</tr>
</tbody>
</table>

GOVERNANCE:

**Voting:** Please indicate which Board(s) has voting rights on this matter (if applicable)

<table>
<thead>
<tr>
<th>Barnet</th>
<th>Camden</th>
<th>Enfield</th>
<th>Haringey</th>
<th>Islington</th>
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<tr>
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<tr>
<td>Paula Kahn</td>
<td>Ellen Schroder</td>
<td>Karen Trew</td>
<td>Paula Kahn</td>
<td>Paula Kahn</td>
</tr>
<tr>
<td>David Riddle</td>
<td>Caroline Rivett</td>
<td>Caroline Rivett</td>
<td>Cathy Herman</td>
<td>Anne Weyman</td>
</tr>
<tr>
<td>Caroline Rivett</td>
<td>Robert Sumerling</td>
<td>Deborah Fowler</td>
<td>Sue Baker</td>
<td>Caroline Rivett</td>
</tr>
<tr>
<td>Bernadette</td>
<td>Karen Trew</td>
<td>Cathy Herman</td>
<td>Anne Weyman</td>
<td>Sorrel Brookes</td>
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<tr>
<td>Conroy</td>
<td>Deborah Fowler</td>
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<tr>
<td>John Carrier</td>
<td>Caroline Taylor</td>
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<td>Robert Sumerling</td>
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<td>Penny Bevan</td>
<td>Shahed Ahmad</td>
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<tr>
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<td>Marek Koperski</td>
<td>Mohammed</td>
<td>Jeanelle De</td>
<td>Bev Evans</td>
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<tr>
<td>Andrew Howe</td>
<td>Joanne Wickens</td>
<td>Abedi</td>
<td>Gruchy</td>
<td>Jeanelle De</td>
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<tr>
<td>Philippa Curran</td>
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<td>Helen</td>
<td>Gruchy</td>
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<tr>
<td>Alison Pointu</td>
<td></td>
<td></td>
<td>Sorrel Brookes</td>
<td>Helen</td>
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Objective(s) / Plans supported by this paper:

- The paper supports the delivery of the North Central London Primary Care Strategic objective of Right Care, Right Place First Time and the longer term integration of Unscheduled Care.

Patient & Public Involvement (PPI):

- LINks members from both Camden and Islington have been consistent members of the Project Board and have actively contributed to the development of service design and specifications.

Equality Impact Analysis:

A full Equalities Impact Analysis has been undertaken and is available as part of the supporting papers. There will be a positive impact for the majority of patients as
there will be more choice locally about where patients can attend. Patients will no longer be able to contact out of hours services directly and will have to use the new 111 service to facilitate this so there is an extra step in the process but adverse impact noted.

**Risks:**
A risk analysis has been completed and is available as part of the supporting papers. A risk identified is that the interface between the out of Hours Service and the Urgent Care Centres will need to be very robust to ensure patient safety. To ameliorate this there will be extensive resilience testing of the IT systems to safeguard the timely transfer of information. All patients will also benefit from a telephone clinical assessment from a GP in Out of Hours to establish the urgency of need and to offer advice before making an appointment with the respective Urgent Care Centre of their choice.

**Resource Implications:**
This development has required internal resources from commissioning and strategy, clinical procurement, finance, public health, communications and contracts. To achieve the service implementation and resilience testing for the pilot additional Project Management time has been secured from the Primary Care Implementation Strategy to support the introduction of the pilot. Additional resources will be required to evaluate the pilot during in 2014. Public Health colleagues have identified some resource to support this process but additional analytical time will be needed at key point in the pilot. External resources required have been by way of clinical and patient engagement.

**Audit Trail:**
The development of the new model for out of hours services has been presented to the following:
- Report to Camden CCG Governing Board (28th March 2012)
- Report to Islington Senior Team Meeting CCG (24th April 2012)
- Presentation by Dr Jo Sauvage to Islington GPs on progress with Out of Hours on the 13th September 2012
- Several meetings between the Hospital Trusts and Acute Commissioners over the summer of 2012 to establish interest in participating in the pilot
- Full participation by LINks members from Camden and Islington on the Out of Hours Project Board including participation in the procurement process for phase 1 of the developments.

**Next Steps:**
1. Present the Consultation and Engagement Plan to Islington Health Scrutiny Committee in February 2013.
2. Present the Consultation and engagement Plan to Camden Health Scrutiny Committee in February 2013.
4. Feedback to the individual CCG Governing Bodies (Camden and Islington) in May 2013
Consultation Plan
Changes to access to the Out of Hours services, Camden and Islington

1. Summary of what is being proposed

Local General Practitioners (GPs) from Camden and Islington, along with patient representatives (via Local Involvement Networks - LINks) from both boroughs have been looking in detail, over the last year, at how Out of Hours care could be improved. The group recognised that there is a need for a more integrated whole system approach to unplanned care, of which Out of Hours (OOH) is a component part. The ideal is to bring together the clinical expertise across unplanned care locally, by optimising the use of current Urgent Care Centres (UCCs), where there are already GPs providing this service and there is access “near patient testing” (X-ray and blood testing) to improve the clinical outcomes for patients. The UCCs also have the medical back up of the hospital, should the patient’s condition deteriorate and they require specialist intervention, or admission. Having access via the UCCs also streamlines the process, so that patients more readily understand how to gain access to the services, by having one clear access point which can cater for a range of presenting needs.

This consultation and engagement plan outlines the desire to pilot an Out of Hours GP service from two Urgent Care Centre sites (Whittington Hospital and Royal Free Hospital). This would be for face to face patient consultations only and would represent a service improvement, as one more access point would be created at the Royal Free UCC and there would be increased GP capacity at the Urgent Care Centres. The St. Pancras site would continue to operate as a base for organising home visits for patients too ill to attend a centre and to see patients when the Urgent Care Centres are closed. It would also provide backup, should any unforeseen problems arise with the introduction of the pilot.

The desire is to test out whether the changes in the way out of hours services are delivered, will be perceived as improving patient choice by providing a greater choice of location, convenient to where patients live. It is anticipated that this new development will provide a more straightforward pathway for patients to access the right care and the right professional, from the start of the patient journey. This should also lead to better health outcomes for those patients who need more immediate access to diagnostics (blood tests, X-rays etc.). It is also an opportunity for patients and stakeholders to provide valuable input into the new service design (specification) to improve the patient experience and quality of care delivered, with the aim of improving the overall sense of satisfaction with the care received.

Those patients with the highest needs (those who are house bound due to severe illness) and who require a particularly responsive service will continue to receive their service from GP’s based at the St. Pancras site. The latter will also provide face to face consultations for the very small number of patients who require this
when the Urgent Care Centres are closed (after 10pm in the evening) and as an alternative for patients living in South Camden and South Islington.

NHS North Central London is committed to engaging key stakeholders appropriately and coordinating a ‘reasonable and proportionate’ approach to consultation.

2. Current Out of Hours Service
Camden, Islington, City and Hackney and Haringey PCTs have a contract with Harmoni to deliver this care up to the end of March 2013. Camden and Islington anticipate extending this to the 30th June 2013 to allow for the public consultation process and resilience testing with the Urgent Care Centres. The current Out of Hours Service includes an advice service, a Face to Face consultation service with a GP or experienced nurse, and a home visiting service by a GP, for those patients who are too ill to travel.

3. Changes on the horizon
There is a national programme to introduce a new telephone service 111 as an alternative to 999 which will offer a much wider range of responses to patients and will link them up with services locally. The 111 service will operate 24 hours a day and will be the first port of call for patients who need to gain access to a whole range of primary care services, including out of hours Care. The introduction of the new 111 service will start locally in early 2013.

This new 111 service presents a real opportunity to support patients to obtain more immediate access to the right care. This will avoid the duplication of effort that is present in the current system and should reduce patients’ frustration at not knowing who to call, to obtain the required assistance. An example of this is that the current Out of Hours service has a relatively high volume of calls for access to an emergency dentist. 111 will be able to direct the patient to the emergency dentist in their area, without having to go through the GP Out of hours services. In time the database that the 111 service is developing will provide opportunities for appointments to local services, with an initial assessment of the presenting need attached and patients will be kept in the loop about what will happen, as a result of their contact with the 111 service.

4. What is the likely impact of these changes to out of hours care
These new national changes will have a direct impact on local services. We anticipate fewer patients being referred to out of hours services as more patients will be directed to the correct service, without having to inappropriately go through the GP out of hours services first. This change presents an opportunity to improve the current GP out of hours service and to focus it more on the patients who need this kind of care, thus providing an improved patient experience and better clinical outcomes for patients.

5. What is the demand for out of hours care?
Local GPs along with patients’ representatives (LINks) have been reviewing the out of Hours data. As part of this process they mapped the whole take up of out of
hours services, against the local catchment area for the nearest hospital to where the patient lives. They looked in detail at the number of patients and when they requested the service. It is clear that there was little demand for face to face consultations with a GP out of Hours during the working week, or after 10pm at night. The largest demand is for access at the week-ends and Bank Holidays. Below (Table 1) is an example of patients living in the Royal Free Hospital catchment area. This table highlights clearly that the largest demand is at week-ends and Bank Holidays and that the numbers attending out of Hours during the week from this area is very, very small (less than 10 people per day).

Table 1
Take up of Out of Hours Care face to face consultations for patients living in the Royal Free Catchment Area.

<table>
<thead>
<tr>
<th>Average Attendances per Day</th>
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</thead>
<tbody>
<tr>
<td>Bank Hol.</td>
</tr>
<tr>
<td>Sun</td>
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<tr>
<td>Sat</td>
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<td>Fri</td>
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<td>Tue</td>
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<tr>
<td>Mon</td>
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</tbody>
</table>

A very similar pattern emerges when this is compared to patients living in Islington. The demand for Out of Hours face to face consultations is also primarily at week-ends and Bank Holidays, when patients regular GP is unavailable.

Table 2
Take up of Out of Hours Care face to face consultations for patients living in the Whittington Hospital Area.
As GPs are already providing a primary care response at the local Urgent Care Centre it makes sense to rethink how Out of Hours might be delivered to make better use of current resources. This would provide clearer access points for patients, particularly as the demand is not for late night consultations, rather day time consultations at week-end and Bank Holidays. There is recognition that patients who need a home visit are often the patients most at risk, so the first priority was to secure a high quality service for those patients who required a GP to visit them at home. Also there needs to be robust arrangement for the small number of patients who can travel to see a GP at night, when the Urgent Care service is closed (after 10pm at night).

The first phase of the commissioning process was to procure a combined Out of Hours Home Visiting Service across Camden and Islington and a small face to face consultation Service for patients after 10pm in the evening. Built into this model is an Out of Hours telephone consultation with a GP for all patients who the 111 service considers to be in need of GP advice, with the facility for a follow up face to face consultation either at the Urgent Care Centre, or at the Out of Hours service at St. Pancras. This allows the GP to make a determination on the urgency of the intervention required and to be able to give immediate advice and guidance to the patient. If the most appropriate disposal is to see the patient at the Urgent Care Centre, the GP will arrange an electronic appointment for them to be seen and will advise the patient when this will be. This will avoid a long wait for the patient and this will be fast tracked through the Urgent Care Centre without the need for further triage.

This service will be for Camden and Islington residents and those registered with Camden and Islington GPs. There will be a period of resilience testing to ensure that there is secure and safe transfer of patient data, from the 111 service to the Out of Hours service. Phase two of the Out of Hours Service, which is the area we are particularly consulting on, as it represents a change in the way the service is delivered, is to pilot the Out of Hours face to face consultations at the local Urgent Care Centres to evaluate its effectiveness. This will inform the overall long term strategy for greater whole system integrating of Unscheduled Care Services. This will be subject to negotiation with the individual Hospital Trusts, as they will
need to increase their GP capacity to respond and be able in time to accept appointment times for patients to be seen at the Urgent Care Centres.

6. Stakeholder Groups
The primary stakeholder group for consultation activities are as follows:

- The local professional GP leadership, via the Clinical Commissioning Group and Professional Executive Committees in Camden and Islington
- The local authorities, Islington Council and Camden Council
- The Local Involvement Networks (LINks – becoming HealthWatch), as part of consultation and project working group
- The Health Scrutiny Committees in Camden and Islington
- The Health and Wellbeing Boards in Camden and Islington
- Local residents and patients

7. Pre Consultation Activities
NHS North Central London has conducted the following pre consultation activity in relation to out of hours services.

- Several meetings with current provider (Harmoni)
- Report to Camden CCG (28 March 2012)
- Report to Islington Senior Team Meeting CCG (24 April 2012)
- Update by Dr Jo Sauvage to Islington GPs on progress with Out of Hours on the 13th September 2012
- Several meetings between the Hospital Trusts and Acute Commissioners over the summer of 2012 to establish interest in participating in the pilot
- Formal confirmation from the Royal Free Hospital, Whittington Health of their active willingness to participate in the pilot received in November 2012
- Joint Boards of NHS North Central London (January 2013)
- Camden Health Scrutiny Committee meeting February 2013
- Islington Overview and Scrutiny meeting February 2013
- Full participation by LINk’s members from Camden and Islington on the Out of Hours Project Board including participation in the procurement process for phase 1 of the developments

8. The ‘four tests’
This project has considered the Secretary of State for Health’s four tests for reconfiguring healthcare services, as follows:

1. Support from **GP commissioners**: A report was prepared and presented to Camden CCG about the proposed changes in out of hours services on the 28 March 2012 and a follow up discussion on progress took place on the April 2012. Camden CCG Board approved the direction of travel. A similar exercise was carried out in Islington and the report was presented to the Senior Management Team of the CCG on 24 April 2012. They were also supportive of the proposals.
2. Strengthened **public and patient engagement**: LINKs members from both Camden and Islington have been members of the Out of Hours Project Board which has been meeting since the autumn of 2011. Throughout this process they have actively participated and positively challenged ideas and assumptions and many changes were made to the home visiting specification to improve the patient experience, based on their feedback. The LINKs members have also been members of the evaluation team as part of the procurement process, for selecting a provider for the out of Hours Home Visiting Service.

The local authorities will be consulted via the Camden Health Scrutiny Committee and Islington Health Scrutiny Committee. Representation will also be made to the individual Directors of Social Services, to ensure that we have captured their views, and incorporate their advice into the public consultation Process.

3. Clarity on the **clinical evidence base**: There is a clinical need to change the way we deliver Out of Hours Care to improve the patient experience and make the patient’s journey simpler. We need to have a seamless transition from day time primary care and management of long term conditions through the whole 24 hour cycle. This will be achieved by sharing clinical patient information and care planning; facilitating greater access to diagnostics, for those patients that require this facility; have on site back up of more specialist physicians for patients with very complex needs, or whose condition is deteriorating.

4. Consistency with current and prospective **patient choice**: Increasing the provision of Out of Hours GP services from two sites to three sites will increase patient choice locally, as to where the individual patient wants to be treated, when they need to access primary care out of hours. There will in time be the opportunity to make advanced appointments at the Urgent Care Centres, which will match with the presenting clinical need - patients will have some input to which time slots best suits their personal circumstances. We will also ensure, via the service specification, that the new Out of Hours GP service offers choice at all times when making referrals to other services.

9. **Equality Impact Assessment**
The plans set out in the proposal do not impact on any group in a negative manner and they improve access overall for the range of people including children, disabled people and those with mobility difficulties.

10. **Consultation timeframe**
The proposal is to consult for 63days/9weeks. However, this will need to be agreed by the two local Health Scrutiny Committees in Camden and Islington. The proposal is to run the consultation from 14 February 2013 to 19 April 2013. This
timeline reflects the need to balance several elements, including stakeholder input into the service specification, national rollout of the NHS 111 phone number, and ensuring the new service is mobilised by July 2013.

11. Consultation document questionnaire
A consultation document will be prepared and published with the EQIA. A Plain English summary version of the consultation document will also be published. The consultation questions will be provided as part of consultation document and also provided as online survey via the NHS North Central London website. The questionnaire has been tested with LINks representatives.

12. Consultation and engagement activity
Please see Appendix A.

13. Collating and analysing responses
A new Project Manager has been appointed and they will be responsible for being the key contact for all responses, enquiries and feedback. Alison Blair, Chief Officer, will be responsible for arranging the analysis of consultation feedback.

14. The decision
Robert Evans interim Associate Director of Primary Care is responsible for ensuring board-level decision on the consultation for the Joint Boards of North Central London. Alison Blair will be responsible for ensuring level decision for the two CCG Governing Bodies of Camden and Islington. Alison will also be responsible for publishing the consultation report.

15. Monitoring
To evaluate how successful this engagement process has been in involving our key stakeholders, we will monitor the following:

- Evidence of local people (patients) inputting into the service specifications
- Evidence of local clinicians and service providers inputting into the service specifications
- Number of complaints/concerns raised by the service’s patients and how these issues were considered / ameliorated.
**A Engagement Activity Plan for proposals to increase access to out of hours GP services in Camden and Islington**

**NOTES:**
1. This plan is for the proposed changes to accessing Out of Hours GP services in Camden and Islington
2. Communications and Engagement period: 14 February to 19th April 2013

<table>
<thead>
<tr>
<th>Stakeholder group</th>
<th>Method of engagement</th>
<th>Date, time, lead officer</th>
<th>Status &amp; feedback recorded</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALL</td>
<td>Consultation is formally launched once it is published on NHS North Central London, NHS Camden (CCG) and NHS Islington (CCG) websites: summary of project and consultation document, questionnaire and contact details</td>
<td>Steven Howard, Web Manager can support 14 February</td>
<td></td>
</tr>
<tr>
<td>NHS</td>
<td>Consultation plan, document Board.</td>
<td>Eilis Kilfeather January 2013</td>
<td></td>
</tr>
<tr>
<td>NHS NCL Joint Boards</td>
<td>Report to SLT; briefing of any issues.</td>
<td>Eilis Kilfeather At launch.</td>
<td></td>
</tr>
</tbody>
</table>
| NHS NCL Senior Leadership Team | Brief NCL and NEL CSU PALS team  
Article in staff e-Bulletin (Connect and CSU e-news)  
Article to CCGs for distribution to staff | Zoë Anderson – via CSU marketing and CCG comms |                           |
<table>
<thead>
<tr>
<th>Stakeholder group</th>
<th>Method of engagement</th>
<th>Date, time, lead officer</th>
<th>Status &amp; feedback recorded</th>
</tr>
</thead>
<tbody>
<tr>
<td>News item on intranets (NCL, C&amp;I CCGs, NEL CSU) Email to Camden and Islington Borough Office team (via CCG Chair and Accountable Officer)</td>
<td>leads</td>
<td>At launch.</td>
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<tr>
<td>NHS London</td>
<td>Letter and consultation document (this is courtesy, if required – but critical for major consultations)</td>
<td>Eilis Kilfeather</td>
<td>At launch</td>
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<td>Statutory sector</td>
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<tr>
<td>Health Overview &amp; Scrutiny Committees</td>
<td>Presentations to Camden and Islington Health Scrutiny Committees in February to gain feedback on the consultation plan. Then, to request response to consultation as consultees. Islington HOSC – 12 February 2013 (<a href="mailto:Rachel.stern@islington.nhs.uk">Rachel.stern@islington.nhs.uk</a>) Camden HOSC – 13 February 2013 (<a href="mailto:hannah.hutter@camden.gov.uk">hannah.hutter@camden.gov.uk</a>)</td>
<td>Zoë Anderson to arrange. Eilis + clinician to attend</td>
<td>February 2013</td>
</tr>
<tr>
<td>Health and Well Being Boards – Camden &amp; Islington</td>
<td>Write to Chair of Board inviting comments on consultation, linking to consultation document and offering presentation.(may decide to brief HWB prior to launching consultation)</td>
<td>Zoë Anderson</td>
<td>At launch</td>
</tr>
<tr>
<td>Councils – Islington and</td>
<td>Write to relevant directors (i.e. Housing and Adult Social Services, Children’s Services etc.), plus courtesy email with link to consultation document to known officers</td>
<td>Zoë Anderson</td>
<td></td>
</tr>
<tr>
<td>Stakeholder group</td>
<td>Method of engagement</td>
<td>Date, time, lead officer</td>
<td>Status &amp; feedback recorded</td>
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<tr>
<td>Camden</td>
<td>in those directorates.</td>
<td>At launch</td>
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<tr>
<td>Relevant MPs</td>
<td>Email with link to consultation document with offer of briefing</td>
<td>Zoë Anderson</td>
<td></td>
</tr>
<tr>
<td>Clinicians</td>
<td>Email with consultation document to primary care services – GPs, pharmacists and dentists.</td>
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<tr>
<td></td>
<td>Article to all Camden and Islington GPs via practice managers GPs to consultation, inviting their comments and encouraging them to promote to their patients. (Comms Team sent via weekly e-News).</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>News item on CCG websites for Camden and Islington</td>
<td>Eilis Kilfeather</td>
<td></td>
</tr>
<tr>
<td>Patients and public</td>
<td>Letter and consultation document to Chair and host lead, inviting them to participate in the consultation – and offer presentation at future Chairs’ Meeting or operational meeting.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Camden LINk &amp; Islington LINk (becoming Health Watch)</td>
<td>Leave printed copies of consultation in waiting area of St Pancras site</td>
<td>Eilis Kilfeather</td>
<td></td>
</tr>
</tbody>
</table>

NHS North Central London is a collaborative working arrangement between Barnet, Camden, Haringey, Enfield and Islington Primary Care Trusts. The Joint Boards of NHS North Central London refers to the joint meeting of the Boards of Barnet, Camden, Haringey, Enfield and Islington Primary Care Trusts.
<table>
<thead>
<tr>
<th>Stakeholder group</th>
<th>Method of engagement</th>
<th>Date, time, lead officer</th>
<th>Status &amp; feedback recorded</th>
</tr>
</thead>
<tbody>
<tr>
<td>users</td>
<td>Attend St Pancras site on an evening and a weekend day to promote consultation to patients and encourage them to complete questionnaire</td>
<td>Comms support from Zoë Anderson March 2013</td>
<td></td>
</tr>
<tr>
<td>Other patients</td>
<td>Article in the NHS North Central London Patient Newsletters for Camden and Islington. <strong>Spring issue</strong></td>
<td>Uche Onyeabo (NCL)</td>
<td></td>
</tr>
<tr>
<td>Public / press</td>
<td>Press release to Camden and Islington media with information on how to get involved in consultation/project. Potential for interview with Dr Jo Sauvage (Islington GP) <em>If it becomes a formal 12-week consultation: place advertisement in local press</em></td>
<td>Felicity Bull (Savaia)</td>
<td></td>
</tr>
<tr>
<td>Providers</td>
<td>Write to Chair of Local Medical Committees (LMC) covering Islington and Camden; promote consultation and offer briefing. (can be via email)</td>
<td>Eilis Kilfeather, with support from Zoe At launch</td>
<td></td>
</tr>
<tr>
<td>Professional committees</td>
<td>Royal Free Hospital, Whittington Hospital, and University College Hospital Email to communications and PPI/PALS leads to brief on project and Chief Executive</td>
<td>Eilis Kilfeather At launch</td>
<td></td>
</tr>
</tbody>
</table>
B Template for enquiries and activities log – adapt to suit you, but key is that all feedback and engagement activities are recorded, and easily packaged if you are called upon by Scrutiny to present them.

<table>
<thead>
<tr>
<th>Date of enquiry / activity</th>
<th>Channel (i.e. email, telephone, meeting, event)</th>
<th>Stakeholder details</th>
<th>Enquiry / activity details</th>
<th>NHS response / action taken</th>
<th>Date of response</th>
<th>Action / approval officer</th>
<th>Feedback recorded (file)</th>
</tr>
</thead>
<tbody>
<tr>
<td>25/10/12</td>
<td>Email and meeting</td>
<td>Individual LiNKs representatives from Camden and Islington asked to comment on the draft proposals</td>
<td>Requested an increase from 8 to 9 weeks to allow more time over the Christmas period</td>
<td>Consultation dates expanded to 9 weeks to allow sufficient time for consideration</td>
<td>25.10.2012</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25/10/12</td>
<td>Email and meeting</td>
<td>Individual LiNKs representatives from Camden and Islington asked to comment on the draft proposals</td>
<td>How would South East Islington patients be catered for as they currently use the Homerton or other hospitals</td>
<td>Agreed to ask patients in the consultation questionnaire to comment on the proposed locations. UCC’s at the Homerton or other hospitals</td>
<td>25/10/2012</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of enquiry / activity</td>
<td>Channel (i.e. email, telephone, meeting, event)</td>
<td>Stakeholder details</td>
<td>Enquiry / activity details</td>
<td>NHS response / action taken</td>
<td>Date of response</td>
<td>Action / approval officer</td>
<td>Feedback recorded (file)</td>
</tr>
<tr>
<td>----------------------------</td>
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<td>------------------</td>
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<td>--------------------------</td>
</tr>
<tr>
<td>25/10/2012</td>
<td>Email and meeting</td>
<td>Individual LINKs representatives from Camden and Islington asked to comment on the draft proposals</td>
<td>Will there be sufficient access to patient medical records and care plans at the Out of Hours and UCC?</td>
<td>Agreed to insert this into the new specification for the Urgent Care Centres</td>
<td>25/10/2012</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix C

Current Out of Hours Care

- NHS Direct
- Out of Hours Call Centre
- Nurse or GP Advice
- Face to face consultations at St. Pancras OOH premises
- Home Visiting Service at the Patients Home
- Emergency Ambulance
- Accident and Emergency
- District Nurses
- End of Life Care
- Emergency Dental Care

899

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Appendix C

How patients will experience the new Integrated Model of Out of Hours Care.

GP out of hours services will be able to contact District Nurses, End of Life Care, Out of Hours Dental care etc. but will not be the primary referral point for the public to access these services.
MEETING: Meeting of the Joint Boards of NHS North Central London
DATE: Thursday 31st January 2013
TITLE: Mental Health and Learning Disabilities High Level Review
LEAD DIRECTOR: Alison Pointu, Director of Quality & Safety
AUTHOR: Louise Lingwood
CONTACT DETAILS: Louise.lingwood@nclondon.nhs.uk
020 7685 6230

SUMMARY:
The high level review of quality and safety of specialist mental health and learning disability services we commission, including those services provided by Barnet, Enfield and Haringey NHS Mental Health Trust, Camden and Islington Foundation Trust, and The Tavistock and Portman NHS Foundation Trust was presented to the Joint Board of NHS North Central London on 29 November 2012. The executive summary and an action plan that has been agreed with each of the Clinical Commissioning Groups (Barnet, Camden, Enfield, Haringey and Islington) to ensure that commissioning oversight transfers from NHS North Central London to each of the Clinical Commissioning Groups from 1 April 2013.

SUPPORTING PAPERS:
N/A

RECOMMENDED ACTION:
The Joint Boards are asked to:
· CONSIDER the revised recommendations and action plan
· APPROVE the report and action plan

LINKS TO NHS NORTH CENTRAL LONDON STRATEGY
This paper supports the objectives of the Quality & Patient Safety Strategy 2011 – 2013, namely to provide assurance to NCL Board and that all services commissioned for the population are safe and are of the highest quality for all patients.
GOVERNANCE:
Voting: Please indicate which Board(s) has voting rights on this matter (if applicable)

<table>
<thead>
<tr>
<th>Barnet</th>
<th>Camden</th>
<th>Enfield</th>
<th>Haringey</th>
<th>Islington</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paula Kahn</td>
<td>Paula Kahn</td>
<td>Paula Kahn</td>
<td>Paula Kahn</td>
<td>Paula Kahn</td>
</tr>
<tr>
<td>David Riddle</td>
<td>Caroline Rivett</td>
<td>Karen Trev</td>
<td>Cathy Herman</td>
<td>Anne Weyman</td>
</tr>
<tr>
<td>Caroline Rivett</td>
<td>Robert Sumerling</td>
<td>Caroline Rivett</td>
<td>Caroline Rivett</td>
<td>Caroline Rivett</td>
</tr>
<tr>
<td>Berndette</td>
<td>Karen Trev</td>
<td>Deborah Fowler</td>
<td>Sue Baker</td>
<td>Sorrel Brookes</td>
</tr>
<tr>
<td>Conroy</td>
<td>Ellen Schroder</td>
<td>Cathy Herman</td>
<td>Anne Weyman</td>
<td>Bernadette</td>
</tr>
<tr>
<td>Robert Sumerling</td>
<td>Deborah Fowler</td>
<td>Sue Baker</td>
<td>Sorrel Brookes</td>
<td>David Riddle</td>
</tr>
<tr>
<td>Caroline Taylor</td>
<td>Caroline Taylor</td>
<td>Caroline Taylor</td>
<td>Caroline Taylor</td>
<td>Conroy</td>
</tr>
<tr>
<td>Bev Evans</td>
<td>Bev Evans</td>
<td>Bev Evans</td>
<td>Bev Evans</td>
<td>Caroline Taylor</td>
</tr>
<tr>
<td>Andrew Howe</td>
<td>Quentin Sandifer</td>
<td>Shahed Ahmad</td>
<td>Jeanelle De</td>
<td>Bev Evans</td>
</tr>
<tr>
<td>Philippa Curran</td>
<td>Penny Bevan</td>
<td>Mohammed</td>
<td>Gruchy</td>
<td>Penny Bevan</td>
</tr>
<tr>
<td>Alison Pointu</td>
<td>Joanne Wickens</td>
<td>Abedi</td>
<td>Helen</td>
<td>S. Gillian</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Pelendrides</td>
<td>Greenhough</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Karen Baggaley</td>
<td>Jennie Hurley</td>
</tr>
</tbody>
</table>

Objective(s) / Plans supported by this paper:
NHS North Central London has set as one of its principal objectives to ensure we commission services which are safe and of increasing quality for the people we serve.

The Strategic Objectives underpinning that are:
1 To review all commissioned services against key safety criteria and agree action plans to address any shortfalls
2 To establish quality markers for all commissioned services and agree improvement trajectories
3 To secure improvements in patient experience

Patient & Public Involvement (PPI): The views of service users and carers were gained via both individual interview and their feedback to the Quality and Safety Committee meeting to hear the ‘Patient Story’.

Equality Impact Analysis: NA

Risks: The content of this paper has not been risk rated

Resource Implications: None

Audit Trail: The review report was discussed at the NHS North Central London Quality & Safety Committee on 5 July 2012 and at the meeting of the Joint Boards of NHS North Central London on 29 November 2012. It has also been circulated to the Chief Executives at Barnet, Enfield and Haringey Mental Health Trust, Camden & Islington NHS Foundation Trust, and The Tavistock and Portman NHS Foundation Trust for comment in August 2012. Final report to the Joint Board of NHS North Central London 29/11/12, and action plan to each of the five CCGs in January 2013.
Next Steps:

- The quality and safety directorate of NHS North Central London will include this as part of the handover material to the new NHS bodies and include the findings in the Trust Quality Risk Profiles for these Trusts.

- CCG quality leads to share review recommendations and action plan with the local CCG quality committee.

- CCGs to take forward recommendations and action plan with Trusts via the clinical quality review meetings and other forums.
Executive Summary

1. Introduction
The Joint Boards of NHS North Central London requested an urgent high level review of quality and safety. Phase 1 of this review focused on local acute hospital services. The purpose of phase 2 of the review is to provide assurance on the specialist mental health and learning disability services we commission, including those services provided by Barnet, Enfield and Haringey NHS Mental Health Trust, Camden and Islington Foundation Trust, and The Tavistock and Portman Foundation Trust.

Between December 2011 and March 2012 a high level review of specialist mental health and learning disability services across North Central London was carried out. This review is a ‘snapshot’ exercise and findings need to be viewed in that context. Most of the information contained in the review is in the public domain. The views of CCGs and mental health service users and carers have also informed the review.

Part One – Mental Health
Table 1 provides a high level overview of the activity and national survey data of this review of local mental health trust services.

NB From Quarter 1 2011/12, a new version of MHMDS includes new data items and is processed using a new system. Some of the changes have been introduced to support the implementation of Payment by Results for mental health. Only provisional data available at time of report production.

<table>
<thead>
<tr>
<th>Data Source</th>
<th>BEHMHT</th>
<th>CIFT</th>
<th>T&amp;P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient admissions 2010/11</td>
<td>Mental Health Minimum Data Set</td>
<td>2,078</td>
<td>1,615</td>
</tr>
<tr>
<td>Patients detained under the MH Act 2010/11</td>
<td>Mental Health Minimum Data Set</td>
<td>1,066</td>
<td>873</td>
</tr>
<tr>
<td>Average length of stay 2010/11</td>
<td>Hospital Episode Statistics</td>
<td>30</td>
<td>19</td>
</tr>
<tr>
<td>Number of supervised community treatment orders 2010/11</td>
<td>Mental Health Minimum Data Set</td>
<td>135</td>
<td>100</td>
</tr>
<tr>
<td>Numbers of people on Care Programme Approach (CPA)</td>
<td>Mental Health Minimum Data Set</td>
<td>6,457</td>
<td>3,449</td>
</tr>
<tr>
<td>National Staff Survey 2011</td>
<td>CQC</td>
<td>3.59/5</td>
<td>3.52/5</td>
</tr>
<tr>
<td>National Service User Survey 2011</td>
<td>CQC</td>
<td>6.4/10</td>
<td>6.2/10</td>
</tr>
</tbody>
</table>
2. Limitations
This review has some limitations to be taken into consideration. Compared to Acute Hospitals the range of data readily available is more limited and data quality is typically weaker and less reliable. For these reasons there are limitations to the findings that need to be taken into consideration and therefore results cannot be viewed as an absolute measurement of a Trust's overall position in relation to quality and safety.

It's important to note that mental health services are provided by a wide range of providers. Both primary care and the voluntary and independent sector in particular play an important role in providing support to people with mental health needs. The scope of this high level review however, has focused primarily on specialist secondary services provided by the three mental health trusts within North Central London. Review methodology that relies largely on publicly available data imposes limits on the range and depth of quality analysis. This review is not sufficient in depth to explore those aspects of quality that are not so easily measurable e.g. recovery and social inclusion.

3. Conclusions – Mental Health

The aim of this review was to provide assurance on the safety of mental health services. The available data suggests that while services are generally safe there are key areas for development indicated. These include the need to improve communication between Trusts and GPs across the Trusts.

Specific to BEHMHT is the need to improve the number of annual Care Programme Approach (CPA) reviews; explore the reasons for reported higher lengths of stay and staff sickness levels and address the concerns of Haringey services users with regard to access to local mental health services. The review has highlighted workforce issues at CIFT in relation to levels of staff turn over. Both BEHMHT and CIFT were in the lowest (worst) 20% when compared to other trusts for staff recommendation of the trust as a place to work or receive treatment, an indicator that was associated with patient safety during the Mid Staffordshire review.
<table>
<thead>
<tr>
<th>Recommendation/Actions</th>
<th>Outcome</th>
<th>Lead</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Improve the communication flow between GPs and both BEHMHT and CIFT through improved sharing of patient information.</td>
<td>Improved communication and better patient care</td>
<td>BEHMHT</td>
<td>April 2013</td>
</tr>
<tr>
<td></td>
<td>Electronic discharge or faxed discharge correspondence to GPs within 72 hours of discharge from hospital or community care</td>
<td>CIFT</td>
<td></td>
</tr>
<tr>
<td>2. BEHMHT introduction of a single point of entry to services including a single contact phone number for GPs especially for emergency access</td>
<td>Better access for service users; Rapid access to specialist services</td>
<td>BEHMHT</td>
<td>April 2013</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. BEHMHT/CIFT to develop a Trust wide action plan to improve the involvement and engagement of service users</td>
<td>Improved feedback from service users; National Patient Survey and local surveys; Service user representation and involvement in key meetings</td>
<td>BEHMHT</td>
<td>April 2013</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CIFT</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>CCG Quality Leads</td>
<td></td>
</tr>
<tr>
<td>Recommendation/Actions</td>
<td>Outcome</td>
<td>Lead</td>
<td>Timescale</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>4. BEHMHT to conduct a thematic analysis of unexpected deaths and suicide Serious Incidents</td>
<td>BEHMHT identify any themes and trends from analysis and share with commissioners at the CQRG meeting to be held on 23 January 2013. Any actions identified are implemented and audited and monitored via the clinical quality review meetings</td>
<td>BEHMHT</td>
<td>January 2012</td>
</tr>
<tr>
<td>Develop an action and monitor implementation of findings</td>
<td></td>
<td></td>
<td>April 2013</td>
</tr>
<tr>
<td>5. All service users on CPA receive an annual review. Action plan developed and monitored after 6 months</td>
<td>Trusts achieve CPA national target for &gt; 90 % completion of annual reviews</td>
<td>BEHMHT</td>
<td>December 2013</td>
</tr>
<tr>
<td>6. BEHMHT and CIFT to address the workforce concerns identified in the high level review.</td>
<td>Assurance that there is the right workforce to deliver services with no reduction in quality Improved staff satisfaction results in the National Staff Survey Improved feedback from patients and their relatives.</td>
<td>CIFT/BEHMHT</td>
<td>April 2013</td>
</tr>
<tr>
<td>Develop an action plan and monitor the plan through the CQR meetings to ensure that the Trust has addressed the workforce concerns identified in the high level review</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Reduce out of area placements. Develop an action plan to reduce the number of out of area placements and monitor the plan through the QIPP meetings with the Trust</td>
<td>Individuals identified in out of area placements and where appropriate moved into stepped down local services or have plans for moving into stepped down facilities</td>
<td>BEHMHT/CCG Commissioners at the QIPP programme board</td>
<td>September 2013</td>
</tr>
<tr>
<td>Recommendation/Actions</td>
<td>Outcome</td>
<td>Lead</td>
<td>Timescale</td>
</tr>
<tr>
<td>------------------------</td>
<td>--------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>8. Improved access to primary care services The Trust and CCGs to work together to develop an action plan that is monitored through the CQR meetings</td>
<td>Increased access to primary care services for those that have mental health problems</td>
<td>CCG Joint Commissioners</td>
<td>December 2013</td>
</tr>
<tr>
<td></td>
<td>Increased physical health checks delivered to those admitted to the MH Trusts</td>
<td>BEHMHT CIFT</td>
<td>March 2013</td>
</tr>
<tr>
<td></td>
<td>Long term health conditions of people with mental health problems monitored in primary care and mental health settings</td>
<td>Trusts and CCGs</td>
<td>August 2013</td>
</tr>
<tr>
<td>9. Increase the opportunities for commissioners and Trusts to meet to discuss quality and safety aspects of the contracts at BEHMHT and CIFT</td>
<td>Regular meetings of the Clinical Quality Review Groups held. Increased focus on quality</td>
<td>CCG Quality Leads</td>
<td>April 2013</td>
</tr>
</tbody>
</table>

**Part Two – Learning Disabilities**

1. **Limitations/Conclusions**

Given the nature of NHS learning disability provision in the sector readily available data is particularly limited. The aim of this review was to provide assurance on the safety of learning disability health services. There is a still a lot to do in some of the North Central London Boroughs to bring about consistent standards of quality and actions required. The findings of the Winterbourne review and the Concordat: Programme of Action will require local agencies to work together to implement the key actions.

This review has provided us with some recommendations for improvements in commissioning for this population; however there is insufficient evidence available to provide assurance in terms of quality and safety of services across all the services we commission and contract for adults with learning disabilities.
Table 3 provides a high level overview of the findings of this review of local learning disability services.

<table>
<thead>
<tr>
<th>Learning Disability Self Assessment Framework 2010/11</th>
<th>NHS London</th>
<th>Barnet</th>
<th>Camden</th>
<th>Enfield</th>
<th>Haringey</th>
<th>Islington</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of people with learning disabilities who have received an annual health check in 2011</td>
<td>Information Centre for Health and Social Care</td>
<td>84%</td>
<td>59%</td>
<td>18%</td>
<td>74%</td>
<td>59%</td>
</tr>
</tbody>
</table>

Table 4 Learning Disabilities Recommendations and Action Plan

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Outcome</th>
<th>Lead</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. CCGs to develop an action plan that sets out how they are going to improve primary care access for adults who have a learning disability. This will be monitored through the CCG quality sub-committee.</td>
<td>Improved primary care registers</td>
<td>CCGs</td>
<td>March 2014</td>
</tr>
<tr>
<td></td>
<td>Increase in the number of people receiving annual health checks</td>
<td>CCGs</td>
<td>March 2014</td>
</tr>
<tr>
<td></td>
<td>Improvement in the linkage between learning disability register and disease register in primary care</td>
<td>CCGs</td>
<td>March 2014</td>
</tr>
<tr>
<td></td>
<td>Increased evidence of joint working with local authorities and public health</td>
<td>CCGs</td>
<td>March 2014</td>
</tr>
<tr>
<td></td>
<td>Increased investment in local specialist services using S75 agreements with local authority</td>
<td>CCGs/LA</td>
<td>March 2014</td>
</tr>
<tr>
<td>Recommendation</td>
<td>Outcome</td>
<td>Lead</td>
<td>Timescale</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
<td>-----------------------</td>
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</tr>
<tr>
<td>2. Respond to the findings of the Winterbourne Final Report and the Concordat: Programme of Action.</td>
<td>CCGs have robust learning disability registers for those that are in receipt of NHS funded care</td>
<td>CCG</td>
<td>March 2013</td>
</tr>
<tr>
<td></td>
<td>CCGs receive learning disability awareness training as part of their development programme</td>
<td>Joint Commissioners</td>
<td>April 2013</td>
</tr>
<tr>
<td></td>
<td>Local implementation plan to address Concordat key actions</td>
<td>CCG/LA</td>
<td>April 2013</td>
</tr>
<tr>
<td></td>
<td>Effective monitoring of specialist placements in and out of area is scheduled to ensure that all people receive at least an annual review and that there are checks to ensure safety</td>
<td>CCG/LA</td>
<td>April 2013</td>
</tr>
<tr>
<td>3. Respond to outcome of the results of Self Assessment Framework (SAF) 2012 through the implementation of an action plan that responds to areas of development identified in the 2012 SAF</td>
<td>Respond to the national consultation re new SAF framework</td>
<td>CCG</td>
<td>February 2012</td>
</tr>
<tr>
<td></td>
<td>Achieve improvement in the overall ratings of the SAF 2013</td>
<td>CCG</td>
<td>November 2013</td>
</tr>
<tr>
<td></td>
<td>Improved awareness of the health and social care needs of this population</td>
<td>CCG</td>
<td>April 2013</td>
</tr>
</tbody>
</table>
MEETING: Meeting of the Joint Boards of NHS North Central London
DATE: 31 January 2013
TITLE: Quality and Safety Committee – Chairs Report
LEAD DIRECTOR: Alison Pointu, Director of Quality and Safety
AUTHOR: David Riddle, Chair of Quality and Safety Committee
CONTACT DETAILS: David.riddle@nclondon.nhs.uk

SUMMARY:
The oversight and assurance functions for Quality and Safety for NHS North Central London are discharged on behalf of the Joint Boards by the Quality and Safety Committee. This paper provides an account of the work of the Committee and an assurance opinion.

SUPPORTING PAPERS:
This paper draws upon the content of the papers presented to the Quality and Safety Committee on 17 December 2012 that are listed in section 2 of the report below. Copies of any of those reports can be supplied to Board Members on request to the committee secretary.

RECOMMENDED ACTION:
The Joint Boards are asked to:
- NOTE the content of the report

LINKS TO NHS NORTH CENTRAL LONDON STRATEGY
This paper links to the Quality and Safety Objectives for NHS North Central London.

GOVERNANCE:
Voting: Please indicate which Board(s) has voting rights on this matter (if applicable)

<table>
<thead>
<tr>
<th>Barnet</th>
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<th>Islington</th>
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Objective(s) / Plans supported by this paper: NHS North Central London has set as one of its principal objectives; to ensure we commission services which are safe and of increasing quality for the people we serve.

The Strategic Objectives underpinning that are:
1. To review all commissioned services against key safety criteria and agree action plans to address any shortfalls
2. To establish quality markers for all commissioned services and agree improvement trajectories
3. To secure improvements in patient experience

Audit Trail: The Joint Boards has first sight of this report.

Patient & Public Involvement (PPI): There has been no direct patient and public involvement in the development of this report, however there has been continued engagement with LINKs members prior to the Quality and Safety Committee meeting.

Equality Impact Assessment: NA

Risks: No risks identified

Resource Implications: There are no resource implications.

Next Steps: The Quality and Safety Committee will meet again in February 2013 and will report again to the NHS North Central London Joint Boards to provide assurance of the handover of quality and safety to the relevant receiving organisations.
1. Assurance Summary
The transition of responsibility for quality to the Clinical Commissioning Groups (CCGs) is proceeding apace. All of the CCGs have set up their local Quality Committees and have or are in the process of building the staff teams to manage quality and safety. Joint Boards can be assured that CCGs are gripping their new responsibilities and working well with NHS North Central London and the embryonic Commissioning Support Unit (CSU) team. CCGs still have to finalise their plans for collaboration and lead roles on the Trust Clinical Quality Review Groups.

There are no new issues of concern in relation to provider performance. Issues of particular note are:

- The rise in cases of Meticillin Resistant *Staphylococcus aureus* (MRSA) and *Clostridium difficile*, especially at Barnet and Chase Farm Hospitals NHS Trust, University College London Hospitals Foundation Trust and Great Ormond Street Hospital Foundation Trust. Overall numbers are still low compared with the position several years ago, but there is a risk of Department of Health thresholds being breached.

- Patient experience with Cancer Services is of continuing concern in University College London Hospitals Foundation Trust and North Middlesex University Hospital where the National Cancer Patient Experience survey shows them to be in the lowest 10% of Trusts in England.

- There are on-going issues with two of the NHS North Central London Mental Health providers. At Barnet, Enfield and Haringey Mental Health Trust there are safeguarding concerns, a seemingly high level of suicide cases, and concerns about management of some community services for Enfield. Quality Summit processes have been initiated by NHS North Central London and the Care Quality Commission is firmly engaged. At Camden and Islington Mental Health Foundation Trust there are concerns about certain workforce issues and the effectiveness of the Clinical Quality Review meeting arrangements as they stand.

In the final meeting held on behalf of the Committee with Local Involvement Networks (LINKs), the Links expressed their anxieties about the slow and uncertain pace of development of Healthwatch in some Boroughs, and real concern how this will impact on patients who want the kind of advice and support that the Patient Advice and Liaison Service at NHS North Central London has been able to give. They also again urge that Clinical Commissioning Groups should continue to work together to ensure that the “big picture” does not get lost sight of as the five borough Clinical Commissioning Groups develop a local focus, and that joint working continues on common concerns such as care homes and pressure ulcers.

2. Introduction
As agreed at the September 2012 meeting, the Quality and Safety Committee agenda for the December meeting was revised to begin to offer enhanced assurance to the Joint Boards of the transition of the responsibility for Quality and Safety to the Clinical Commissioning Groups. The agenda and items for discussion were therefore presented in three parts:

Part 1 Clinical Commissioning Group Reports
- Reports from each of the five Clinical Commissioning Groups of North Central London.
Part 2 Performance matters

- Executive Report on Quality and Safety
- Quality Assurance Dashboard
- Serious incident report
- PALs and Complaints report
- Individual treatment requests
- Infection control report

Part 3 Corporate matters

- Primary Care update
- NHS North Central London Risk register for quality and safety
- Equality and Diversity report
- Quality and Safety Transition
- Minutes of the serious incident overview panel (August, September, October 2012)

The following sections provide an overview of the key points discussed and actions agreed.

3. Part 1: Reports on Quality and Safety in Clinical Commissioning Groups
The Quality Lead from each Clinical Commissioning Group provided an update on quality; including an overview of the governance arrangements established and the key issues and concerns for their Clinical Commissioning Group.

3.2 Barnet Clinical Commissioning Group – Lucy Botting
3.2.1 A Quality and Clinical Risk Committee was established in October 2012.

3.2.2 Safeguarding Children
Safeguarding children training figures are monitored within the commissioned services by Barnet Clinical Commissioning Group. Concerns noted include:
- Royal Free London NHS Foundation Trust level 3 training figures are currently at 68% and are therefore being closely monitored against a revised training plan by the designated Nurse.
- At 31st October 51% of General Practitioners within Barnet had attended Safeguarding Children training.

3.2.3 Safeguarding Adults
Barnet Clinical Commissioning Group is represented at the Safeguarding Adults Partnership Board (SAPB) and has reporting systems, including early warning systems around care placements in place.

3.2.4 Complaints and Patient Advice Liaison Service (PALS)
Key issues for Barnet are access to General Practitioner appointments and registration administration. This will be reported to locality provider groups for improvement action plans. Other issues include funding for continuing care placements, In vitro fertilisation (IVF), cancer treatments and psychological therapies, dental band charges, poor clinical care in Barnet dental services (7 complaints).

3.2.5 Provider quality
Key concerns include:
• Mixed sex accommodation breaches at Barnet & Chase Farm Hospitals NHS Trust; a remedial action plan is in place.
• MRSA at Barnet & Chase Farm Hospitals NHS Trust: 4 cases reported against a threshold of 4; the four cases are not related and thorough investigation of each case has been undertaken.
• Safeguarding concerns at Barnet Enfield & Haringey NHS Trust: In October 2012 five safeguarding alerts were issued from The Oaks, a ward on the Chase Farm site. The NHS North Central London Quality directorate in partnership with Enfield Council are monitoring this closely.
• Serious incidents at Barnet Enfield & Haringey NHS Trust; following an increase in patient suicide, the Trust is undertaking a review of all cases over the last three years, the final report was presented at the Clinical Quality Review meeting in November 2012, an action plan will be reviewed at the January meeting.
• A Quality Summit was held in October 2012 with partner agencies. Concerns are being followed up through the Clinical Quality Review meetings and a follow up Quality Summit planned for January 2013.
• Access to emergency/crisis services at Barnet Enfield & Haringey NHS Trust, identified through GP concerns.
• Pressure ulcers at Central London Community Healthcare Trust; the Trust are working with commissioners to identify root causes with the aim of mitigation and action planning to address this and work together to implement the Harm Free Care Programme.
• Case loads for Health Visitors within Central London Community Healthcare Trust are large; although based on the “deprivation model” Barnet establishment is rated as green in terms of their required Health Visiting workforce. This is being monitored closely by Barnet Clinical Commissioning Group.

3.3 Camden Clinical Commissioning Group – Neeshma Shah
3.3.1 Camden Clinical Commissioning Group has had a quality and safety committee since April 2012.

3.3.2 Safeguarding children and adults
Camden Clinical Commissioning Group monitors its commissioned services against the NHS North Central London safeguarding metrics. Concern was noted about training rates at Great Ormond Street Hospital Foundation Trust; Camden Clinical Commissioning Group has written to the Chair of the Trust Board and the Trust has provided an action plan and progress is being monitored at the Clinical Quality Review meetings. Camden will be taking part in the Ofsted/Care Quality Commission (CQC)/multi agency pilot in January 2013.

Camden Clinical Commissioning Group has clinician and executive representation on the Safeguarding Adults Partnership Board (SAPB) and reporting/early warning systems in place in relation to adult safeguarding alerts.

3.3.3 Camden Clinical Commissioning Group reviews complaints and PALS data monthly at the quality and safety committee. Key issues for Camden are access to GP appointments and registration administration. These, together with the results of the GP patient survey, are being reviewed by the locality groups.

3.3.4 Provider quality
Key concerns for Camden Clinical Commissioning Group include:
• University College London Hospitals Foundation Trust has reported 29 cases of *Clostridium difficile*, which is above the year to date trajectory of 24 cases. A reduction strategy is in place and being monitored at CQR meetings.

• University College London Hospitals Foundation Trust has underperformed during October against the A&E 4 hour waits, due to lack of bed availability in the tower. Focused project work is underway and Camden clinical commissioners have visited Accident & Emergency to ensure the quality of care is not being adversely affected.

• University College London Hospitals Foundation Trust performed below the expected range in the cancer patient experience survey, it was in the lowest 10% of the country.

• Great Ormond Street Hospital Foundation Trust has exceeded its thresholds for MRSA and *Clostridium difficile*. A peer review has been undertaken and is being monitored through the clinical quality review meetings.

• Great Ormond Street Hospital Foundation Trust has reported an increase in the number of grade 3/4 pressure ulcers within the intensive care unit. Action plans are being monitored at the clinical quality review meetings.

• Central North West London Foundation Trust mandatory training figures require improvement and this is being monitored through the clinical quality review meetings.

• Camden Clinical Commissioning Group is concerned about a lack of meaningful data and early warning systems at Camden & Islington NHS Foundation Trust. There are also concerns relating to workforce issues, highlighted in the recent high level review of mental health services carried out by NHS North Central London. This is being addressed through the clinical quality review meetings, which are being increased in frequency from quarterly to monthly and a robust action plan is being prepared in collaboration with clinical commissioners to address the outcomes of the high level review.

3.3.5 Camden has a low coverage rate for breast screening (61.68%). A comprehensive plan is in place to improve coverage. Cervical screening rates are also low (66.40%) and a series of remedial actions are being implemented to address this.

3.4 Enfield Clinical Commissioning Group – Aimee Fairbarns

3.4.1 A Quality and Clinical Risk Committee was established in October 2012. Enfield appointed a Director of Quality Services and Integrated Governance in November 2012. A key priority for Enfield Clinical Commissioning Group is rapid recruitment to vacancies in the Quality and Governance directorate.

3.4.2 The Safeguarding Strategy for Enfield Clinical Commissioning Group is under development and permanent appointment to the Designated Nurse and Doctor roles is underway. Work on safeguarding alerts with nursing homes is underway with Barnet Enfield & Haringey NHS Trust and Central North West London NHS Foundation Trust.

3.4.3 The Complaints policy is currently being reviewed. The top five issues for complaints and concerns for Enfield were administration/operating systems, funding of services, manner and attitude of staff, referral issues and registration issues.

3.4.4 Provider quality
Key concerns include:
• Barnet and Chase Farm Hospitals NHS Trust - Mixed sex accommodation breaches
• North Middlesex University Hospital NHS Trust cancer patient experience survey results ranked them in the lowest 10 per cent in the country. A remedial action plan is being monitored closely at the clinical quality review meetings.
• Barnet Enfield & Haringey NHS Trust serious incidents (as outlined in Barnet report)
• Barnet and Chase Farm Hospitals NHS Trust MRSA cases (as outlined in Barnet report)
• Barnet and Chase Farm Hospitals NHS Trust have reported three Never Events this year; a retained foreign object, inappropriate administration of daily oral methotrexate (Herts resident) and wrong gas administration (Herts resident). Implementation of action plans is being monitored through the clinical quality review meetings.

3.4.5 The next steps for Enfield Clinical Commissioning Group include the development of a quality framework and enhanced collaboration with other Clinical Commissioning Groups and the Commissioning Support Unit for North East London.

3.5 Haringey Clinical Commissioning Group – Sarah Timms
3.5.1 Haringey has a Quality Committee meeting monthly, which reports to the Haringey Governing Body.

3.5.2 The Safeguarding Strategy was formally adopted in October 2012 and all statutory safeguarding children posts are filled. Two independent hospitals and a nursing home are currently under review by the local authority and Haringey Clinical Commissioning Group in terms of safeguarding adults.

3.5.3 The complaints policy is currently under development. Key issues arising from complaints in 2012/13 are related to appointments/access at GP practices.

3.5.4 Provider quality
Key concerns for Haringey Clinical Commissioning Group include:
• Results of both the National patient experience and the Cancer patient experience surveys at North Middlesex University Hospital NHS Trust were poor. A Quality Summit was convened to review this and the outputs from that summit are being closely monitored through the clinical quality review meetings.
• North Middlesex University Hospital NHS Trust reported a Never Event in quarter 2, involving a retained vaginal pack following oophrectomy. This implementation of actions is being monitored.
• There are concerns over the performance of Whittington Health NHS Trust with regard to 4 hour A&E waits. The Trust has a revised action plan which is being overseen by NHS London and by NHS North Central London via the clinical quality review meetings.
• The target for new birth visits by Whittington Health is unlikely to be met for 2012/13. The Trust has been asked for an improvement plan.
• Whittington Health reported 35 serious incidents in quarter 2, which represents a 40% increase from quarter 1. 22 of these relate to pressure ulcers and the Trust have presented detailed analysis of these to the clinical quality review group and has set a reduction target of 70% for in patient pressure ulcers and 30% for community pressure ulcers.
• Barnet Enfield & Haringey NHS Trust serious incidents (as Barnet report)
3.5.5 The next steps for Haringey Clinical Commissioning Group include completion of a work programme to mitigate the risk of duplication and omission.

3.5.6 The Committee noted that the Clinical Commissioning Groups need to be alert to the changes in management at North Middlesex University Hospital Trust and take the opportunity to engage with senior management and ensure the clinical quality review meetings are robust with senior management and clinical engagement.

3.6 Islington Clinical Commissioning Group – Martin Machray

3.6.1 Islington has been operating in line with the Department of Health Guidance to take operational responsibility for quality since October 2012, with an established Quality and Safety Committee that reports to the Governing Body.

3.6.2 Provider quality

Key concerns for Islington include:

- Serious incidents at Moorfields Eye Hospital Foundation Trust, in particular three Never Events relating to the insertion of the wrong lens. An action plan is being monitored at the clinical quality review meetings.
- The challenges of establishing an integrated care organisation and Foundation Trust pipeline are being monitored closely at Whittington Health NHS Trust.
- Concerns re senior clinical and managerial commitment to the Clinical Quality Review processes at Camden & Islington NHS Foundation Trust were flagged as a concern by Islington Clinical Commissioning Group.
- Low levels of staff satisfaction at Camden & Islington NHS Foundation Trust and slow return of serious incident investigation reports are being closely monitored in collaboration with NHS North Central London Safety Team.
- A rise in Clostridium difficile rates at University College London Hospitals Foundation Trust; has led to an established action plan to address this with urgency.

3.6.3 Complaints are monitored by the Clinical Commissioning Group and the key issues for Islington are access to GP appointments with a smaller number of complaints relating to quality of care received. Health care received in prisons remains a key focus for Islington, and is part of the planned handover to the NHS Commissioning Board.

3.6.4 Safeguarding

Islington is represented at the Safeguarding Adult Partnership Board. It was noted that there had been a significant increase in safeguarding alerts over the past two years. This is thought to be attributable to improved communications and reporting.

An Ofsted/CQC thematic inspection of joint working between children’s and adults services in Islington where there are parental mental health or substance misuse issues was recently undertaken, which went well. A joint action plan has been developed from the feedback and will be overseen by Islington Child Safeguarding Board.

A Learning Disability Self Assessment Framework has been submitted to NHS London, which was accepted as a strong overall submission. Islington retained an amber rating overall with work to do on Health Action planning and monitoring of Mental Capacity Act activity.

3.7 Overall assurance of Clinical Commissioning Group readiness

The reports from the Clinical Commissioning Groups demonstrate that they are addressing quality monitoring in a robust and innovative manner. The Committee asked all of the
Clinical Commissioning Groups to consider how they will be engaging other primary care providers with the quality agenda and also asked each Clinical Commissioning Group to provide assurance as to how they will work collaboratively with other Clinical Commissioning Groups and the Commissioning Support Unit, to ensure the benefits of the cluster-wide view of quality are not lost during transition and beyond.

The Clinical Commissioning Groups highlighted their shared view that duplication was safer than omission at this time, and the Committee fully endorses that view.

4. Performance matters

Issues discussed included:

- The Liverpool Care Pathway has attracted media attention in recent weeks in relation to consent, communication with patients and relatives/carers and documentation. Use of the Liverpool Care Pathway has been reviewed at all clinical quality review meetings with providers to ensure appropriate implementation, with particular focus on involvement of patients and their families.
- The PALS function will move over to Healthwatch in April 2013. The local Healthwatch organisations are at different stages of development, which poses a risk in terms of the handover of the signposting function from PALS. Local leads have met with NHS North Central London PALS and Complaints Team to outline key areas of work.
- All acute trusts are required to implement the Friends and Family Test by April 2013. The implementation of this test is being monitored at Clinical Quality Review meetings with each Trust; all acute Trusts are reporting a confidence in readiness at 1 April 2013.
- Each of the five boroughs have submitted a learning disabilities self assessment framework and validation with NHS London has been completed, awaiting results January 2013.
- There were four Never Events reported by North Central London Trusts in Quarter 2. These included two at Barnet & Chase Farm Hospitals NHS Trust (wrong gas administration and inappropriate administration of methotrexate), one at North Middlesex University Hospital NHS Trust (retained foreign object post operation) and one at University College London Hospital Foundation Trust (retained foreign object post operation). Investigation reports and action plans are being monitored through the clinical quality review meetings.
- Individual Funding Requests (106) have been received between April 2011 and November 2012. 22% of these requests have been approved, 33% declined, 14% are awaiting further information from the applicant and 31% are being prepared for presentation to the panel. It was noted that these figures show some improvement. The Committee expressed concern that there is continued evidence of a lack of speed with responses from public health especially in Barnet and Enfield. The Committee also noted that there had been a serious incident related to the individual funding process and asked for assurance of how the learning will be incorporated into the process. Both of these issues have been communicated to the lead within the North East London Commissioning Support Unit and they are actively working with the public health teams to resolve these issues.
- The North East London Commissioning Support Unit will lead this process on behalf of Clinical Commissioning Groups from April 2013. As part of the transition the Commissioning Support Unit is reviewing the whole process and is developing a new operating model for the Individual Funding Request process that aims to improve both efficiency and consistency across North Central and East London.
5. Corporate matters
5.1 As part of transition to the National Commissioning Board, there has been an increase in the number of meetings to consider practitioner performance and management of the performers list and there is now a robust system in place including close scrutiny of all applications and supporting evidence. The Committee asked for further clarification to be provided about the role of the Clinical Commissioning Group in relation to performance and quality of service of primary care practitioners. The performance roles of the NHS National Commissioning Board and Clinical Commissioning Groups will be raised at the weekly receiver handover meetings with the NHS National Commissioning Board, London.

5.2 The Committee discussed and commented on a draft Annual Report of the Primary Care Trusts on Equality and Diversity, which must be published on the NHS North Central London web site by 31 January 2012.

5.3 Legacy, Handover and Closure
Legacy, handover and closure remains a priority programme for sending organisations e.g. Primary Care Trusts/Strategic Health Authorities. Progress with the transition of Quality and Safety is rated as green in the highlight report.

A Quality and Safety workshop is being held for Barnet and Enfield Clinical Commissioning Groups in January 2013.

Handover documents have now been prepared for all functions relating to quality and safety and quality risk profiles have been developed for each commissioned Trust. These will be shared with receiving organisations in January 2013, following feedback from NHS London.

6. Conclusion
The Committee will continue to provide oversight of Quality and Safety during the transition period to ensure that patient safety continues to be given a high priority.

The Committee will continue to support the Clinical Commissioning Groups to take the lead for Quality and Safety and will receive reports from Barnet, Camden, Enfield, Haringey and Islington at the next meeting in February 2013, which may well be the final meeting of the Committee.
The allegations of abuse involving Jimmy Savile as reported in the media, are appalling allegations and deeply disturbing. The recent publication of the Metropolitan Police report on 11 January 2013, has confirmed the scale and nature of the incidents described which are deeply distressing for all of those involved.

The Secretary of State has appointed Kate Lampard, a barrister and Vice Chair of NHS South of England, to provide assurance that the Department and the relevant NHS organisations are following a robust process aimed at protecting the interest of patients. She will also look, as part of that work, at NHS wide procedures, in the light of the findings of the reviews, to see whether they need tightening. When this work has concluded sharing of will occur of any learning relevant for the wider system across the service as a whole.

In the meantime, Trusts have been asked to take the opportunity to review their Board arrangements and practices relating to vulnerable people, particularly in relation to: safeguarding; access to patients (including that afforded volunteers or celebrities); and listening to and acting on patient concerns.

NHS North Central London in partnership with Barnet, Camden, Enfield, Islington and Haringey Clinical Commissioning Groups has sought assurance from each of the NCL Trusts in terms of their review of both policy and process.

NHS North Central London Quality & Safety directorate has received written assurance from each of our Trusts. These are being quality assured and areas of best practice will be shared with each of the Trusts by 1 February 2013. NHS North Central London and the CCG quality leads will use the existing Clinical Quality Review group meetings with each of the Trusts to review and monitor action plans through to implementation.

SUPPORTING PAPERS:
David Nicholson letter Gateway 18350 (Appendix 1)

RECOMMENDED ACTION:
The Joint Boards are asked to:
• NOTE and comment on the content of the report
• APPROVE the actions relating to oversight by commissioners of the Trusts action plans

LINKS TO NHS NORTH CENTRAL LONDON STRATEGY

NHS North Central London has set as one of its principal objectives to ensure we commission services which are safe and of increasing quality for the people we serve.

GOVERNANCE:

Voting: Please indicate which Board(s) has voting rights on this matter (if applicable)

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Audit Trail: This paper has not been received by any other committee

Patient & Public Involvement (PPI): NA

Equality Impact Assessment: NA

Risks: The content of this paper has not been risk rated.

Resource Implications: There is no resource implications associated with this paper.

Next Steps:

- The quality and safety directorate in partnership with CCG quality leads will complete a quality assurance check of the written responses submitted by all our Trusts
- Good practice will be shared with each of our Trusts by 1 February 2013
- A detailed report on the quality assurance of the Trust responses will be completed and shared with the CCGs and tabled at the Quality and Safety Committee 21 February 2013
- Identification of other organisations where we should be seeking assurance.
1. INTRODUCTION

The allegations of abuse involving Jimmy Savile as reported in the media, and the recent publication of the Metropolitan Police report on 11 January 2013, have confirmed the scale and nature of the incidents described which are deeply distressing for all of those involved.

The Secretary of State has appointed Kate Lampard, a barrister and Vice Chair of NHS South of England, to provide assurance that the Department and the relevant NHS organisations are following a robust process aimed at protecting the interest of patients. She will also look, as part of that work, at NHS wide procedures, in the light of the findings of the reviews, to see whether they need tightening. When this work has concluded sharing of will occur of any learning relevant for the wider system across the service as a whole.

Sir David Nicholson, NHS Chief Executive has written to all Trusts to confirm these arrangements (in detail practices relating to vulnerable people particularly in relation to safeguarding, access to patients including that afforded to celebrities or volunteers, and listening and acting on patient concerns). NHS North Central London in partnership with Barnet, Camden, Enfield, Islington and Haringey Clinical Commissioning Groups followed up the Sir David Nicholson request with a letter that sought written assurances from each of the North Central London Trusts.

2. PROGRESS TO DATE

NHS North Central London has received written assurance from each of our large commissioned health services following their review of practices relating to vulnerable people particularly in relation to safeguarding, access to patients including that afforded to celebrities or volunteers, and listening and acting on patient concerns.

The North Central London Trusts which have provided their assurance are:

1. Barnet and Chase Farm Hospital NHS Trust
2. Whittington Health NHS Trust (Includes Haringey and Islington Community Health Services)
3. North Middlesex University Hospital NHS Trust
4. University College London NHS Foundation Trust
5. Royal Free London NHS Foundation Trust
6. Barnet, Enfield and Haringey NHS Mental Health Trust (Includes Enfield Community Health Services)
7. Camden and Islington NHS Foundation Trust
8. Tavistock and Portman NHS Foundation Trust
9. Royal National Orthopaedic Hospital NHS Trust
10. Moorfields Eye Hospital NHS Foundation Trust
11. Great Ormond Street Hospital for Children NHS Foundation Trust
12. Central & North West London NHS Foundation Trust (Camden Community Services)
13. Central London Community Health NHS Trust (Barnet Community Services)
4 Next Steps

NHS North Central London, Quality & Safety directorate and the CCGs are quality assuring the responses from each of the 13 Trusts, and the outcome will be shared with the Trusts by 1 February 2013. The quality assurance outcome will be formally tabled at the Quality and Safety Committee 21 February 2013.

NHS North Central London and the CCG quality leads will use the existing Clinical Quality Review group meetings established with each of the Trusts to ensure that the action plans are closely monitored through to implementation.

NHS North Central London and CCGs have considered whether other providers of health services should be asked for the same level of assurance, and as a result our two out of hours providers Barndoc and Harmoni have been sent a letter requesting assurances. Once received their responses will be subject to the same quality assurance process and monitoring as the 13 Trusts.

5. CONCLUSION

All 13 Trusts have provided written assurance that they have carried out a review based on the three areas outlined in the Sir David Nicholson letter.

- Practices relating to vulnerable people particularly in relation to safeguarding
- Access to patients including that afforded to celebrities or volunteers
- Listening and acting on patient concerns

The quality assurance process being carried out by NHS North Central London in partnership with the CCGs will ensure that we share any areas of good practice with the Trusts, and that we take our commissioning responsibilities and safety of patients very seriously.
Date: 12 November 2012

To:
All Chairs and Chief Executives of NHS Trusts in England
All Chairs and Chief Executives of NHS Foundation Trusts in England

Cc:
Monitor
All Chairs and Chief Executives of Primary Care Trusts in England
All Chairs and Chief Executives of Strategic Healthcare Authorities in England
All Chief Executives of Local Authorities in England

Gateway reference: 18350

Dear Colleague

**Savile Allegations**

You will all have seen the recent media coverage of the allegations of abuse involving Jimmy Savile. These are appalling allegations and it is deeply disturbing to think that abuses of this nature may have occurred in NHS organisations.

The three NHS organisations about whom allegations of abuse have been made – Stoke Mandeville Hospital, Leeds General Infirmary and West London Mental Health Trust – are working closely with the police and Local Safeguarding Boards, undertaking reviews to ascertain what happened and whether there are any lessons to learn. In addition the Department of Health is holding a review into Savile’s role at Broadmoor Hospital for the period it was responsible for its management.

The Secretary of State has appointed Kate Lampard, a barrister and Vice Chair of NHS South of England, to provide assurance that the Department and the relevant NHS organisations are following a robust process aimed at protecting the interest of patients. She will also look, as part of that work, at NHS wide procedures, in the light of the findings of the reviews, to see whether they need tightening. When this work has concluded we will share any learning relevant for the wider system across the service as a whole.
However, in the meantime, I would ask that you take the opportunity to review, with your Boards, and working as necessary with local agencies, your own arrangements and practices relating to vulnerable people, particularly in relation to: safeguarding; access to patients (including that afforded volunteers or celebrities); and listening to and acting on patient concerns. I have discussed and agreed this approach with David Bennett, Chief Executive of Monitor.

While the nature of protection for children and young people in the NHS is far in advance of what it was in the 1970s and 1980s, we must be absolutely sure that all our existing NHS procedures are robust.

Thank you in advance for actively considering and reviewing your position on this important issue.

Kind regards

Sir David Nicholson KCB CBE
NHS Chief Executive
Meeting of the Joint Boards of NHS North Central London

Thursday, 31 January 2013

Month 8 and 9 Finance Report

Bev Evans, Director of Finance

Alex Stiles, Deputy Director of Finance

Alex.Stiles@nclondon.nhs.uk

This paper presents the financial position for month 8 and 9.

None.

The Joint Boards are asked to:

• NOTE the financial position for month 8 and 9.

The Joint Boards are asked to:

NHS North Central London has submitted financial plans for 2012/13 to the Department of Health, setting out an expectation of meeting a control total surplus of £31.2m, as set out in the March 2012 Joint Boards paper regarding the 2012/13 budget. This paper addresses the need for financial reporting and control in respect of this target.
**Audit Trail:** The M8 and M9 financial position was discussed at the Financial Recovery and QIPP Committee on 21 December 2012 and 20 January 2013 respectively.

**Patient & Public Involvement (PPI):** There has been no PPI for this paper.

**Equality Impact Assessment:** No Equality Impact Assessment is planned or has been undertaken for the finance report itself, though individual QIPP schemes undergo the assessment.

**Risks:** The paper includes a financial risk assessment. There are no other material risks associated with this paper.

**Resource Implications:** There are no direct resource implications for this paper, as it is not a project proposal for additional internal resourcing, nor is it assuming additional external resourcing. The potential resource implications to deliver turnaround require consideration.

**Next Steps:** The Finance Report will be reported on a monthly basis to the Financial Recovery and QIPP Committee and the Joint Boards.
1. EXECUTIVE SUMMARY

1.1 NHS North Central London has set a financial plan for 2012/13 which aims to achieve a surplus of £31.2m across the Cluster and is on track. At month 9:

- Barnet, Enfield and Haringey are each overspent year to date by £0.3m, £0.5m and £3.6m respectively.

- Camden and Islington are both under spent against plan by £2.4m and £5.5m respectively.

- The in month, year to date and forecast outturn position at month 9 improved considerably from the previous month following confirmation from the SHA of return of the full 2% non-recurrent funding and confirmation that the PCT’s will not be ‘top-sliced’ for the 70% non-elective cap.

- The key drivers of this position are acute overspends (all PCTs except Islington) which is largely accounted for by unidentified QIPP (Barnet, Enfield and Haringey).

- Risk share arrangements are in place to enable each PCT to meet their respective control totals this year. Focus on addressing the underlying run rate position within Barnet, Enfield and Haringey to a sustainable position and successful identification, implementation and delivery of QIPP savings remains a key priority. For Camden and Islington, the focus is on ensuring effective investment plans are implemented.

- As part of the overall cluster strategy for 2012/13, investment in primary care transformation through the Primary Care Strategy is a key focus and considerable progress on effective delivery has been made in the last couple of months for all 5 PCTs.

1.2 The table on the following page shows the year to date position at month 8 and month 9 and detail the key movements in the forecast outturn position from month 7 to month 8 and month 8 to month 9.
### Month 8 Position

<table>
<thead>
<tr>
<th></th>
<th>Control Total £k</th>
<th>Actual £k</th>
<th>Variance £k</th>
<th>Rating</th>
<th>Month</th>
<th>Control Total £k</th>
<th>Actual £k</th>
<th>Variance £k</th>
<th>Rating</th>
<th>Forecast Variance Rating</th>
<th>Change in Forecast</th>
<th>Previous Month</th>
<th>Change</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barnet</td>
<td>0</td>
<td>(199)</td>
<td>(199)</td>
<td>RED</td>
<td>0</td>
<td>(512)</td>
<td>(512)</td>
<td>RED</td>
<td></td>
<td>(3,705)</td>
<td>(3,705)</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Enfield</td>
<td>(0)</td>
<td>(495)</td>
<td>(494)</td>
<td>RED</td>
<td>0</td>
<td>(1,893)</td>
<td>(1,893)</td>
<td>RED</td>
<td></td>
<td>(0)</td>
<td>(5,038)</td>
<td>25</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Haringey</td>
<td>42</td>
<td>(978)</td>
<td>(1,020)</td>
<td>RED</td>
<td>333</td>
<td>(4,007)</td>
<td>(4,340)</td>
<td>RED</td>
<td></td>
<td>(0)</td>
<td>(6,099)</td>
<td>25</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Camden</td>
<td>1,799</td>
<td>1,961</td>
<td>162</td>
<td>GREEN</td>
<td>14,396</td>
<td>15,344</td>
<td>948</td>
<td>RED</td>
<td></td>
<td>21,594</td>
<td>17,154</td>
<td>25</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Islington</td>
<td>757</td>
<td>330</td>
<td>(426)</td>
<td>RED</td>
<td>6,057</td>
<td>11,610</td>
<td>5,553</td>
<td>RED</td>
<td></td>
<td>9,085</td>
<td>9,068</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>Total Cluster</strong></td>
<td>2,598</td>
<td>619</td>
<td>(1,978)</td>
<td>RED</td>
<td>20,785</td>
<td>20,542</td>
<td>(244)</td>
<td>RED</td>
<td></td>
<td>31,180</td>
<td>11,247</td>
<td>25</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

### Movement from Month 7 to Month 8

<table>
<thead>
<tr>
<th></th>
<th>In Month Variance £k</th>
<th>YTD Variance £k</th>
<th>Forecast Variance £k</th>
<th>Variance %</th>
<th>Rating</th>
<th>Forecast Variance Prior Month £k</th>
<th>Forecast Change £k</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>(4,630)</td>
<td>(16,355)</td>
<td>(23,486)</td>
<td>(1.8)%</td>
<td>RED</td>
<td>(22,251)</td>
<td>(1,235)</td>
<td>Acute in-sector performance accounts for the majority of the worsening position</td>
</tr>
<tr>
<td>Non Acute</td>
<td>2,038</td>
<td>4,989</td>
<td>20,432</td>
<td>3.4%</td>
<td>GREEN</td>
<td>13,202</td>
<td>7,230</td>
<td>Majority relates to forecast spend on Camden’s investment plan (£5m) and prescribing (£1m) the remainder is across various non acute areas relates to a reduction in forecast spend on Camden’s investment plan. £1m improved performance on prescribing</td>
</tr>
<tr>
<td>NCB</td>
<td>371</td>
<td>(1,578)</td>
<td>(4,233)</td>
<td>(0.9)%</td>
<td>AMBER</td>
<td>(5,142)</td>
<td>909</td>
<td>Majority relates to improvement on specialist commissioning relating to SCBU which is not subject to a risk share arrangement</td>
</tr>
<tr>
<td>Public Health</td>
<td>(53)</td>
<td>567</td>
<td>332</td>
<td>1.1%</td>
<td>GREEN</td>
<td>83</td>
<td>249</td>
<td></td>
</tr>
<tr>
<td>Operating Costs</td>
<td>(47)</td>
<td>8,640</td>
<td>8,084</td>
<td>7.7%</td>
<td>GREEN</td>
<td>7,307</td>
<td>777</td>
<td>Anticipated savings on borough, PH and commissioning support costs</td>
</tr>
<tr>
<td>Reserves &amp; Contingency</td>
<td>343</td>
<td>3,494</td>
<td>10,118</td>
<td>32.9%</td>
<td>GREEN</td>
<td>9,118</td>
<td>1,000</td>
<td>Reduction in expenditure against reserves</td>
</tr>
<tr>
<td><strong>Surplus/(Deficit)</strong></td>
<td>(1,978)</td>
<td>(243)</td>
<td>11,247</td>
<td>0.4%</td>
<td>RED</td>
<td>2,317</td>
<td>8,930</td>
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### Month 8 Position

<table>
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<tr>
<th>Control</th>
<th>Month</th>
<th>Actual</th>
<th>Variance</th>
<th>Rating</th>
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<th>Control</th>
<th>Forecast</th>
<th>Variance</th>
<th>Rating</th>
<th>Control</th>
<th>Forecast</th>
<th>Variance</th>
<th>Rating</th>
<th>Change in Forecast</th>
</tr>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Barnet</td>
<td>(0)</td>
<td>219</td>
<td>219</td>
<td>GREEN</td>
<td>0</td>
<td>(293)</td>
<td>(293)</td>
<td>RED</td>
<td>0</td>
<td>(2,500)</td>
<td>(2,500)</td>
<td>RED</td>
<td>0</td>
<td>(2,500)</td>
<td>(2,500)</td>
<td>RED</td>
</tr>
<tr>
<td>Enfield</td>
<td>0</td>
<td>1,336</td>
<td>1,336</td>
<td>GREEN</td>
<td>0</td>
<td>(556)</td>
<td>(557)</td>
<td>RED</td>
<td>(0)</td>
<td>(3,466)</td>
<td>(3,466)</td>
<td>RED</td>
<td>(0)</td>
<td>(3,466)</td>
<td>(3,466)</td>
<td>RED</td>
</tr>
<tr>
<td>Haringey</td>
<td>43</td>
<td>734</td>
<td>691</td>
<td>GREEN</td>
<td>375</td>
<td>(3,273)</td>
<td>(3,648)</td>
<td>RED</td>
<td>500</td>
<td>(4,301)</td>
<td>(4,801)</td>
<td>RED</td>
<td>500</td>
<td>(4,301)</td>
<td>(4,801)</td>
<td>RED</td>
</tr>
<tr>
<td>Camden</td>
<td>1,799</td>
<td>3,293</td>
<td>1,494</td>
<td>RED</td>
<td>16,195</td>
<td>18,637</td>
<td>2,443</td>
<td>RED</td>
<td>21,594</td>
<td>38,952</td>
<td>17,358</td>
<td>RED</td>
<td>21,594</td>
<td>38,952</td>
<td>17,358</td>
<td>RED</td>
</tr>
<tr>
<td>Islington</td>
<td>757</td>
<td>715</td>
<td>(42)</td>
<td>RED</td>
<td>6,814</td>
<td>12,325</td>
<td>5,511</td>
<td>RED</td>
<td>9,085</td>
<td>18,753</td>
<td>9,668</td>
<td>RED</td>
<td>9,085</td>
<td>18,753</td>
<td>9,668</td>
<td>RED</td>
</tr>
<tr>
<td>Total Cluster</td>
<td>2,599</td>
<td>6,298</td>
<td>3,700</td>
<td>RED</td>
<td>23,384</td>
<td>26,840</td>
<td>3,456</td>
<td>RED</td>
<td>31,180</td>
<td>47,438</td>
<td>16,259</td>
<td>RED</td>
<td>31,180</td>
<td>47,438</td>
<td>16,259</td>
<td>RED</td>
</tr>
</tbody>
</table>

### Movement from Month 8 to Month 9

<table>
<thead>
<tr>
<th>In Month</th>
<th>YTD</th>
<th>Forecast</th>
<th>Variance</th>
<th>Rating</th>
<th>Forecast</th>
<th>Variance</th>
<th>Rating</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>In Month</td>
<td>£k</td>
<td>Var</td>
<td>£k</td>
<td>%</td>
<td>£k</td>
<td>Var</td>
<td>£k</td>
<td></td>
</tr>
<tr>
<td>Acute</td>
<td>2,081</td>
<td>(14,274)</td>
<td>(18,683)</td>
<td>(1.4)%</td>
<td>RED</td>
<td>(23,486)</td>
<td>4,803</td>
<td></td>
</tr>
<tr>
<td>Non Acute</td>
<td>1,918</td>
<td>6,907</td>
<td>22,890</td>
<td>3.8%</td>
<td>GREEN</td>
<td>20,432</td>
<td>2,458</td>
<td></td>
</tr>
<tr>
<td>NCB</td>
<td>(1,312)</td>
<td>(2,891)</td>
<td>(4,890)</td>
<td>(1.1)%</td>
<td>RED</td>
<td>(4,233)</td>
<td>(657)</td>
<td></td>
</tr>
<tr>
<td>Public Health</td>
<td>104</td>
<td>670</td>
<td>548</td>
<td>1.8%</td>
<td>GREEN</td>
<td>332</td>
<td>216</td>
<td></td>
</tr>
<tr>
<td>Operating Costs</td>
<td>1,961</td>
<td>10,601</td>
<td>7,643</td>
<td>6.8%</td>
<td>GREEN</td>
<td>8,084</td>
<td>(441)</td>
<td></td>
</tr>
<tr>
<td>Reserves &amp; Contingency</td>
<td>(1,051)</td>
<td>2,443</td>
<td>8,751</td>
<td>18.1%</td>
<td>GREEN</td>
<td>10,118</td>
<td>(1,367)</td>
<td></td>
</tr>
<tr>
<td>Surplus/(Deficit)</td>
<td>3,700</td>
<td>3,457</td>
<td>16,259</td>
<td>0.6%</td>
<td>RED</td>
<td>11,247</td>
<td>5,012</td>
<td></td>
</tr>
</tbody>
</table>

The change in FOT is largely as a result of confirmation that the 70% non-elective top-slice will be retained by the PCTs.
Increase under-spend on Islington’s investment reserves (£1m), reduction on Community services (£0.6m) and Prescribing (£0.5m) account for the changes in FOT on non-acute.
Majority relates to improvement on specialist commissioning relating to SCBU which is not subject to a risk share arrangement.
Change in FOT relating to capital charges.
Anticipated additional costs relating to Barnet.
1.3 The position by borough as at month 9 is detailed below;

**NHS Barnet**

<table>
<thead>
<tr>
<th>Service</th>
<th>In Month Variance</th>
<th>YTD Variance</th>
<th>Forecast Variance</th>
<th>Variance</th>
<th>Rating</th>
<th>Forecast Variance Prior Month</th>
<th>Forecast Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>£1,024</td>
<td>£(3,241)</td>
<td>£(4,830)</td>
<td>1.5%</td>
<td>RED</td>
<td>£(6,047)</td>
<td>1,217</td>
</tr>
<tr>
<td>Non Acute</td>
<td>£1,024</td>
<td>£1,146</td>
<td>£1,305</td>
<td>0.8%</td>
<td>GREEN</td>
<td>£(336)</td>
<td>1,641</td>
</tr>
<tr>
<td>NCB</td>
<td>£(349)</td>
<td>£999</td>
<td>£(1,252)</td>
<td>1.3%</td>
<td>RED</td>
<td>£(874)</td>
<td>£(378)</td>
</tr>
<tr>
<td>Public Health</td>
<td>£(38)</td>
<td>£(34)</td>
<td>£(95)</td>
<td>4.1%</td>
<td>RED</td>
<td>0</td>
<td>£(95)</td>
</tr>
<tr>
<td>Operating Costs</td>
<td>£(285)</td>
<td>£2,104</td>
<td>£906</td>
<td>4.9%</td>
<td>GREEN</td>
<td>719</td>
<td>187</td>
</tr>
<tr>
<td>Reserves &amp; Contingency</td>
<td>£(1,157)</td>
<td>£732</td>
<td>£1,466</td>
<td>8.7%</td>
<td>GREEN</td>
<td>£2,833</td>
<td>(1,367)</td>
</tr>
<tr>
<td>Surplus/(Deficit)</td>
<td>£219</td>
<td>£(292)</td>
<td>£(2,500)</td>
<td>0.4%</td>
<td>AMBER</td>
<td>£(3,705)</td>
<td>1,205</td>
</tr>
</tbody>
</table>

Barnet has set a financial plan for 2012/13 which aims to achieve a breakeven position. At month 9:

Barnet’s position improved by £0.2m reducing the year to date (YTD) overspend to £0.3m. The forecast outturn before mitigating actions is a deficit of £2.5m.

In line with the risk share agreement between all 5 PCTs, the forecast outturn for NHS Barnet will breakeven in line with control total and plan.

**The key drivers of the position are:**

**Acute** – In month the position improved by £1m as a result of confirmation from the SHA that the PCT will not be top-sliced for the 70% non-elective cap. This offset in-month overspends relating to contracts with BCF, Royal Free and UCLH.

**Non-Acute** – the position improved in month by £1m, due to underspends on older people, learning difficulties, continuing care and community services.

**NCB** – In month the position has worsened due to additional costs relating to specialised commissioning due to increase in SCBU activity. This is also causing part of the YTD over-spend. The other areas of overspend YTD are Pharmacy costs, ophthalmic and dental spend.

**The forecast outturn has improved by £1.2m this month the key movements are:**

**Acute** – The forecast outturn has improved as a result of the adjustment for the 70% non-elective cap.

**Non Acute** – The key improvements in the forecast outturn relate to older people, community services and prescribing.
**NHS Enfield**

Enfield has set a financial plan for 2012/13 which aims to achieve a breakeven position. At month 9:

Enfield's position improved by £1.3m reducing the YTD overspend to £0.6m. The forecast outturn before mitigating actions is a deficit of £3.5m.

In line with the risk share agreement between all 5 PCTs, the forecast outturn for NHS Enfield will breakeven in line with control total and plan.

**The key drivers of the position are:**
Acute – In month the position improved by £1m as a result of confirmation from the SHA that the PCT will not be top-sliced for the 70% non-elective cap. This offset in-month overspends relating to contracts with BCF, Royal Free and UCLH.

Unidentified QIPP – this is also part of the cause of the acute overspends.

**The forecast outturn position has improved by £1.6m in month, the key factors are:**
Acute – The majority of the movement relates to the adjustment for the 70% non-elective cap.

Non Acute – Improved forecast outturn on prescribing and learning disabilities.
Operating Costs – anticipated increased running costs.
Haringey has set a financial plan for 2012/13 which aims to achieve a £500k surplus. In line with the risk share agreement between all 5 PCTs, the forecast control total surplus will be delivered.

At month 9:

Haringey’s position improved by £0.6m reducing the YTD overspend to £3.6m. The forecast outturn before mitigating actions is a deficit of £4.8m.

The key drivers of the position are:
Acute – In month the position improved by £0.6m as a result of confirmation from the SHA that the PCT will not be top-sliced for the 70% non-elective cap. Year to date UCLH is driving the majority of the acute over-performance, a significant proportion of which relates to QIPP gap.

The forecast outturn position has improved by £1.4m from last month, the key factor is:
Acute – The movement relates to the adjustment for the 70% non-elective cap.

Camden has set a financial plan for 2012/13 which aims to achieve a £21.6m surplus. At month 9:
Camden’s position improved by £1.5m and the year to date surplus has increased to £2.4m above the planned year to date surplus of £16.2m. The forecast outturn is a surplus of £17.2m against the planned surplus. In line with the risk share agreement in place, the forecast control total of £21.6m will be delivered.

The key drivers of the position are:
Acute overspends – In month the adjustment for the top slice for the 70% non-elective cap was offset by acute over-performance predominately at UCLH. Year to date UCLH and Royal Free is driving the majority of the acute over-performance.

Non Acute under spends – The year to date under-spend relates to slippage on new investments in services.

Operating costs – The in month and year to date under spend is primarily due to under spend on public health where largely as a result of expenditure having been budgeted twice, both within public health and acute/non acute areas.

The forecast for Camden remains in line with last month the key changes are:
Acute – improved forecast outturn due to adjustment for non-elective cap.

Public Health – reduced forecast expenditure on sexual health budgets.

Operating Costs – increased forecast spend on capital charges and estates.

NHS Islington

<table>
<thead>
<tr>
<th>In Month Variance £k</th>
<th>YTD Variance £k</th>
<th>Forecast Variance £k</th>
<th>Variance %</th>
<th>Rating</th>
<th>Forecast Variance Prior Month £k</th>
<th>Forecast Change £k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>94</td>
<td>517</td>
<td>1,194</td>
<td>0.5%</td>
<td>GREEN</td>
<td>1,276</td>
</tr>
<tr>
<td>Non Acute</td>
<td>(70)</td>
<td>1,266</td>
<td>3,739</td>
<td>3.5%</td>
<td>GREEN</td>
<td>3,059</td>
</tr>
<tr>
<td>NCB</td>
<td>(428)</td>
<td>(51)</td>
<td>(244)</td>
<td>(0.3)%</td>
<td>AMBER</td>
<td>362</td>
</tr>
<tr>
<td>Public Health</td>
<td>11</td>
<td>58</td>
<td>85</td>
<td>0.9%</td>
<td>GREEN</td>
<td>85</td>
</tr>
<tr>
<td>Operating Costs</td>
<td>166</td>
<td>2,044</td>
<td>2,658</td>
<td>8.5%</td>
<td>GREEN</td>
<td>2,050</td>
</tr>
<tr>
<td>Reserves &amp; Contingency</td>
<td>186</td>
<td>1,677</td>
<td>2,236</td>
<td>24.0%</td>
<td>GREEN</td>
<td>2,236</td>
</tr>
</tbody>
</table>

| Surplus/(Deficit)    | (42)           | 5,511                | 9,668      | 0.0%   | RED                             | 9,068             | 600               |

Islington has set a financial plan for 2012/13 which aims to achieve a £9.1m surplus. At month 9:

Islington’s position is a year to date surplus of £5.6m against plan. The forecast outturn is a surplus of £9.1m against plan.

The key drivers of the position are:
NHS Commissioning Board – The in-month over-spend relates to Specialist Commissioning and medical budgets.

The forecast outturn has improved from month 6, the key changes are:
Non Acute – reduction in the forecast expenditure against investment reserves.
NHS Commissioning Board – Increase in the forecast outturn on primary care medical and Specialist Commissioning relating to SCBU.

Operating Costs – anticipated reduction in costs on capital charges.

2. RISKS AND OPPORTUNITIES

2.1 The table on the following page sets out the risks and opportunities for NHS North Central London starting with the forecast detailed above. The risk assessment shows that Barnet, Enfield and Haringey have net risks to the achievement of their plans, while Camden and Islington have net opportunities and are at risk of exceeding their control totals. As described in section 1, a risk share arrangement is in place to mitigate the position for 2012/13.

<table>
<thead>
<tr>
<th></th>
<th>Net Risk Assessment</th>
<th>Barnet</th>
<th>Enfield</th>
<th>Haringey</th>
<th>Camden</th>
<th>Islington</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forecast Outturn before Risks &amp; Opps</td>
<td>16.2</td>
<td>(2.5)</td>
<td>(3.6)</td>
<td>(4.7)</td>
<td>17.3</td>
<td>9.7</td>
</tr>
<tr>
<td>Additional QIPP Risk / Increase Costs</td>
<td>(23.0)</td>
<td>(10.1)</td>
<td>(3.9)</td>
<td>(2.0)</td>
<td>0.0</td>
<td>(7.0)</td>
</tr>
<tr>
<td>Total Risks</td>
<td>(6.8)</td>
<td>(12.6)</td>
<td>(7.5)</td>
<td>(6.7)</td>
<td>17.3</td>
<td>2.7</td>
</tr>
<tr>
<td>Opportunities in Development</td>
<td>8.5</td>
<td>3.4</td>
<td>1.3</td>
<td>0.8</td>
<td>0.0</td>
<td>3.0</td>
</tr>
<tr>
<td>Further Slippage in Investment Plans</td>
<td>7.0</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
<td>3.0</td>
<td>4.0</td>
</tr>
<tr>
<td>Total Opportunities</td>
<td>15.5</td>
<td>3.4</td>
<td>1.3</td>
<td>0.8</td>
<td>3.0</td>
<td>7.0</td>
</tr>
<tr>
<td>Net (risk) / Opportunities</td>
<td>8.7</td>
<td>(9.2)</td>
<td>(6.2)</td>
<td>(5.9)</td>
<td>20.3</td>
<td>9.7</td>
</tr>
</tbody>
</table>

Access to Prior Year Surplus     | 14.4                |

Net (risk) / Opportunities       | 23.1                |

Net (risk) / Opportunities (Current Month) | 8.7 | (9.2) | (6.2) | (5.9) | 20.3 | 9.7 |

Net (risk) / Opportunities (Prior Month) | 0.2 | (10.4) | (8.3) | (7.4) | 17.2 | 9.1 |

Movement                       | 8.5 | 1.2 | 2.1 | 1.5 | 3.1 | 0.6 |

Closing the QIPP Gap – Schemes under consideration
2.2 In order to close the 2012/13 QIPP gap that is driving the acute over-performance and improve the underlying recurrent run rate as detailed in section 3 the following schemes are being developed and implemented.

- **Pain Management** – In Enfield Trusts have agreed a contract variation and a service delivery model. The expected start date is 1st April 2013. Barnet are also interested in the service and will be holding separate discussions with the relevant Trusts. In Haringey the chronic pain pathway is now in place and a communications programme is underway to raise awareness with GPs.

- **Comprehensive Falls System** – Task and finish groups are underway to design the service with links with Frail Elderly and Frailty Clinics in Barnet. Barnet expect to complete the business case by the end of January 2013. In Enfield work is ongoing looking at the wider falls service. Modelling work is being undertaken to look at the impact of the introduction of a comprehensive falls service with a workshop being held in January 2013 to agree how implementation will be taken forward. A workshop was held in Haringey and key milestones agreed to deliver a comprehensive falls strategy in 2013/14.

- **CCG Systematic Review** – Following the comprehensive benchmarking review a number of schemes have been identified and were taken to Barnet’s CCG Board in December. Five areas for further scoping were agreed (pneumococcal vaccinations, nursing homes, community services, cancer and RAID (mental health)). In Haringey, four priority areas for planned care redesign have been identified (Cardiology, Urology, Gastroenterology and Orthopaedics). In Enfield, a presentation of the key findings was made to the CCG Executive in December. Clinical and management leads will be agreed for each workstream and the proposed schemes have been added to the draft QIPP programme for 2013/14.

3. **UNDERLYING RECURRENT RUN RATE**

3.1 The underlying run rate takes into account non-recurrent elements included within the year to date position. The two material non recurrent elements are:

- 2% ‘top-slice’ of the revenue resource limit for non-recurrent expenditure. Barnet, Enfield and Haringey have set aside less than 2%, while Camden and Islington have set aside more than 2% to compensate.

- Barnet Enfield and Haringey have all received a share of non-recurrent funds that have been released to the in-year position in 2012/13.

3.2 The run rate position shows that overall NHS North Central London is still in a negative run rate but that the trend has continued in a positive direction with the spend reducing month on month. This is largely due to the investment plans within Camden and Islington not matching the planned levels of expenditure. However, the plan assumes that the run rate significantly improves in the second half of the year for Barnet, Enfield and Haringey as further QIPP schemes were expected to start. This position is being actively monitored with the CCGs to ensure mitigations are enacted as required.
4. **BALANCE SHEET KPIs**

4.1 As well as ensuring that NHS North Central London meets its income and expenditure control totals for each of the 5 PCTs, there are other targets that the organisation need to meet these are;

- **Cash Resource Limit** - Each PCT needs to ensure that the cash spent is within the limit set by the Department of Health.

- **Capital Resource Limit** - Each PCT needs to ensure that the capital investment programme is spent in line with the Capital Resource Limit.

- **Better Payments Practice Code (BPCC)** – All NHS organisations are required to pay 95% of their valid invoices by value and by volume within 30 days of receipt.

4.2 Key issues with achieving the KPI’s are raised below;

- **Cash Resource Limit** - NHS North Central London expects to meet the cash targets this year, however aged debt remains high. The position continues to improve with over-due debts reducing by £3.3m, after having adjusted for credit notes, in month 9. Temporary resource has been bought into the Finance team which has contributed to this improved position.
The table below shows the current position on overdue debtors.

<table>
<thead>
<tr>
<th>NCL Sector - overdue debtors</th>
<th>Not Due</th>
<th>0-30 days overdue</th>
<th>31-60 days overdue</th>
<th>60-90 days overdue</th>
<th>90+ days overdue</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£k</td>
<td>£k</td>
<td>£k</td>
<td>£k</td>
<td>£k</td>
<td>£k</td>
</tr>
<tr>
<td>NHS</td>
<td>35,001</td>
<td>456</td>
<td>77</td>
<td>68</td>
<td>19,325</td>
<td>54,927</td>
</tr>
<tr>
<td>Non NHS</td>
<td>7,203</td>
<td>124</td>
<td>146</td>
<td>72</td>
<td>5,393</td>
<td>12,938</td>
</tr>
<tr>
<td>Total Debtors</td>
<td>42,204</td>
<td>580</td>
<td>223</td>
<td>140</td>
<td>24,718</td>
<td>67,865</td>
</tr>
</tbody>
</table>

Meetings with the top ten NHS providers to address the overall debtors and creditors position are in train led by the Director of Finance and month 10 will show further reduction in the overall aged position. The position is being closely monitored by the Financial Recovery and QIPP Committee monthly and reported through to NHS London and is a key focus for the Legacy, Handover and Closedown work.

- **Capital Resource Limit** - The cluster has a capital programme totalling £48.6m, of which £31.1m has been incurred at month 9. A significant proportion of this (£28.4m) related to Finchley Memorial Hospital, which has been brought onto the balance sheet. Of the remaining £20.2m, only £2.7m has been incurred at month 9. There was a significant under spend on the capital programme in 2011/12. It is important that capital programmes progress quickly to ensure that the resources available are utilised effectively during 2012/13 and plans are being monitored closely with the respective leads to identify and remedy slippage as a priority.

The proposed key areas of spend are;

- Finchley Memorial Hospital (transfer to balance sheet and completion) £33.0m
- GP IT Projects £3.5m
- CCG/CSU Projects £1.7m
- Service Investment – Edgware £1.5m
- Enfield Community Services £1.1m
- Various Estate Projects £7.8m

- **BPCC** - All NHS Organisations are required to pay 95% of their valid invoices by value and by volume within the 30 days of receipt. Barnet, Enfield, Haringey and Islington PCTs are on target to achieve their BPCC in respect of value of NHS invoices, however are failing to meet their other targets. A number of actions have been taken to improve the flow and authorisation of invoices within workflow and communications have been made to all budget holders from the Director of Finance. The focus is now on clearing as many invoices as possible ahead of the 31 March 2013 deadline for closedown. As older invoices are cleared this will adversely impact the BPCC if not disputed.
5. CONCLUSION

4.1 The Joint Boards are asked to:

- NOTE the month 8 and month 9 position of the 5 PCTs.

<table>
<thead>
<tr>
<th>NCL Sector - BPPC Cumulative M1 to M9</th>
<th>Number</th>
<th>£000s</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-NHS Payables</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Non-NHS Trade Invoices Paid in the Month</td>
<td>47,968</td>
<td>164,901</td>
</tr>
<tr>
<td>Total Non-NHS Trade Invoices Paid Within Target</td>
<td>28,071</td>
<td>94,787</td>
</tr>
<tr>
<td>Percentage of Non-NHS Trade Invoices Paid Within Target</td>
<td>58.52%</td>
<td>57.48%</td>
</tr>
<tr>
<td><strong>NHS Payables</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total NHS Trade Invoices Paid in the Month</td>
<td>13,946</td>
<td>1,366,950</td>
</tr>
<tr>
<td>Total NHS Trade Invoices Paid Within Target</td>
<td>5,764</td>
<td>1,311,396</td>
</tr>
<tr>
<td>Percentage of NHS Trade Invoices Paid Within Target</td>
<td>41.33%</td>
<td>95.94%</td>
</tr>
</tbody>
</table>
**MEETING:** Meeting of the Joint Boards of NHS North Central London  
**DATE:** Thursday, 31 January 2013  
**TITLE:** Financial Recovery & Quality, Innovation, Productivity and Prevention (QIPP) Committee Report Part 1  
**LEAD DIRECTOR:** Anne Weyman, Chair of the Financial Recovery and QIPP Committee  
**AUTHOR:** Joanna Georgiades, Interim Senior Board Coordinator  
**CONTACT DETAILS:** joanna.georgiades@nclondon.nhs.uk  

**SUMMARY:**  
This paper updates the Joint Boards on the activities of the Financial Recovery & QIPP Committee in November and December 2012.

**SUPPORTING PAPERS:**  
None.

**RECOMMENDED ACTION:**  
The Joint Boards are asked to:  
- **NOTE** the report.

**LINKS TO NHS NORTH CENTRAL LONDON STRATEGY**


The Committee’s duties include, but are not limited to, overseeing the delivery of savings plans, ensuring that expected benefits are realised and risks mitigated, and the review and development of the NCL QIPP Plan and associated implementation plans.

The Committee ensures that high-level health impact assessments of key proposals are undertaken, and identifies any potentially adverse impact on service quality, patient experience, or the achievement of priority outcomes. It ensures that the QIPP Plan is supported by robust financial planning.

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NHS North Central London is a collaborative working arrangement between Barnet, Camden, Haringey, Enfield and Islington Primary Care Trusts.  
The Joint Boards of NHS North Central London refers to the joint meeting of the Boards of Barnet, Camden, Haringey, Enfield and Islington Primary Care Trusts.
GOVERNANCE:
Voting: Please indicate which Board(s) has voting rights on this matter (if applicable)

<table>
<thead>
<tr>
<th>Barnet</th>
<th>Camden</th>
<th>Enfield</th>
<th>Haringey</th>
<th>Islington</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paula Kahn</td>
<td>David Riddle</td>
<td>Caroline Rivett</td>
<td>Robert Sumerling</td>
<td>Karen Trew</td>
</tr>
<tr>
<td>Caroline Rivett</td>
<td>Karen Trew</td>
<td>Caroline Taylor</td>
<td>Deborah Fowler</td>
<td>Cathy Herman</td>
</tr>
<tr>
<td>Robert Sumerling</td>
<td>Ellen Schroder</td>
<td>Deborah Fowler</td>
<td>Caroline Taylor</td>
<td>Sue Baker</td>
</tr>
<tr>
<td>Bev Evans</td>
<td>Penny Bevan</td>
<td>Shahed Ahmad</td>
<td>Mohammed Abedi</td>
<td>Jeanelle de Gruchy</td>
</tr>
<tr>
<td>Andrew Howe</td>
<td>Marek Koperski</td>
<td>Helen Pelendrides</td>
<td>Karen Baggaley</td>
<td></td>
</tr>
<tr>
<td>Philippa Curran</td>
<td>Joanne Wickens</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alison Pointu</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Objective(s) / Plans supported by this paper:
Principle Objective 2: To deliver the NHS North Central London QIPP Plan.

Patient & Public Involvement (PPI): Patient and public involvement has been sought through existing channels and meetings with patients and representative groups to inform the work that is presented to the Committee.

Equality Impact Assessment: Not applicable.

Risks: There are no new risks to be recorded.

Resource Implications: There are no direct resource implications from this report.

Audit Trail: There is no audit trail for this report.

Next Steps: The Financial Recovery & QIPP Committee Report is a standing item on the Joint Boards agenda.
1. SUMMARY

1.1 This report provides an overview of the November and December meetings of the Financial Recovery and Quality, Innovation, Prevention and Productivity (QIPP) Committee. The November and December Committees focused on financial risk delivery of QIPP 2012/13 and 2013/14. Also resource requirements until year end.

2. BOARD ASSURANCE FRAMEWORK (BAF) AND RISK REGISTER

2.1 The BAF was reviewed; the Committee were informed a new risk had been added reflecting potential disruption to the delivery of core business during transition. This was discussed in more detail as part of the update on organisational change.

2.2 The Committee agreed that it would be useful to contextualise the escalation of risks due to transition, so to better understand escalation where mitigating actions were in place. It was agreed to add a column to the BAF reflecting environmental drivers.

2.3 The development of shadow BAFs by the Clinical Commissioning Groups was discussed along with the process of transferring inherited risk.

3. QIPP PLAN UPDATE AND MONTH 7 and 8 FINANCE REPORTS

3.1 The Committee reviewed the implementation and delivery of the QIPP programme at borough and cluster level. Detail of the work being undertaken to help each borough to achieve run rate balance at year end, and the associated risk were discussed in detail in Part 2 of the meeting.

3.2 An update of the programme management function was given, noting the transfer of staff into new positions within the CSU and emerging organisations, noting that the QIPP delivery and planning was now firmly established within the Clinical Commissioning Groups. Formal reports were now being received and fed back into the financial reports.

3.3 Risks related to the sustainability of the QIPP 2013/14 programme were discussed in the light of the Clinical Commissioning group provision of a programme management role.

3.4 It was anticipated that the Northern boroughs would meet the control total but not all would achieve run rate balance.

3.5 There was a discussion on staff retention until full function transition to help manage the workload of the finance team. It was recognised that a residual resource would be required post March 31 2013 to complete closedown.

4. Primary Care Investment Update

4.1 The Committee received a report outlining the governance processes for, and progress against, the primary care investment plans. There was an under-spend in
the level of investment, committed costs stood at £6m at the time of the report, with 27 business cases in progress with a total value of £4.3m.

4.2 The central vision of the primary care strategy was discussed as the development of a local network model for the delivery of primary care, with primary care ownership. The Committee were informed of a proposal to evaluate the programme looking at the effectiveness of the primary care strategy, aligning key objectives where appropriate to the Barnet, Enfield and Haringey Clinical Strategy.

5. Corporate Governance Framework Manual Update

5.1 Changes to the signatory arrangements for Agresso were approved subject to the delegated authority being made to the specific named interim heads of services. It was agreed that this would facilitate the signing of invoice process during the transition period.

6. PART II

6.1 In accordance with the Standing Financial Instructions, the meetings held in November and December 2012 considered:

- Enfield Integrated Performance Report
- Diabetes and Prevalence Gap LES
- Contract Award Report for the Children and Young Person Weight Management service for NHS Islington.
- DVT and Enfield Community Anticoagulation Service LES
- Enfield Integrated Care Admission Avoidance and Discharge Support Service
- Accounts payable and receivable updates
- Camden and Islington Out of Hours Contract
- Organisational update
- Care Home LES
- IMOS Contract Award
- Community ENT Service for Barnet and Enfield – contract award
- IMT Detailed Business Case – Camden

7 CONCLUSION

7.1 The Joint Boards are asked to:

- REVIEW and NOTE the activities of the Committee
MEETING: Meeting of the Joint Boards of NHS North Central London
DATE: 31 January 2013
TITLE: Performance Report
LEAD DIRECTOR: Sylvia Kennedy, Interim Director of Strategy and Performance
AUTHOR: Frank Coathorpe and Lorna Kent Senior Performance Managers
CONTACT DETAILS: Frank.coathorpe@nclondon.nhs.uk
Lorna.kent@nclondon.nhs.uk
020 7685 6290 / 6291

SUMMARY:

This report provides a summary of latest achievement against national performance standards across the cluster.

SUPPORTING PAPERS:

None.

RECOMMENDED ACTION:

The Joint Boards are asked to:
- NOTE the latest position and actions to address areas of under-performance

LINKS TO NHS NORTH CENTRAL LONDON STRATEGY

The national performance measures cover a wide range of quality standards on the delivery of health care and are intrinsically linked to North Central London’s vision to improve the health and wellbeing of our population, reduce inequalities and maximise value in terms of outcomes, quality and efficiency from services provided to patients.

Most notable are the links between the strategic goal of tackling health inequalities and the performance measures on screening programmes, referral-to-treatment times (including cancer waiting times), health checks and supporting people to quit smoking. Similarly, there are performance measures that link to the strategic goal to provide children with the best start in life, including immunisation uptake, breastfeeding rates and early access to maternity services.

GOVERNANCE:

Voting: Please indicate which Board(s) has voting rights on this matter (if applicable)
Objective(s) / Plans supported by this paper: This paper covers the latest performance data available for each area. It should be noted that performance data is taken from a variety of sources which have differing reporting cycles: this report aims to present the most recent data available.

Patient & Public Involvement (PPI): There has been no PPI involvement to date.

Equality Impact Analysis: The NHS Operating Framework sets out a comprehensive range of performance targets designed to measure quality and access to health services provided to local communities.

Risks: Performance is risk rated using a “traffic-light” system of green for performance that is on track; amber for performance falling below agreed threshold and red where there are serious concerns. This “RAG-rating” is consistent with the NHS London Performance Framework and follows national thresholds for achievement. The reasons for under-performance and the controls and assurance in place to address this are reported by topic and organisational area.

Resource Implications: As above, the impact on resources will be included on specific performance areas.

Audit Trail: Performance information is obtained from a variety of sources: these are referenced on tables throughout the document. In order to present the most recent information to the Joint Boards, some provisional data is used and may be subject to change.

Various sections of the report will have been presented to other groups – for example provider trust performance is reviewed by senior members of the performance and contracts' teams and remedial action agreed, if required, at the weekly Acute, Community and Mental Health Contract Management Group.

Next Steps: Performance is reported to every meeting of the Joint Boards, with latest performance achievements and appropriate actions in place.

Abbreviations: The following abbreviations for the acute trusts are used in the tables throughout this section:

BCFH – Barnet & Chase Farm Hospitals
GOSH – Great Ormond Street Hospital
MEH - Moorfields Eye Hospital
NMUH – North Middlesex University Hospital
BEHMHT – Barnet, Enfield and Haringey Mental Health Trust

RFH – Royal Free Hampstead
RNOH – Royal National Orthopaedic Hospital
UCLH – University College London Hospitals
Whit – Whittington Health
CIFT – Camden and Islington Foundation Trust
EXECUTIVE SUMMARY

This report provides a summary of latest achievement for North Central London organisations against the integrated performance measures as set out in the Operating Framework for the NHS in England 2012/13.

Acute

There is continued good performance overall against the referral-to-treatment time with all North Central London trusts meeting national measures for admitted and non-admitted treatments as well as incomplete targets. All the trusts that have reported patients waiting 52 weeks or more are on track to deliver against plan, with both Great Ormond Street and Barnet & Chase Farm reporting that they have reduced the number of patients waiting longer than 52 weeks ahead of November plan.

The majority of North Central London trusts met the diagnostics standard at the end of November, the exception being UCLH, which reported that 4.3% patients waited longer than six weeks for a diagnostics test. The Trust reported that this was due to high sickness absences coupled with reduction in operational capacity. A detailed recovery plan has been requested from the Trust as a matter of urgency.

There are currently concerns with regards to delivery of the A&E standard for the second half of 2012/13 for some local providers, especially with the onset of winter and associated pressures. Overall, all trusts reported meeting the 95% standard for A&E waiting times in Quarter 3 2012/13 with the exception of UCLH due to eight weeks underperformance earlier in the quarter (between 30 September to 18 November). However, the Trust has consistently met the standard since 25 November, and the impact of the actions now in place within the Trust and those planned in the coming weeks, should ensure delivery of the 95% standard in Quarter 4. Both Barnet and Chase Farm (BCFH) and the Whittington have reported that they missed the A&E standard for three consecutive weeks (between the 23 December 2012 to 6 January 2013), and the North Middlesex missed the standard for the week ending 6 January 2013. The trusts have actions plans in place to improve performance.

Barnet & Chase Farm has reported 3 mixed sex accommodation (MSA) breaches in November: a continued improvement on its October position (12 breaches). The Trust has a recovery plan in place which has been agreed with and monitored by NELCSU. The Royal Free also reported 3 breaches in November. Action being taken by the Trust will be discussed at the January Clinical Quality Review Group meeting.

Mental Health: Improved Access to Psychological Therapies (IAPT)

November data shows some improvement across all boroughs in terms of patients entering treatment in-line with recovery trajectories, however only Haringey is currently achieving its Department of Health target. Actions undertaken within each borough are detailed in the body of the report.

Community
The end of year position for NHS North Central London for **Health Visitor Numbers** is estimated to be 21.11 wte below plan. Limited recruitment is anticipated until further newly qualified health visitors are available. Providers continue to drive recruitment and retention campaigns to mitigate this position.

**Public Health**

Enfield is making ongoing improvements to increase the uptake of **Childhood Immunisations**. Improving GP engagement and implementation of the GAIT tool have been successful initiatives to improve this.

Meetings with maternity providers have taken place to identify target areas for service improvement to increase **Maternity Early Access** performance through the reduction of DNAs, flexible clinic access and exploring the feasibility of developing community booking hubs in deprived and culturally challenging areas. Providers are developing action plans to underpin this work.

Significant improvement in Enfield’s delivery of **NHS Health Checks** means that all boroughs other than Barnet achieved their Quarter 2 year-to-date plan. Barnet has made excellent progress in a short period engaging 50 out of 63 practices into the LES programme.

With the exception of Haringey, there has been good progress across North Central London against the **4 Week Smoking Quitters** target. Haringey’s performance is expected to improve through a set of actions that will target high risk groups, enhance marketing and communications and improve data collection. An update of Haringey’s progress will be available at the end of quarter 4.

**Winter Planning**

North Central London trusts (both acute and community) have experienced incidences of norovirus leading to bed closures in November and December, although the total number of reported incidents of norovirus within North Central London for November and December 2012 is 57% down on the previous year with 2,610 incidents in 2011 and 1,493 incidents in 2012. There have been only isolated cases of norovirus reported for January. System management across the health economy is supported with regular teleconferences with providers and monitoring of capacity demands.

**Winter Funding**

The Department of Health has allocated £82.5m to London to support local resilience during this winter and to ensure that access to elective and non-elective care is maintained during the remainder of 2012/13. Cluster CEOs were asked to work with their CCGs, CSUs and acute trusts to identify funding bids by 19 December against the following priorities: Maintaining A&E performance; maintaining LAS performance; providing additional PICU capacity (Via Specialised Commissioning); supporting CCGs with community beds; and supporting early discharge teams for stroke patients. The first two tranches of funding against bids received has been allocated, subject to delivery of improved performance, for the following NCL organisations:
The first two tranches of funding against bids received has been allocated, subject to delivery of improved performance, for the following NCL organisations:

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Tranche 1</th>
<th>Tranche 2</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barnet and Chase Farm:</td>
<td>£1,710,000</td>
<td>£1,710,000</td>
<td></td>
</tr>
<tr>
<td>North Middlesex:</td>
<td>£500,000</td>
<td>£517,000</td>
<td>£1,017,000</td>
</tr>
<tr>
<td>Royal Free:</td>
<td>£1,000,000</td>
<td>£1,000,000</td>
<td></td>
</tr>
<tr>
<td>UCLH:</td>
<td></td>
<td>£1,100,066</td>
<td>£1,100,066</td>
</tr>
<tr>
<td>Whittington:</td>
<td>£200,000</td>
<td>£490,000</td>
<td>£690,000</td>
</tr>
<tr>
<td>Barnet CCG</td>
<td></td>
<td>£173,000</td>
<td>£173,000</td>
</tr>
<tr>
<td>Enfield CCG</td>
<td></td>
<td>£250,000</td>
<td>£250,000</td>
</tr>
<tr>
<td>Central London Community Healthcare</td>
<td></td>
<td>£205,000</td>
<td>£205,000</td>
</tr>
<tr>
<td>Central and North West London</td>
<td></td>
<td>£86,000</td>
<td>£86,000</td>
</tr>
<tr>
<td><strong>NCL Total:</strong></td>
<td><strong>£3,410,000</strong></td>
<td><strong>£2,821,066</strong></td>
<td><strong>£6,231,066</strong></td>
</tr>
</tbody>
</table>

Tranche 3 funding will be allocated by the end of January 2013.

The Department of Health expects feedback from the Commissioning Board London on how the £82.5m has been spent by 28th February 2013. There will be a need to monitor the impact of the schemes on system performance, and appropriate systems will be put in place to support this work.

**Summary tables** are provided at the end of this report that show actual performance against target and compare latest performance against the previous reporting period.
ACUTE PERFORMANCE

1.2 A&E waiting times

Table 1: A&E Recent Performance (Type 1 only)

<table>
<thead>
<tr>
<th></th>
<th>02-Dec</th>
<th>09-Dec</th>
<th>16-Dec</th>
<th>23-Dec</th>
<th>30-Dec</th>
<th>06-Jan</th>
<th>13-Jan</th>
<th>Q3</th>
<th>Q4TD</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCFH</td>
<td>94.85%</td>
<td>92.56%</td>
<td>95.00%</td>
<td>92.65%</td>
<td>92.76%</td>
<td>94.93%</td>
<td>90.50%</td>
<td>95.46%</td>
<td>92.76%</td>
</tr>
<tr>
<td>NMUH</td>
<td>96.14%</td>
<td>93.30%</td>
<td>94.09%</td>
<td>96.06%</td>
<td>95.97%</td>
<td>93.92%</td>
<td>92.58%</td>
<td>95.13%</td>
<td>93.26%</td>
</tr>
<tr>
<td>RFH</td>
<td>95.15%</td>
<td>93.05%</td>
<td>95.89%</td>
<td>95.68%</td>
<td>95.69%</td>
<td>96.93%</td>
<td>93.66%</td>
<td>95.80%</td>
<td>95.33%</td>
</tr>
<tr>
<td>UCLH</td>
<td>96.31%</td>
<td>97.51%</td>
<td>97.92%</td>
<td>95.35%</td>
<td>97.94%</td>
<td>95.62%</td>
<td>96.86%</td>
<td>94.13%</td>
<td>96.25%</td>
</tr>
<tr>
<td>Whitt</td>
<td>97.24%</td>
<td>95.74%</td>
<td>96.74%</td>
<td>91.65%</td>
<td>94.52%</td>
<td>92.51%</td>
<td>92.28%</td>
<td>95.32%</td>
<td>92.40%</td>
</tr>
<tr>
<td>NCL</td>
<td>95.86%</td>
<td>94.30%</td>
<td>95.81%</td>
<td>94.22%</td>
<td>95.12%</td>
<td>94.77%</td>
<td>93.03%</td>
<td>95.15%</td>
<td>93.91%</td>
</tr>
<tr>
<td>London</td>
<td>93.58%</td>
<td>91.01%</td>
<td>90.76%</td>
<td>93.22%</td>
<td>90.26%</td>
<td>90.26%</td>
<td>Not Available</td>
<td>93.22%</td>
<td>Not Available</td>
</tr>
</tbody>
</table>

Source: Unify

The 95% standard for A&E waiting times was met by all North Central London trusts in Quarter 3 with the exception of UCLH due to eight weeks underperformance earlier in the quarter (between 30 September to 18 November). However, UCLH has consistently met the standard since 25 November, and the impact of the actions now in place within the Trust and those planned in the coming weeks, should ensure delivery of the 95% standard in Quarter 4.

Both Barnet and Chase Farm (BCFH) and the Whittington reported that they missed the standard for the last four weeks (23 December to 13 January). BCFH attributed underperformance to bed capacity and delays in treatment decisions, while the Whittington reported that the A&E breaches were due to delays in time to first assessment as well as bed capacity pressures. The North Middlesex reported that it missed the A&E waiting time standard for the week ending 6 and 13 January 2013 due to clinical and bed capacity pressures. The Royal Free reported that it missed the standard for the week ending 13 January due to bed pressures.

Barnet and Chase Farm have developed an action plan which includes embedding the new medical model. As part of this action plan the Trust is implementing new models of working similar to the Medical Model in Surgery, Gynaecology and Paediatrics. It is reviewing medical and nursing staffing to cope with the peaks in attendees and working with hospital doctors to discuss productivity issues, and clarifying expectations around A&E performance.
The Whittington has an improvement plan in place. The Trust has reported that the introduction of its Rapid Assessment and Treatment Model by which every patient arriving at the major’s area of A&E is seen by a senior medical officer is reducing the time to treatment: the Trust is seeking to reduce current mean waits from 80-90 minutes to 60 minutes. To improve flow management of admitted patients, and avoid unnecessary admissions, the Trust has strengthened joint working arrangements between A&E and the acute admissions ward. The work on flow management and quicker clinical decision making has been supported by the introduction of the Acute Medical Consultant rota (November 2012) ensuring consistent presence of Consultant decision makers within the acute care pathway seven days a week.

The North Middlesex also has an action plan in place. To help manage pressures on A&E the Trust has agreed to fund additional therapies staff until the end of March 2013 to support admission avoidance work. Additional A&E consultant cover is provided on weekends. Following increased Paediatric attendances as a result of the closure of the Evergreen walk in clinic, the North Middlesex has put in place additional nursing resources during times of higher activity (2pm to 10pm). An additional A&E doctor has now been recruited and is dedicated resource to support flow & management in paediatrics during the peak periods.

The Royal Free has an action plan. It is seeking to ensure arrangements are in place to provide consultant led discharge rounds throughout the holiday period but in particular during the weekend preceding the first working week. In addition the trust is reviewing its elective admissions to determine whether to downscale elective activity on the Monday and Tuesday following extended bank holiday weekends.

All trusts with the exception of UCLH which met the A&E standard for the week ending 13 January have asked to provide a copy of the elective profile to facilitate informed discussions with North Central London Trusts on capacity planning to support delivery of the A&E standard.

1.3 Winter Planning

North Central London trusts (both acute and community) experienced incidences of norovirus leading to bed closures in November and December. Table 1 provides a comparison of reported bed loss due to norovirus for November – December 2012 compared with the same period on the previous year. The figures highlighted in red show where performance is worse than last year: Barnet and Chase Farm, Great Ormond Street, and UCLH have reported higher levels of reported incidents this year compared with last. However, the total number of reported incidents of norovirus within NCL for November and December 2012 is 57% down on the previous year: 2610 incidents in 2011, and 1493 incidents in 2012. There have been only isolated cases of norovirus reported for January.

Infection control is one of the areas discussed with providers through the teleconferences with acute providers (currently three times a week). The effect of seasonal pressures on trust performance is further described under the A&E and ambulance turnaround sections.

<table>
<thead>
<tr>
<th>Period</th>
<th>BCFH</th>
<th>GOSH</th>
<th>Moor</th>
<th>North Mid</th>
<th>RFH</th>
<th>RNOH</th>
<th>Whit</th>
<th>UCLH</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nov</td>
<td>366</td>
<td>52</td>
<td>0</td>
<td>0</td>
<td>11</td>
<td>0</td>
<td>160</td>
<td>224</td>
<td>813</td>
</tr>
</tbody>
</table>
1.4 Winter Funding
The Department of Health has allocated £82.5m to London to support local resilience during this winter and to ensure that access to elective and non-elective care is maintained during the remainder of 2012/13. Of the £82.5m: £57.5m is available for health with £25m ear marked for social care which has been distributed to Local Authorities with a requirement for PCTs and Local Authorities to agree how this funding is spent. The DH expects to see a reduction in the number of delayed transfers of care attributable to social care as a result.

On 14th December Cluster CEOs were asked to work with their CCGs, CSUs and acute trusts to identify bids by 19th December against the following priorities:

• Maintaining A&E performance (in particular supporting Type 1 performance and the trauma pathway and focusing on winter planning “red” rated health economies)
• Maintaining LAS performance, and support to “gatekeeper” role (via LAS Commissioners)
• Additional PICU capacity (Via Specialised Commissioning)
• Supporting CCGs with community beds
• Stroke – supporting early discharge teams

The first two tranches of funding against bids received has been allocated, subject to delivery of improved performance, for the following NCL organisations:

<table>
<thead>
<tr>
<th></th>
<th>Tranche 1</th>
<th>Tranche 2</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barnet and Chase Farm:</td>
<td>£1,710,000</td>
<td></td>
<td>£1,710,000</td>
</tr>
<tr>
<td>North Middlesex:</td>
<td></td>
<td>£517,000</td>
<td>£1,017,000</td>
</tr>
<tr>
<td>Royal Free:</td>
<td>£1,000,000</td>
<td></td>
<td>£1,000,000</td>
</tr>
<tr>
<td>UCLH:</td>
<td></td>
<td>£1,100,066</td>
<td>£1,100,066</td>
</tr>
<tr>
<td>Whittington:</td>
<td>£200,000</td>
<td>£490,000</td>
<td>£690,000</td>
</tr>
<tr>
<td>Barnet CCG</td>
<td></td>
<td></td>
<td>£173,000</td>
</tr>
<tr>
<td>Enfield CCG</td>
<td></td>
<td></td>
<td>£250,000</td>
</tr>
<tr>
<td>Central London Community Healthcare</td>
<td>£205,000</td>
<td>£205,000</td>
<td></td>
</tr>
<tr>
<td>Central and North West London</td>
<td>£86,000</td>
<td></td>
<td>£86,000</td>
</tr>
<tr>
<td>NCL Total:</td>
<td>£3,410,000</td>
<td>£2,821,066</td>
<td>£6,231,066</td>
</tr>
</tbody>
</table>
Tranche 3 funding will be allocated by the end of January 2013.

The Department of Health expects feedback from the Commissioning Board London on how the £82.5m has been spent by 28th February 2013. There will be a need to monitor the impact of the schemes on system performance, and appropriate systems will be put in place to support this work.

1.5 Ambulance handover times

Table 3: 4 week average position at w/c 31 December 2012

<table>
<thead>
<tr>
<th></th>
<th>% within 15 Mins</th>
<th>% within 30 Mins</th>
<th>60 Mins Breaches</th>
<th>% HAS completed</th>
<th>HAS completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barnet</td>
<td>87.6%</td>
<td>98.0%</td>
<td>0</td>
<td>93.9%</td>
<td>1496</td>
</tr>
<tr>
<td>Chase Farm</td>
<td>86.1%</td>
<td>99.0%</td>
<td>0</td>
<td>82.0%</td>
<td>955</td>
</tr>
<tr>
<td>North Middlesex</td>
<td>79.8%</td>
<td>98.1%</td>
<td>0</td>
<td>89.1%</td>
<td>2173</td>
</tr>
<tr>
<td>Royal Free</td>
<td>87.9%</td>
<td>98.8%</td>
<td>2</td>
<td>92.4%</td>
<td>1551</td>
</tr>
<tr>
<td>UCLH</td>
<td>92.0%</td>
<td>99.3%</td>
<td>1</td>
<td>88.8%</td>
<td>1768</td>
</tr>
<tr>
<td>Whittington</td>
<td>70.5%</td>
<td>95.1%</td>
<td>1</td>
<td>71.2%</td>
<td>1156</td>
</tr>
<tr>
<td>NCL Total</td>
<td><strong>84.3%</strong></td>
<td><strong>98.1%</strong></td>
<td><strong>4</strong></td>
<td><strong>86.7%</strong></td>
<td><strong>9099</strong></td>
</tr>
<tr>
<td>London</td>
<td><strong>76.1%</strong></td>
<td><strong>95.3%</strong></td>
<td><strong>191</strong></td>
<td><strong>87.2%</strong></td>
<td><strong>52517</strong></td>
</tr>
<tr>
<td>Threshold</td>
<td>85.0%</td>
<td>95.0%</td>
<td>0</td>
<td>90.0%</td>
<td>-</td>
</tr>
</tbody>
</table>

*Source: LAS Hospital Alert System*

North Central London has been consistently meeting the 30-minute standard (4 week average performance). There have been 21 reported sixty minute breaches between April and December 2012: a reduction on the 170 reported during the same period last year and work with trusts is ongoing to improve handover systems to minimise further breaches.

Trust performance on the 85% handover standard within 15 minutes remains more variable, and despite improvements since April, underperformance is still reported at the North Middlesex and Whittington (4 weekly average). Similarly, further work is being undertaken with trusts to support improvements to data completeness recording of the Hospital based alert system. A contract query notice was issued to the Whittington on 15 January 2013 to discuss the actions being taken in order to facilitate improved performance by the trust. Bed capacity pressures slowing the flow of patients from A&E have contributed to handover delays. However, performance is discussed with local trusts through the monthly Contract Review and Clinical Quality Review Group meetings to support improvement of turnaround times.
### 1.6 18-Week Referral-To-Treatment

#### Table 4: North Central London: Referral-to-Treatment Waiting Times (provider perspective)

<table>
<thead>
<tr>
<th>Nov-2012</th>
<th>Admitted</th>
<th>Non-admitted</th>
<th>Incomplete</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>18 weeks</td>
<td>Volume</td>
<td>18 weeks</td>
</tr>
<tr>
<td>BCF</td>
<td>94.9%</td>
<td>↓ 2109</td>
<td>99.2%</td>
</tr>
<tr>
<td>GOSH</td>
<td>93.8%</td>
<td>↓ 159</td>
<td>95.3%</td>
</tr>
<tr>
<td>MEH</td>
<td>90.3%</td>
<td>↑ 2280</td>
<td>96.2%</td>
</tr>
<tr>
<td>NMUH</td>
<td>96.5%</td>
<td>↓ 454</td>
<td>98.4%</td>
</tr>
<tr>
<td>RNOH</td>
<td>92.3%</td>
<td>↓ 876</td>
<td>96.9%</td>
</tr>
<tr>
<td>RFH</td>
<td>91.4%</td>
<td>↑ 2021</td>
<td>98.8%</td>
</tr>
<tr>
<td>UCLH</td>
<td>93.4%</td>
<td>↑ 2704</td>
<td>96.6%</td>
</tr>
<tr>
<td>Whit</td>
<td>90.3%</td>
<td>↓ 719</td>
<td>98.7%</td>
</tr>
<tr>
<td>NCL</td>
<td>92.8%</td>
<td>↓ 11322</td>
<td>97.5%</td>
</tr>
<tr>
<td><strong>Threshold</strong></td>
<td>90%</td>
<td>↓</td>
<td>95%</td>
</tr>
</tbody>
</table>

Source: Unify2 provisional data

#### Table 5: North Central London: Referral-to-Treatment Waiting Times (commissioner perspective)

<table>
<thead>
<tr>
<th>Nov-2012</th>
<th>Admitted</th>
<th>Non-admitted</th>
<th>Incomplete</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>18 weeks</td>
<td>Volume</td>
<td>18 weeks</td>
</tr>
<tr>
<td>Barnet</td>
<td>94.2%</td>
<td>↓ 1913</td>
<td>98.8%</td>
</tr>
<tr>
<td>Camden</td>
<td>93.9%</td>
<td>↑ 1008</td>
<td>98.8%</td>
</tr>
<tr>
<td>Enfield</td>
<td>93.9%</td>
<td>↓ 1404</td>
<td>98.8%</td>
</tr>
<tr>
<td>Haringey</td>
<td>93.0%</td>
<td>↓ 1147</td>
<td>98.8%</td>
</tr>
<tr>
<td>Islington</td>
<td>90.3%</td>
<td>↓ 1008</td>
<td>98.6%</td>
</tr>
<tr>
<td>NCL Average</td>
<td>90.3%</td>
<td>↓ 6480</td>
<td>98.6%</td>
</tr>
<tr>
<td><strong>Threshold</strong></td>
<td>90%</td>
<td>↓</td>
<td>95%</td>
</tr>
</tbody>
</table>

#### Table 6: Number of patients waiting over 52 weeks on RTT incomplete pathway (provider perspective)

<table>
<thead>
<tr>
<th></th>
<th>Oct-12</th>
<th>Nov-12</th>
<th>Dec-12</th>
<th>Jan-13</th>
<th>Feb-13</th>
<th>Mar-13</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCFH</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>All 52 week+ waiters are within T&amp;O specialty.</td>
</tr>
<tr>
<td>Actual</td>
<td>12</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan</td>
<td>13</td>
<td>10</td>
<td>8</td>
<td>5</td>
<td>3</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>GOSH</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>All 52 week+ waiters have been recorded as ‘other’ specialty waits.</td>
</tr>
<tr>
<td>Actual</td>
<td>3</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan</td>
<td>5</td>
<td>5</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>NMUH</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Currently on track</td>
</tr>
<tr>
<td>Actual</td>
<td>1</td>
<td>0</td>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Plan</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>
1.7 Diagnostic Waits

Table 7: 2012/13 Performance diagnostics waits of <1% of six week breaches (provider perspective)

<table>
<thead>
<tr>
<th>Month</th>
<th>Apr-12</th>
<th>May-12</th>
<th>Jun-12</th>
<th>Jul-12</th>
<th>Aug-12</th>
<th>Sep-12</th>
<th>Oct-12</th>
<th>Nov-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCFH</td>
<td>0.24%</td>
<td>0.12%</td>
<td>0.05%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.02%</td>
</tr>
<tr>
<td>GOSH</td>
<td>6.09%</td>
<td>5.78%</td>
<td>8.99%</td>
<td>7.93%</td>
<td>6.31%</td>
<td>0.85%</td>
<td>0.17%</td>
<td>0.63%</td>
</tr>
<tr>
<td>Moorfields</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>NMUH</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.44%</td>
</tr>
<tr>
<td>RNOH</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
<tr>
<td>Royal Free</td>
<td>0.71%</td>
<td>0.87%</td>
<td>0.76%</td>
<td>0.72%</td>
<td>0.79%</td>
<td>1.00%</td>
<td>0.73%</td>
<td>0.89%</td>
</tr>
<tr>
<td>UCLH</td>
<td>0.51%</td>
<td>0.24%</td>
<td>0.35%</td>
<td>0.10%</td>
<td>0.69%</td>
<td>0.34%</td>
<td>0.20%</td>
<td>4.29%</td>
</tr>
</tbody>
</table>
### Table 8: 2012/13 Performance diagnostics waits of <1% of six week breaches (commissioner perspective)

<table>
<thead>
<tr>
<th></th>
<th>Apr-12</th>
<th>May-12</th>
<th>Jun-12</th>
<th>Jul-12</th>
<th>Aug-12</th>
<th>Sep-12</th>
<th>Oct-12</th>
<th>Nov-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barnet</td>
<td>0.6%</td>
<td>0.5%</td>
<td>0.7%</td>
<td>0.8%</td>
<td>0.8%</td>
<td>0.4%</td>
<td>0.3%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Camden</td>
<td>0.4%</td>
<td>0.4%</td>
<td>0.8%</td>
<td>0.6%</td>
<td>0.8%</td>
<td>0.7%</td>
<td>0.6%</td>
<td>2.2%</td>
</tr>
<tr>
<td>Enfield</td>
<td>0.1%</td>
<td>0.3%</td>
<td>0.4%</td>
<td>0.3%</td>
<td>0.6%</td>
<td>0.3%</td>
<td>0.3%</td>
<td>0.3%</td>
</tr>
<tr>
<td>Haringey</td>
<td>0.1%</td>
<td>0.2%</td>
<td>0.7%</td>
<td>0.6%</td>
<td>0.6%</td>
<td>0.3%</td>
<td>0.1%</td>
<td>0.6%</td>
</tr>
<tr>
<td>Islington</td>
<td>0.4%</td>
<td>0.4%</td>
<td>0.5%</td>
<td>0.7%</td>
<td>1.0%</td>
<td>0.2%</td>
<td>0.4%</td>
<td>2.2%</td>
</tr>
<tr>
<td><strong>NCL Average</strong></td>
<td>0.3%</td>
<td>0.4%</td>
<td>0.6%</td>
<td>0.6%</td>
<td>0.8%</td>
<td>0.4%</td>
<td>0.3%</td>
<td>1.2%</td>
</tr>
</tbody>
</table>

Source: Unify2

Less than 1% of patients awaiting diagnostics tests should wait longer than 6 weeks. Nearly all of North Central London trusts have reported performance within the tolerance levels in November with the exception of the UCLH, which reported an underperformance of 4.3% with 223 patients waiting longer than 6 weeks. The Trust reported that this was due to high sickness absences coupled with reduction in operational capacity. A detailed recovery plan has been requested from the Trust. The Royal Free has reported a steady increase in breaches (within standard) since April 2012. This is a weaker area in the Trust’s performance and, given it is not a Monitor requirement, is being monitored through the monthly Clinical Quality Review and Contract Review Meetings.

### 1.8 Cancer Waiting Times

#### Table 9. Cancer Waiting Times (Provider perspective)

<table>
<thead>
<tr>
<th></th>
<th>Two Week Wait</th>
<th>31 Day First Treatment</th>
<th>31 Day Subsequent Treatment</th>
<th>31 Day Subsequent Treatment</th>
<th>62 Day Standard</th>
<th>CRS 62 Day Screening</th>
<th>Breast Symptom Two Week</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct-12</td>
<td>2013/14</td>
<td>2013/14</td>
<td>2013/14</td>
<td>2013/14</td>
<td>2013/14</td>
<td>2013/14</td>
<td>2013/14</td>
</tr>
<tr>
<td></td>
<td>nt (Drug)</td>
<td>nt (surgery)</td>
<td>Standard</td>
<td>Wait</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------</td>
<td>-----------</td>
<td>--------------</td>
<td>----------</td>
<td>------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BCFH</td>
<td>93.5%</td>
<td>100%</td>
<td>80.7%</td>
<td>94.2%</td>
<td>94.8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GOSH</td>
<td>NA</td>
<td>100%</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moorfield</td>
<td>100%</td>
<td>NA</td>
<td>NIL</td>
<td>NA</td>
<td>NA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NMUH</td>
<td>96.6%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>96.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Royal Free</td>
<td>98.6%</td>
<td>100%</td>
<td>95.5%</td>
<td>100%</td>
<td>90.9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RNOH</td>
<td>100%</td>
<td>100%</td>
<td>83.3%</td>
<td>100%</td>
<td>80.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>UCLH</td>
<td>94.5%</td>
<td>100%</td>
<td>78.6%</td>
<td>100%</td>
<td>94.8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whittington</td>
<td>92.5%</td>
<td>100%</td>
<td>75.0%</td>
<td>NA</td>
<td>94.8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NCL</td>
<td>96.5%</td>
<td>100%</td>
<td>85.8%</td>
<td>94.4%</td>
<td>95.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operation Standard</td>
<td>93%</td>
<td>96%</td>
<td>98%</td>
<td>94%</td>
<td>85%</td>
<td>90%</td>
<td>93%</td>
</tr>
</tbody>
</table>

Source: NHS London

Table 10. Cancer Waiting Times (Commissioner perspective)

<table>
<thead>
<tr>
<th>October 2012</th>
<th>Two Week Wait</th>
<th>31 Day First Treatment</th>
<th>31 Day Subsequent Treatment (Drug)</th>
<th>31 Day Subsequent Treatment (surgery)</th>
<th>62 Day Standard</th>
<th>CRS 62 Day Screening Standard</th>
<th>Breast Symptom Two Week Wait</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barnet</td>
<td>91.3%</td>
<td>99.2%</td>
<td>100%</td>
<td>100%</td>
<td>84.4%</td>
<td>100%</td>
<td>93.4%</td>
</tr>
<tr>
<td>Camden</td>
<td>96.6%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>95.0%</td>
<td>97.7%</td>
</tr>
<tr>
<td>Enfield</td>
<td>96.4%</td>
<td>97.7%</td>
<td>100%</td>
<td>100%</td>
<td>73.5%</td>
<td>100%</td>
<td>98.9%</td>
</tr>
<tr>
<td>Haringey</td>
<td>93.9%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>93.3%</td>
<td>100%</td>
<td>95.2%</td>
</tr>
<tr>
<td>Islington</td>
<td>94.6%</td>
<td>95.0%</td>
<td>100%</td>
<td>100%</td>
<td>91.3%</td>
<td>100%</td>
<td>92.5%</td>
</tr>
<tr>
<td>NCL</td>
<td>94.6%</td>
<td>99.4%</td>
<td>99.0%</td>
<td>100%</td>
<td>86.8%</td>
<td>93.8%</td>
<td>95.5%</td>
</tr>
<tr>
<td>Standard</td>
<td>93%</td>
<td>96%</td>
<td>98%</td>
<td>94%</td>
<td>85%</td>
<td>90%</td>
<td>93%</td>
</tr>
</tbody>
</table>

Source: NHS London

Patient choice has been cited as the main reason for The Whittington’s underperformance on the 2-week urgent GP referral and breast symptom two week waits. In addition, the Trust adopted a new service model earlier this year whereby diagnostic tests are
undertaken in primary care before the patient attends hospital. This new model has resulted in delays in performance. The Whittington is looking into improving endoscopy capacity for the straight-to-test referrals and has provided an additional weekly breast clinic session.

The Whittington also underperformed on the 62 standard (low volumes) due to a combination of clinical and patient delays. The Cancer team is continuing to work with the Trust to explore ways that potential improvements on the pathway can be made. A contract query notice was issued to the Whittington on 15 January 2013 to discuss the actions being taken in order to facilitate improved performance by the trust.

The North Central London Cancer Commissioning Team has discussed underperformance on the 62 day standards with RNOH, Royal Free and Barnet and Chase Farm to explore areas of improvement. These regular monthly meetings with the trusts focus on detailed breach analyses and where necessary, to identify any underlying systemic issues that may impact on waiting times performance.

From a borough-level perspective, Barnet did not meet the 93% 2 week wait threshold, 55 Barnet resident patients breached out of a total of 632 patients seen, almost all were due to patient choice. The 62 day standard was also missed when 7 patients out of 45 resulted in the standard being breached.

Enfield did not meet the 62 day standard as 9 patients out of a total of 34 patients breached the standard. 5 of the patients who breached the standard were treated at Barnet and Chase Farm, 2 at UCLH and 2 at Royal Free.

Camden did not meet the standard due to a patient breaching the standard at the Royal Free for clinical reasons. The patient has since been treated at the Royal Free.

1.9 Infection Control

<table>
<thead>
<tr>
<th></th>
<th>MRSA</th>
<th></th>
<th>CR Difficile</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mthly</td>
<td>Mthly Plan</td>
<td>YTD Incidents</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BCF</td>
<td>0</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>GOSH</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>MEH</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>NMUH</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>RNOH</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>RFH</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>UCLH</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Whitt</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

Source: Health Protection Agency

Please note: the UCLH breach data does not include the MRSA incident where the UCLH has been informed (following appeal) that the breach will not count against the trusts’ performance trajectory.
Table 12: Infection control; Borough Update December 2012

<table>
<thead>
<tr>
<th>Borough</th>
<th>MRSA</th>
<th>C. difficile</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Threshold</td>
<td>Reported</td>
</tr>
<tr>
<td>Barnet</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Camden</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Enfield</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>Haringey</td>
<td>6</td>
<td>2</td>
</tr>
</tbody>
</table>

**Details**

- **MRSA Cases** – 4 Community / 2 Hospital. Root Cause Analysis (RCA) allocated to relevant Infection Control teams for further review. This is at threshold for annual acquisition.
- **C. difficile Cases** – 37 community / 23 Hospital, this is above their trajectory (58) for this stage of year.

- **MRSA Cases** - 2 Community / 4 Hospital. This is at threshold for annual acquisition.
- **C. difficile** – 23 Community / 21 Hospital. This is above YTD trajectory (36) for this stage in the year.

- **MRSA Cases** – 2 Community / 2 Hospital. The recent hospital acquisitions were reported by BCF (see acute trust table above for further detail)
- **C. difficile Cases** – 20 Community / 12 Hospital, this is within their trajectory (56) at this stage of the year.

**MRSA Cases** – 2 Community, one RCA has been lead by the RFH but NHS NCL are looking to expand this to include
community involvement.

**C. diff Cases** – 13 Community / 14 Hospital, this is within trajectory (40) for this stage of year.

<table>
<thead>
<tr>
<th>Islington</th>
<th>5</th>
<th>3</th>
<th>46</th>
<th>50</th>
</tr>
</thead>
</table>

**MRSA cases** – 3 Community cases

**C. diff Cases** – 29 Community / 21 Hospital, this is above their annual threshold of 46 cases for the year.

All North Central London trusts, with the exception of Barnet and Chase Farm, Great Ormond Street, the Royal Free and the Whittington are within their annual thresholds for **MRSA** at December 2012. The Royal Free has made an appeal on one of the breaches: an initial review by NCL failed to find sufficient grounds for approving this appeal and the Royal Free has been given an opportunity to provide further evidence to demonstrate this was an unavoidable case.

With regard to **Clostridium difficile** performance, RNOH reached its annual threshold of 3 incidents; it is currently reporting 6 breaches. All other trusts are reporting performance below the annual infection control ceiling, although Great Ormond Street, the Royal Free, RNOH and UCLH are all reporting incidents above in-year trajectory. In the case of the Royal Free, the Trust have **Clostridium difficile** care bundles and pathways in place but report an increase in positive cases due to changes to testing commenced in April 2012. The action plans by all the North Central London trusts to improve performance on both the MRSA and **Clostridium difficile** standards are discussed at their monthly infection control committee meetings, and reviewed at the monthly Clinical Quality Review Meetings.

Peer reviews follow-up meetings are being organised with GOSH and North Middlesex to review progress on implementing actions identified at the Confirm and Challenge meetings in July 2012. There has been slippage in arranging these meetings although meetings on progress are now planned to take place in January 2013 for both Trusts. The NCL infection control lead has reviewed progress through the monthly Trust infection control meetings.

Great Ormond Street has reported 2 Trust attributable MRSA bacteraemia during the year to date, which will be discussed at the January Clinical Quality Review Group meeting. North Middlesex’s Director of Infection Prevention and Control (DIPC); the nurse consultant and Assistant Director of Nursing posts are currently vacant, and will not be filled until January 2013. The NHS NCL infection control lead has asked to be included in the induction programme for the new nurse consultant and DIPC to ensure that expectations regarding the implementation of recommendations are understood. The Trust has reported zero attributable MRSA bacteraemia and has now been MRSA bacteraemia free for over one year.

1.10 Mixed Sex Accommodation

**Table 13: Mixed Sex Accommodation: NCL Sector Performance**
<table>
<thead>
<tr>
<th>Month</th>
<th>Apr-12</th>
<th>May-12</th>
<th>Jun-12</th>
<th>Jul-12</th>
<th>Aug-12</th>
<th>Sep-12</th>
<th>Oct-12</th>
<th>Nov-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCFH</td>
<td>0</td>
<td>19</td>
<td>7</td>
<td>0</td>
<td>20</td>
<td>22</td>
<td>12</td>
<td>3</td>
</tr>
<tr>
<td>GOSH</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Moorfields</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>NMUH</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Royal Free</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>RNOH</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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<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Whittington</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>7</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>NCL Total</strong></td>
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<td>20</td>
<td>8</td>
<td>9</td>
<td>24</td>
<td>23</td>
<td>13</td>
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<td>0</td>
<td>0</td>
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</tr>
</tbody>
</table>

Source: Unify2

Table 14: Mixed Sex Accommodation: NCL Sector Performance (Commissioner perspective)

<table>
<thead>
<tr>
<th>Month</th>
<th>Apr-12</th>
<th>May-12</th>
<th>Jun-12</th>
<th>Jul-12</th>
<th>Aug-12</th>
<th>Sep-12</th>
<th>Oct-12</th>
<th>Nov-12</th>
</tr>
</thead>
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<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Enfield</td>
<td>0</td>
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<td>0</td>
<td>0</td>
<td>6</td>
<td>6</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Haringey</td>
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<td>0</td>
<td>1</td>
<td>7</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
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<td>0</td>
<td>2</td>
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</tr>
<tr>
<td><strong>NCL Total</strong></td>
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<td>5</td>
<td>9</td>
<td>20</td>
<td>17</td>
<td>10</td>
<td>6</td>
</tr>
</tbody>
</table>

Source: Unify2

Barnet & Chase Farm and the Royal Free within North Central London underperformed against this standard during November 2012. With mixed sex accommodation breaches also reported at Barts Health (out of sector Trust). The breaches at all three Trusts have been as a result of delays in stepping down from high intensity care back to the ward.

Barnet and Chase Farm has seen an improvement in recent months in line with its improvement trajectory of zero breaches by January 2013. The Royal Free has an improvement plan in place which is seeking to improve coordination between specialty teams, theatre and Intensive Therapy Unit (ITU). The work is being implemented through the Trust’s theatre strategy group and ITU short life working group. This underperformance was discussed with the Royal Free at the recent Clinical Quality Review Group meeting on the 9 January 2013; a copy of the Trust’s improvement plan has been requested and is expected the week during the week beginning 21 January 2013. Details on actions being taken at Barts Health has been requested from the Trust.

Performance is reviewed internally through the NCL POD Performance Management Group Meeting, and discussed with trusts at their Clinical Quality Review Group, and through contract monitoring group.
1.11 Venous Thromboembolism (VTE) screening

### Table 15: Percentage of adult patients assessed for VTE on admission

<table>
<thead>
<tr>
<th>Trust</th>
<th>Apr-12</th>
<th>May-12</th>
<th>Jun-12</th>
<th>Jul-12</th>
<th>Aug-12</th>
<th>Sep-12</th>
<th>Oct-12</th>
<th>Nov-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCFH</td>
<td>90.5%</td>
<td>91.3%</td>
<td>93.2%</td>
<td>93.3%</td>
<td>93.51%</td>
<td>93.78%</td>
<td>94.09%</td>
<td>92.79%</td>
</tr>
<tr>
<td>GOSH</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>89.995%</td>
<td>90.86%</td>
<td>96.87%</td>
<td>96.09%</td>
</tr>
<tr>
<td>Moorfields</td>
<td>91.7%</td>
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<td>94.7%</td>
<td>93.9%</td>
<td>94.04%</td>
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</tr>
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<td>94.6%</td>
<td>94.02%</td>
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</tr>
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<td>97.0%</td>
<td>97.82%</td>
<td>94.82%</td>
<td>98.67%</td>
<td>97.24%</td>
</tr>
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<td>94.21%</td>
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<td>95.57%</td>
<td>95.81%</td>
<td>96.12%</td>
<td>97.18%</td>
</tr>
<tr>
<td>NMUH</td>
<td>91.3%</td>
<td>92.1%</td>
<td>92.9%</td>
<td>94.6%</td>
<td>94.02%</td>
<td>94.34%</td>
<td>94.34%</td>
<td>95.61%</td>
</tr>
<tr>
<td>Threshold</td>
<td>&gt;90%</td>
<td>&gt;90%</td>
<td>&gt;90%</td>
<td>&gt;90%</td>
<td>&gt;90%</td>
<td>&gt;90%</td>
<td>&gt;90%</td>
<td>&gt;90%</td>
</tr>
</tbody>
</table>

Source: Unify2; NHS London

All North Central London trusts achieved the Venous Thromboembolism standard during November 2012. Performance for all trusts is monitored through Clinical Quality Review Groups to ensure sustained delivery of the standard.

## 2 NON ACUTE PERFORMANCE

### 2.2 Childhood immunisations

### Table 16: Performance against childhood immunisation trajectories for Q2 12/13

<table>
<thead>
<tr>
<th></th>
<th>Barnet</th>
<th>Camden</th>
<th>Enfield</th>
<th>Haringey</th>
<th>Islington</th>
</tr>
</thead>
<tbody>
<tr>
<td>DtaP/IPV Hib 1 yr</td>
<td>94.0%</td>
<td>95.8%</td>
<td>90.0%</td>
<td>91.0%</td>
<td>85.0%</td>
</tr>
<tr>
<td>PCV 2yr</td>
<td>89.0%</td>
<td>91.3%</td>
<td>85.0%</td>
<td>87.0%</td>
<td>85.0%</td>
</tr>
<tr>
<td>Hib/MenC 2yr</td>
<td>91.5%</td>
<td>91.3%</td>
<td>86.0%</td>
<td>87.6%</td>
<td>81.0%</td>
</tr>
<tr>
<td>MMR 2yr</td>
<td>90.5%</td>
<td>91.1%</td>
<td>86.0%</td>
<td>86.6%</td>
<td>78.0%</td>
</tr>
<tr>
<td>DtaP/IPV 5yr</td>
<td>85.5%</td>
<td>85.9%</td>
<td>70.0%</td>
<td>79.3%</td>
<td>80.0%</td>
</tr>
<tr>
<td>MMR 5yr</td>
<td>83.8%</td>
<td>83.8%</td>
<td>74.0%</td>
<td>80.0%</td>
<td>80.0%</td>
</tr>
</tbody>
</table>

Source: Q2 12/13 HPA COVER return
**Key = Green - achieved plan, Amber - within 1% of plan, red - below plan**

North Central London’s plans show progress towards World Health Organisation recommendations for herd immunity

Overall boroughs are performing well against childhood immunisations. Barnet are achieving all targets with the exception of 2 year Hib/Men C and are now only 0.2% off target for this KPI. Haringey’s performance has fallen for both 1 year DtaP/IPV and 2 year PCV. This is against an increase in both immunisation uptake and population for the 1 year programme but a decrease in uptake for the 2 year vaccine. Recovery is expected with the publication of Q.3 data.

Enfield is the most challenged borough for immunisation uptake but have been commended by NHS London on their work programme to improve immunisation uptake. Initiatives include improving GP engagement, installation of the GAIT tool during January and campaigns to raise awareness of childhood immunisation programmes.

### 2.2 4-week smoking quitters

**Table 17: 4-week smoking quitters Q2 activity**

<table>
<thead>
<tr>
<th></th>
<th>Qtr 1</th>
<th>Qtr 2</th>
<th>Cumulative Plan</th>
<th>Cumulative Activity</th>
<th>Qtr2 RAG Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barnet</td>
<td>626</td>
<td>461</td>
<td>1035</td>
<td>1087</td>
<td>G</td>
</tr>
<tr>
<td>Camden</td>
<td>231</td>
<td>213</td>
<td>443</td>
<td>444</td>
<td>G</td>
</tr>
<tr>
<td>Enfield</td>
<td>322</td>
<td>305</td>
<td>600</td>
<td>627</td>
<td>G</td>
</tr>
<tr>
<td>Haringey</td>
<td>363</td>
<td>280</td>
<td>800</td>
<td>643</td>
<td>R</td>
</tr>
<tr>
<td>Islington</td>
<td>594</td>
<td>432</td>
<td>952</td>
<td>1026</td>
<td>G</td>
</tr>
</tbody>
</table>

Across NHS NCL there has been good progress against the 4 week smoking quitters plan. The exception is Haringey which is currently below plan by 157 quitters. The provider of smoking cessation services for Enfield and Haringey is Innsvision who have agreed a set of actions to increase referrals and reduce GP expenditure. Plans include strategies to effectively follow up smoking quitters, capture and monitor high risk groups such as those with mental health issues, communication and marketing strategies and the commissioning of a new web-based IT system simplifying the recording of this activity in the community.
2.3 Maternity assessment by 13th week of pregnancy

Table 18: Maternity Access 12+6 Weeks Q4 11/12

At the time of writing this report meetings have been held with The Whittington, UCLH, The Royal Free and North Middlesex Hospitals. These meetings have been supported by revised trust and borough performance dashboards which indicate trends, impact of performance against individual KPI’s and the contribution of these to the overall execution of the early access target. Common themes include late referrals related to cultural groups and beliefs, DNAs and late booking of women who do present early. Actions are being taken by each provider to reduced the incidence of DNAs, simplify access to booking clinics through initiatives to escalate capacity constraints and improve flexibility of appointments. The Whittington alone has the opportunity to improve performance for Haringey by 6% through initiatives to half their DNA rate.

Opportunities have been identified to hold ‘drop in’ booking clinics in the heart of the most deprived communities, in particular, Haringey. Maternity units are constrained by appropriate venues and charges made by primary care for rooms. There is scope to explore the reinvestment of these charges into the provision of flexible, community booking hubs. This will be investigated with the boroughs of Haringey and Enfield throughout quarter 4.
2.4 NHS Health Checks

Table 19: NHS Health Checks Performance Q2 12/13

<table>
<thead>
<tr>
<th>Borough</th>
<th>Offered Q2 YTD</th>
<th>Delivered Q2 YTD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barnet</td>
<td>6 (0.0%) against a plan of 6,751</td>
<td>6 (0.0%) against a plan of 2,700</td>
</tr>
<tr>
<td>Camden</td>
<td>7,854 (15.8%) against plan of 4,671</td>
<td>2,680 (5.4%) against plan of 1,635</td>
</tr>
<tr>
<td>Enfield</td>
<td>5,933 (7.5%) against plan of 7,900</td>
<td>3,016 (3.8%) against plan of 2,750</td>
</tr>
<tr>
<td>Haringey</td>
<td>8,269 (14.9%) against plan of 4,994</td>
<td>3,602 (6.5%) against plan of 2,250</td>
</tr>
<tr>
<td>Islington</td>
<td>5,674 (13.3%) against plan of 2,985</td>
<td>3,614 (8.5%) against plan of 1,500</td>
</tr>
</tbody>
</table>

Since funding was secured in October, Barnet has further increased its uptake of practices into the health check LES. At the last update, 25 practices had signed up; this has now increased to 50 achieving a 79% sign up success rate in quarter 3.

A dedicated health improvement practitioner has been allocated to the programme for Barnet providing training and implementing systems to record and capture all Health Check activity which has taken place during the reporting period. Through these measures Barnet are confident that they will meet their revised cumulative position by the end of quarter 4.

Enfield has increased its uptake of practices into the health check LES by a further 8 since the last report, now totalling 38 practices. The funding continues to be used to roll out the programme and it is expected that quarter 3 data will show a marked improvement against the offered plan.

2.4 Health Visitor Numbers

There is a lag of 3 months in the data reported. September/October 2012 is the most up to date but not confirmed by NHS London.

<table>
<thead>
<tr>
<th>Borough</th>
<th>April 13 Target</th>
<th>August 31st reported position</th>
<th>Provisional September position</th>
<th>Provisional October position</th>
<th>Change since Aug 12</th>
<th>Gap</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barnet</td>
<td>35.2</td>
<td>35.24</td>
<td>36.25</td>
<td>37.25</td>
<td>↑2.01</td>
<td>+2.05</td>
</tr>
<tr>
<td>Camden</td>
<td>30.0</td>
<td>21.18</td>
<td>25.18</td>
<td>26.18</td>
<td>↑5.0</td>
<td>-3.82</td>
</tr>
<tr>
<td>Enfield</td>
<td>48.7</td>
<td>35.93</td>
<td>42</td>
<td>41.6</td>
<td>↑5.67</td>
<td>-7.1</td>
</tr>
<tr>
<td>Haringey</td>
<td>97.3</td>
<td>78.70</td>
<td>84.1</td>
<td>*</td>
<td>↑5.4</td>
<td>-12.24</td>
</tr>
<tr>
<td>Islington</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NCL total</td>
<td>211.2</td>
<td>171.05</td>
<td>187.53</td>
<td>*</td>
<td>↑18.08</td>
<td>-21.11</td>
</tr>
</tbody>
</table>

*Please note that not all October data is available at time of reporting

All boroughs are showing a positive trajectory of improvement since the last final reported position at the end of August 2012. Most boroughs anticipate that recruitment will be limited throughout quarter 4 until such time London
reaches a critical mass of newly qualified health visitors of which NHS London are aware. Despite this, providers continue to drive initiatives to help sustain their current position through strategies to improve recruitment and retention.

**Barnet** is confident in achieving the target for April 2013 and will in fact overachieve by an estimated 2 WTE’s. However, Barnet is concerned about this over achievement being against a low recruitment trajectory which may fail to address caseload size adequately.

**Camden’s** provisional October position shows a gap against the April target of 3.82 WTE. Though the recruitment trajectory has been positive throughout October closing the gap by a further 4 WTE, the net position will remain unchanged due to further resignations.

**Enfield** has a gap of 7.1 WTE against their provisional October position which has improved significantly from their August gap of 12.77 WTE. Following a meeting with commissioners to review NHS London Health Visitor definitions, this number is likely to improve further by 3.9 WTE. Recruitment is expected to improve throughout quarter 4 with the revised increase in Health Visitor pay banding and release of national advert.

Despite strong initiatives by **Haringey and Islington’s** provider, Whittington Health, to train, recruit and retain health visitors, a stable workforce has been challenging to achieve due to retirement, leavers and capacity for trainees. The end of September position shows a gap of 13.2 WTE against the April 2013 target. This gap is expected to be 12.24 WTE by end March 2013.

Whittington Health, Barnet and Camden have shared concerns about the potential impact on local recruitment initiatives through competition with neighbouring Enfield and the increase in health visitor pay banding. To date, there has been no evidence of this.

### 2.5 Improved Access to Psychological Therapies

November data shows some improvement across all boroughs in terms of patients entering treatment in-line with recovery trajectories, however only Haringey is currently achieving its Department of Health target. Camden’s commissioners met with CIFT on 18th January to seek assurance that IAPT productivity will improve and that the 8.9% target will be met or exceeded with the current workforce. The Trust has agreed to produce by 25th January a comprehensive IAPT action plan to demonstrate how productivity will increase with measures and milestones, as well as the impact of actions on key performance indicators for each quarter and must show how the target for under-represented groups will be met. Enfield is currently conducting capacity and demand modelling to understand the level of service that can be provided within the current resource allocation and what would be required to provide access to 15% of the population with depression. Islington CCG has written to CIFT to formally request a breakdown of expenditure of the IAPT budget following the decline in activity in 2013. The Trust has also been asked to provide a service recovery plan with planned trajectories through to 2015.
## Appendix 1: Overview of Acute and Non-Acute Targets

<table>
<thead>
<tr>
<th>Table 21: Acute Measures Provider perspective</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Joint Boards Part 1 page 145</strong></td>
</tr>
</tbody>
</table>

### Four-hour max wait in A&E

<table>
<thead>
<tr>
<th>BCFH</th>
<th>GOSH</th>
<th>Moorfields</th>
<th>NMUH</th>
<th>RNOH</th>
<th>Royal Free</th>
<th>UCLH</th>
<th>Whittington</th>
</tr>
</thead>
<tbody>
<tr>
<td>93.20%</td>
<td>↓</td>
<td>NA</td>
<td>99%</td>
<td>↓</td>
<td>94.70%</td>
<td>↑</td>
<td>NA</td>
</tr>
</tbody>
</table>

### Referral to Treatment

| RTT: 90% admitted performance | 95% | ↓ | 94% | ↑ | 90% | ↓ | 97% | ↓ | 92% | ↑ | 91% | ↓ | 93% | ↑ | 90% | ↑ |
| RTT: 95% non-admitted | 99% | ↓ | 95% | ↓ | 96% | ↓ | 98% | ↑ | 97% | ↑ | 99% | ↑ | 97% | ↓ | 99% | ↑ |
| RTT: 92% incomplete | 92% | ↓ | 95% | ↑ | 92% | ↑ | 99% | ↓ | 96% | ↓ | 92% | ↓ | 92% | ↑ | 94% | ↑ |

### Infection Control

- **Infection control: Clostridium Difficile**
  - 13 → 7 → 0 → 16 ↓ 6 ↓ 35 → 42 ↓ 10 ↓

- **Infection control: MRSA**
  - 4 → 2 ↓ 0 → 0 → 2 → 1 → 1 →

### Cancer waiting times

| Cancer waits: 2 week GP referral-to-appt | 94% | ↓ | NA | 100% | → | 97% | ↓ | 100% | → | 99% | ↑ | 95% | ↑ | 92.50% | ↑ |
| Cancer waits: 2 week breast symptomatic target | 95% | ↑ | NA | NA | 97% | ↓ | NA | 100% | ↑ | 96% | ↑ | 87% | ↓ |
| Cancer waits: 31 days diagnosis to treatment | 98% | ↓ | 100% | → | 100% | 100% | → | 96% | ↑ | 98% | ↓ | 99% | ↑ | 100% | → |
| Cancer waits: 31 days diagnosis to treatment subsequent drug treatment | 100% | → | 100% | → | NA | 100% | → | NA | 100% | → | 99% | ↑ | 100% | → |
| Cancer waits: 31 days diagnosis to treatment subsequent surgery | 96% | ↑ | NIL | NIL | 100% | → | 100% | → | 96% | ↓ | 100% | ↑ | 100% | → |
| Cancer waits: 31 days treatment subsequent radiotherapy | NIL | NA | NA | 100% | → | NA | 100% | → | 100% | ↑ | NA |     |     |     |
| Cancer waits: 62 days referral to treatment | 80.70% | ↓ | NA | NIL | 100% | ↑ | 75% | ↓ | 91% | ↑ | 89% | ↑ | 79% | ↓ |
| Cancer waits: 62 days referral to treatment - referral from screening | 94% | ↑ | NA | NA | 100% | → | NA | 83% | ↓ | 100% | ↑ | NIL |     |     |
| Cancer waits 62 days upgrade | 99.00% | ↓ | NA | NA | 100% | → | 100% | 100% | → | 87.50% | ↓ | 100% | → |
| 18 week waits - audiology | 100% | → | NA | NA | NA | NA | 100% | → | 100% | → | 100% | → |     |     |
| Diagnostic waits > 6 wks | 0% | ↓ | 1% | ↓ | 0% | → | 0% | ↓ | 0% | → | 1% | ↓ | 4% | ↓ | 1% | ↓ |
| VTE assessment | 93% | ↓ | NA | 96% | ↓ | 95% | ↑ | 97% | ↓ | 96% | ↑ | 95% | ↑ | 97% | ↑ |
| Mixed sex accommodation breaches | 2 | ↑ | 0 | → | 0 | → | 0 | → | 0 | → | 4 | ↓ | 0 | → | 0 | → |
Moorfields offers a Type 2 A&E service
<table>
<thead>
<tr>
<th>Measure</th>
<th>Date of Current Data</th>
<th>Barnet</th>
<th>Camden</th>
<th>Enfield</th>
<th>Haringey</th>
<th>Islington</th>
</tr>
</thead>
<tbody>
<tr>
<td>Four-hour max wait in A&amp;E</td>
<td>Dec-12</td>
<td>93.60 %</td>
<td>↓ 91.30 %</td>
<td>↓ 93.80 %</td>
<td>↓ 95.00 %</td>
<td>↓ 96.10 %</td>
</tr>
<tr>
<td>RTT: 90% admitted performance</td>
<td>Nov-12</td>
<td>94.20 %</td>
<td>↓ 93.90 %</td>
<td>↑ 93.90 %</td>
<td>↓ 93.00 %</td>
<td>↓ 90.30 %</td>
</tr>
<tr>
<td>RTT: 95% non-admitted performance</td>
<td>Nov-12</td>
<td>98.80 %</td>
<td>↓ 98.60 %</td>
<td>↑ 98.40 %</td>
<td>↓ 98.70 %</td>
<td>↑ 98.30 %</td>
</tr>
<tr>
<td>RTT: 92% incomplete pathways</td>
<td>Nov-12</td>
<td>93.10 %</td>
<td>↓ 93.40 %</td>
<td>↑ 93.50 %</td>
<td>↓ 94.60 %</td>
<td>↑ 93.10 %</td>
</tr>
<tr>
<td>18 week waits - audiology</td>
<td>Nov-12</td>
<td>100% → 100% → 100% → 98.90 %  ↑ 99.40 %</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic waits &gt; 6 wks</td>
<td>Nov-12</td>
<td>0.54% ↓ 2.21% ↓ 0.30% ↓ 0.62% ↓ 2.18% ↓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infection control: Clostridium Difficile (Monthly)</td>
<td>Dec-12</td>
<td>60 ↓ 44 ↓ 32 → 27 ↓ 50 ↓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infection control: MRSA (Monthly)</td>
<td>Dec-12</td>
<td>6 → 6 ↓ 4 → 2 → 3 →</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer waits: 2 week GP referral-to-appt</td>
<td>Oct-12</td>
<td>91.30 % ↓ 96.60 % ↑ 96.40 % ↓ 93.90 % ↓ 94.60 % ↑</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer waits: 2 week breast symptomatic target</td>
<td>Oct-12</td>
<td>93.40 % ↓ 97.70 % ↑ 98.90 % ↑ 95.20 % ↑ 92.50 % ↑</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer waits: 31 days diagnosis to treatment</td>
<td>Oct-12</td>
<td>99.20 % ↑ 100% → 97.70 % ↓ 99.30 % ↑ 100% ↑</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer waits: 31 days diagnosis to treatment subsequent drug treatment</td>
<td>Oct-12</td>
<td>100% → 100% ↑ 100% → 100% ↑ 95.00 % ↓</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer waits: 31 days diagnosis to treatment subsequent surgery</td>
<td>Oct-12</td>
<td>100% → 100% → 100% → 100% ↑ 100% →</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer waits: 31 days treatment subsequent radiotherapy</td>
<td>Oct-12</td>
<td>100% → 100% → 100% → 100% → 100% →</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer waits: 62 days referral to treatment</td>
<td>Oct-12</td>
<td>84.40 % ↓ 91.30 % ↑ 73.50 % ↓ 93.30 % ↑ 91.30 % ↑</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer waits: 62 days referral to treatment - referral from screening</td>
<td>Oct-12</td>
<td>100% → 75.00 % ↓ 100% → 100% → NIL ↑</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer waits 62 days upgrade</td>
<td>Oct-12</td>
<td>95.80 % ↓ NIL → 100% → 100% → 100% →</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mixed sex accommodation breaches</td>
<td>Nov-12</td>
<td>4 ↑ 0 → 1 ↑ 1 ↓ 0 ↑</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measure</td>
<td>Date of Current Data</td>
<td>Barnet</td>
<td>Camden</td>
<td>Enfield</td>
<td>Haringey</td>
<td>Islington</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
<td>---------------------</td>
<td>--------</td>
<td>--------</td>
<td>---------</td>
<td>----------</td>
<td>-----------</td>
</tr>
<tr>
<td>Stroke: Time on stroke unit</td>
<td>Q2121 3</td>
<td>94.60%</td>
<td>↓</td>
<td>95.10%</td>
<td>↑</td>
<td>94.60%</td>
</tr>
<tr>
<td>Stroke: TIA Assess within 24hrs</td>
<td>Q2121 3</td>
<td>81.80%</td>
<td>↑</td>
<td>63.60%</td>
<td>↓</td>
<td>86.40%</td>
</tr>
<tr>
<td>Deaths in usual place of residence</td>
<td>Q2111 2</td>
<td>35.60%</td>
<td>↓</td>
<td>38.80%</td>
<td>↑</td>
<td>30.90%</td>
</tr>
<tr>
<td>Maternity access at 12 weeks</td>
<td>Q4111 2</td>
<td>83.64%</td>
<td>↑</td>
<td>107.0%</td>
<td>0%</td>
<td>84.20%</td>
</tr>
<tr>
<td>MH Early intervention in psychosis</td>
<td>Q2121 3</td>
<td>25</td>
<td>52</td>
<td>26</td>
<td>26</td>
<td>49</td>
</tr>
<tr>
<td>MH Home Treatment episodes</td>
<td>Q2121 3</td>
<td>367</td>
<td>395</td>
<td>356</td>
<td>467</td>
<td>564</td>
</tr>
<tr>
<td>CPA 7-day follow-up</td>
<td>Q2121 3</td>
<td>99.30%</td>
<td>↓</td>
<td>97.50%</td>
<td>↑</td>
<td>98.60%</td>
</tr>
<tr>
<td>IAPT in treatment as % of total with depression</td>
<td>Q2121 3</td>
<td>1.34%</td>
<td>3.56%</td>
<td>1.32%</td>
<td>4.03%</td>
<td>4.84%</td>
</tr>
<tr>
<td>IAPT completed treatment moving to recovery (Quarterly)</td>
<td>Q2121 3</td>
<td>52.48%</td>
<td>46.00%</td>
<td>44.55%</td>
<td>41.34%</td>
<td>37.83%</td>
</tr>
<tr>
<td>IAPT completed treatment moving to recovery (YTD)</td>
<td>Q2121 3</td>
<td>45.93%</td>
<td>44.49%</td>
<td>42.28%</td>
<td>42.39%</td>
<td>38.07%</td>
</tr>
<tr>
<td>Under-18 conception rate per 1,000 females 15-17yrs -Annual</td>
<td>2010</td>
<td>22</td>
<td>↑</td>
<td>27.7</td>
<td>↑</td>
<td>34</td>
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<tr>
<td>Under-18 conception rate per 1,000 females 15-17yrs -Quarterly</td>
<td>Q2111 2</td>
<td>10</td>
<td>21</td>
<td>30.2</td>
<td>42.5</td>
<td>30.3</td>
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<tr>
<td>Chlamydia screening</td>
<td>Q2121 3</td>
<td>2.55%</td>
<td>3.57%</td>
<td>3.83%</td>
<td>3.18%</td>
<td>3.48%</td>
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<tr>
<td>Breast screening aged 47-49 and 71-</td>
<td>Q4101</td>
<td>64.80%</td>
<td>26.10%</td>
<td>49.20%</td>
<td>41.80%</td>
<td>38.00%</td>
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<td>Measure</td>
<td>Date of Current Data</td>
<td>Barnet</td>
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<tr>
<td>Emergency admissions for Long Term Conditions</td>
<td>Q1112 1</td>
<td>7,301</td>
<td>4,025</td>
<td>5,175</td>
<td>4,300</td>
<td>4,122</td>
</tr>
<tr>
<td>GP referrals using Choose and Book</td>
<td>Nov–12</td>
<td>37.60</td>
<td>38.82</td>
<td>42.20</td>
<td>34.57</td>
<td>44.23</td>
</tr>
<tr>
<td>GP survey - satisfaction opening hours</td>
<td>Q2121 3</td>
<td>73.90</td>
<td>73.80</td>
<td>79.20</td>
<td>75.00</td>
<td>74.60</td>
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<td>Dental Access - pts treated in last 24 months</td>
<td>Sep–12</td>
<td>149.0</td>
<td>119.12</td>
<td>158.5</td>
<td>157.3</td>
<td>101.0</td>
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<tr>
<td>Category</td>
<td>Year</td>
<td>Male/Male</td>
<td>CVD</td>
<td>Cancer</td>
<td>Childhood Obesity % in Reception who are obese</td>
<td>Childhood Obesity % Reception height &amp; weight recorded</td>
</tr>
<tr>
<td>-------------------------------------------------------</td>
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<td>-----------------------------------------------</td>
<td>-----------------------------------------------------</td>
</tr>
<tr>
<td>Male mortality rate (per 100,000) all ages</td>
<td>2008</td>
<td>575.9</td>
<td>707.4</td>
<td>625.2</td>
<td>769</td>
<td>852</td>
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<tr>
<td>Female mortality rate (per 100,000) all ages</td>
<td>2008</td>
<td>399</td>
<td>443.2</td>
<td>452.8</td>
<td>426.6</td>
<td>533.9</td>
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<tr>
<td>CVD mortality rate (per 100,000) Under 75s</td>
<td>2008</td>
<td>51.5</td>
<td>78.4</td>
<td>70.9</td>
<td>86.1</td>
<td>120</td>
</tr>
<tr>
<td>Cancer mortality rate (per 100,000) Under 75s</td>
<td>2008</td>
<td>97</td>
<td>106</td>
<td>106</td>
<td>122</td>
<td>134.3</td>
</tr>
<tr>
<td>Childhood Obesity % in Reception who are obese</td>
<td>20101</td>
<td>9.54%</td>
<td></td>
<td></td>
<td>↑ 11.12%</td>
<td>↑ 14.57%</td>
</tr>
<tr>
<td>Childhood Obesity % Reception height &amp; weight recorded</td>
<td>20101</td>
<td>85.06%</td>
<td>96.57%</td>
<td>89.12%</td>
<td>83.08%</td>
<td>85.28%</td>
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<tr>
<td>Childhood Obesity % in Year 6 who are obese</td>
<td>20101</td>
<td>19.50%</td>
<td></td>
<td></td>
<td>↑ 22.46%</td>
<td>↑ 25.18%</td>
</tr>
<tr>
<td>Childhood Obesity % Year 6 height and weight recorded</td>
<td>20101</td>
<td>85.68%</td>
<td>94.72%</td>
<td>90.22%</td>
<td>81.22%</td>
<td>87.85%</td>
</tr>
<tr>
<td>Immunisation, 1 yr old DtaP/IPV/Hib</td>
<td>Q2121</td>
<td>95.80%</td>
<td>91.00%</td>
<td>86.10%</td>
<td>91.40%</td>
<td>95.30%</td>
</tr>
<tr>
<td>Immunisation, 2 yrs PCV</td>
<td>Q2121</td>
<td>91.30%</td>
<td>87.00%</td>
<td>83.40%</td>
<td>85.60%</td>
<td>90.10%</td>
</tr>
<tr>
<td>Immunisation, 2 yrs Hib/MenC</td>
<td>Q2121</td>
<td>91.30%</td>
<td>87.60%</td>
<td>80.20%</td>
<td>89.70%</td>
<td>90.10%</td>
</tr>
<tr>
<td>Immunisation, 2 yrs MMR</td>
<td>Q2121</td>
<td>91.10%</td>
<td>86.60%</td>
<td>83.90%</td>
<td>87.50%</td>
<td>90.50%</td>
</tr>
<tr>
<td>Immunisation, 5 yrs DtaP/IPV</td>
<td>Q2121</td>
<td>85.90%</td>
<td>79.30%</td>
<td>81.30%</td>
<td>85.50%</td>
<td>84.80%</td>
</tr>
<tr>
<td>Immunisation, 5 yrs MMR</td>
<td>Q2121</td>
<td>83.80%</td>
<td>80.00%</td>
<td>78.30%</td>
<td>83.90%</td>
<td>83.30%</td>
</tr>
<tr>
<td>No. of Drug Users in treatment</td>
<td>Jul-12</td>
<td>562</td>
<td>1,267</td>
<td>680</td>
<td>879</td>
<td>1072</td>
</tr>
<tr>
<td>No of Health Visitors</td>
<td>Aug-12</td>
<td>35.2</td>
<td>21</td>
<td>36</td>
<td>46.5</td>
<td>33.2</td>
</tr>
</tbody>
</table>

**Source:** various

**Commentary:** ↑ = Performance Improve ↓ = Performance declined.

Data period/date in red indicates provisional figures

Immunisation ratings are against recovery plans moving towards WHO recommendations of 95%.
MEETING: Meeting of the Joint Boards of NHS North Central London  
DATE: 31 January 2013  
TITLE: NHS Barnet CCG Performance Report  
LEAD DIRECTOR: John Morton Chief Officer: NHS Barnet CCG  
AUTHOR: Cynthia Folarin Interim Director Quality and Assurance  
CONTACT DETAILS: Cynthia.folarin@nclondon.nhs.uk

SUMMARY:

NHS Barnet Clinical Commissioning Group (CCG) a Wave 3 CCG commenced the formal authorisation process in October 2012.

This paper provides an update for the Joint Boards of NHS North Central London on Barnet CCG progression towards establishment, authorisation, finance and performance.

SUPPORTING PAPERS:

- Barnet CCG Authorisation Update Report (monthly reports available)
- Barnet CCG: Borough Directors Report (monthly reports available)
- Barnet CCG: Conditions Letter – NHSCB
- Barnet CCG: CQR Minutes
- Barnet CCG: Governing Body Papers (Part 1)
- Barnet CCG: Audit Committee Minutes
- Barnet CCG: QIPP Minutes
- Barnet CCG: Integrated Performance Report

RECOMMENDED ACTION:

The Barnet Primary Care Trust Board is asked to:

- NOTE and COMMENT on this report

LINKS TO NHS NORTH CENTRAL LONDON STRATEGY

This paper supports the implementation of the NHS North Central London Strategic Commissioning plan and operating plan 2012/13.

GOVERNANCE:

Voting: Please indicate which Board(s) has voting rights on this matter (if applicable)

<table>
<thead>
<tr>
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<td>Robert Sumering</td>
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NHS North Central London is a collaborative working arrangement between Barnet, Camden, Haringey, Enfield and Islington Primary Care Trusts.

The Joint Boards of NHS North Central London refers to the joint meeting of the Boards of Barnet, Camden, Haringey, Enfield and Islington Primary Care Trusts.
Objective(s) / Plans supported by this paper: this paper provides narrative for the CCG authorisation process: supporting all 6 clinical domains and in addition give an overview of the underpinning CCG strategic and operating plans.

Patient & Public Involvement (PPI): A Communications and Engagement Strategy has been developed as part of the process for establishing the CCG. As a consequence a number of Community engagement forums have now been planned.

Equality Impact Analysis: None specifically in relation to this paper.

Risks: That NHS Barnet CCG is not authorised or that significant conditions are applied to the authorisation status. This is mitigated through robust processes to ensure all requirements are identified and plans in place to meet the requirements agreed. Authorisation has been identified as a strategic risk for the organisation and controls are in place.

Resource Implications: The paper describes the current CCG financial position.

Audit Trail: The paper refers to a number of CCG Committees.

Next Steps: A further report on performance will be next reported to NHS Barnet Primary Care Trust Board Governing Body Board Meeting in {March 2013}
EXECUTIVE SUMMARY

1. INTRODUCTION

NHS Barnet CCG is working towards key milestones to achieve wave 3 authorisation. The recent conditions letter identified 15 remaining points for which the required evidence is being collated. In accordance with the timeline highlighted below, NHS Barnet CCG must ensure that it completes a number of key outputs before 30 January deadline. The following report outlines the steps undertaken to achieve these milestones and performance of the CCG in key areas.

2. Authorisation process

Barnet CCG is currently working towards collating the evidence required for fifteen key lines of enquiry as illustrated in conditions letter. Of the fifteen conditions, nine are at level 3 (level 3 and above need sign off by the NCB from March 2013 onwards) and therefore evidence for these will be submitted during March and not in the January window. The required evidence for the remaining six must be compiled within a ten working day window which began on 17th January and ends on 30th January, this is in hand.

3. Strategic and Operational Plan

The development of the Barnet CCG Strategic Plan continues with engagement with the Barnet Health and Well Being Board, the Mental Health Partnership Board and other stakeholders. This work has also informed the Barnet 2013/14 Operating Plan and summary ‘plan on a page’ which will be submitted to NHS Commissioning Board on 25 January 2013. The Barnet CCG Board are considering the three local outcome measures that will be used to assess how well the CCG is delivering the plan. These will need to be agreed with the Health and Well Being Board and the NHS Commissioning Board. This will happen during February and March.

Once developed the strategic commissioning plan, incorporating QIPP plans for 2013/14 to 2015/16, and the 2013/14 operating plan will be shared with CCG member practices for approval.

4. Organisational Development

CCG Board has now moved into its final phase (January -- March 2013) of development in preparation for statutory authorisation. Board development has primarily concentrated on enabling board members to understand their accountabilities around the Quality agenda; Board Assurance Framework and managing risk.

4.1 Governance Structures

NHS Barnet CCG has four sub committees of the Governing Body:
- QIPP Finance and Performance Committee
- Quality and Clinical Risk Committee
- Audit Committee
- Remuneration Committee
The first three of these committees (QIPP, Quality and Audit) are now meeting regularly and the first remuneration committee is in discussion.

4.2 Achievements of the Board and other CCG Committees

NHS Barnet CCG’s governance structures continue to develop and are embedding effectively. The following headlines can be reported for the groups that met recently:

4.2.1 Governing Board

The Board met in December. Key highlights were:

The Board responded to a number of questions relating to Patient and Public Engagement. The Board provided assurance around the CCG’s engagement processes, and advised that there are a number of public engagement events planned which will continue to be supported by the working relationship with LINKs.

The Barnet CCG Board formally adopted the Standards for NHS Boards and Clinical Commissioning Governing Bodies in England. Details will be published on the Barnet CCG website.

The Board reviewed the Integrated Board report and noted a number of modifications that it would wish to be incorporated into the report that would provide more localised detail on the performance of secondary care providers.

The Board met in January. Key areas covered were:

An overview of the NHS Operating Framework was presented highlighting the Commissioning Board’s approach to providing services and identified the themes around ensuring equity and respect for all communities.

The Board reviewed the key risks for the CCG identified in the BAF & Risk Register, which include financial assumptions of the Finchley Memorial business case, QIPP position and retrospective claims, specifically noting that the northern boroughs would have the highest levels of claims.

For more information please refer to the CCG Governing Body minutes 06-12-12 Board minutes for 03-01-13 have not yet been ratified.

4.2.2 Audit Committee

The Audit committee met on 13th December 2012. Highlights from this meeting were:

It was agreed that the financial aspects of the risk register should be reported to the Audit Committee.

Discussions took place about how data provided to support the Clinical Quality process could be provided that would translate into more meaningful information and how this would add value to CCGs in the north working collaboratively.
A corporate legacy list is to be developed to provide a comprehensive record of actions that need to be put in place and/or executed prior to the 31st March.

4.2.3 Quality & Safety Committee

Agreement has been reached on managing and reporting on Clinical Quality Review (CQR) meetings for Trusts where Barnet CCG is currently the lead commissioner. GP Board members agreed to jointly chair meetings with the executive lead at Royal Free, Royal National Orthopaedic Hospital and have a presence at Barnet & Chase Farm; and Barnet, Enfield and Haringey Mental Health Trust CQR boards.

The Governing Body and CCG Quality Leads have been made aware of the recent Barnet & Chase Farm external investigation into the accuracy and reporting of the A&E waiting time target (95% cent of patients to be seen, treated, admitted or discharged within four hours) at Chase Farm Hospital. The Trust has reviewed other performance targets areas and found no further evidence of misreporting. Barnet CCG Boards’ principal responsibility, working with Enfield CCG, will be to ensure the implementation and monitoring of the action plan.

4.2.4 Finance, Performance and QIPP Committee

The Barnet CCG QIPP recovery programme included the establishment of a local PMO to underpin delivery of QIPP and other strategic projects. There are weekly PMO meetings to review projects with individual directors and managers. Work is ongoing to stretch existing schemes and identify new schemes to deliver savings this year and ensure robust effective plans are in place and delivering throughout 2013/14.

The 2012/13 QIPP target is £30.1m. For the first 9 months, QIPP of £9.4m has been achieved against a YTD target of £20.6m. A risk assessment is undertaken for all projects each month and for M9 this has resulted in a QIPP full year FOT of £15.6m giving an adverse variance to plan of £14.5m.

Schemes that have worked well in 12/13 include:

Medicines Management in Primary Care and in Acute
Older People Care Homes LES, Rapid Response ICT and Rapid Response Palliative Care
Continuing Healthcare
Mental Health Complex Care OATS
GP List Maintenance

Success can be attributed to early development of schemes prior to commencement of financial year and thus the ability to deliver savings from Month 1.

Looking forward to 2013/14 we are working with the CCG Board to develop a programme of schemes to deliver our strategic priorities under the following headings:

Integrated Care
Primary Care
Health & Wellbeing
Clinical & cost effectiveness

Under the priorities, initial focus has been on elective pathways, picking up eleven elective pathways where Barnet has both high activity/high spend and significant potential for reducing costs. These have been identified as priority areas and approved by the CCG Board for work up to business case by the end of January.

Taking forward the lessons learned from 12/13, in particular the need to have plans in place before 1st April, a detailed timeline of scoping, development and implementation has been agreed; this is very ambitious and reliant on additional resource being brought in to provide the support needed to work up accurate and deliverable plans in time for implementation in 2013/14. Following agreement for further project management resource by the Barnet FPQ group and the NCL Finance Director, 6 project managers have been engaged.

This additional resource will also be deployed to develop additional QIPP schemes as these are identified through on-going benchmarking and support from the CCG Board. A number of schemes identified through comprehensive benchmarking were taken to the CCG Board on 20th December and five areas for further scoping were agreed – pneumococcal vaccinations, nursing homes, community services, cancer and RAID (mental health). PMO is developing links with the CSU Delivery Improvement team in terms of benchmarking, informatics, finance and contracting expertise to ensure robust evidence to support QIPP plans.

5. Finance Report

Month 9 finance report highlights are:

Barnet's position improved by £219k from month eight, reducing the cumulative deficit to £(292)k, year to date.

The basis of Barnet’s 2012/13 budget was to deliver a breakeven control total. To ensure this, £(47.4)m of gap needed to be filled as follows:

£17.3m non recurrent support
£30.1m QIPP schemes (of which £23.3m identified and £6.8m unidentified QIPP)

Month 9 saw a favourable position in month of £219k, main drivers being positive moves within delegated acute (release of readmissions payments) and non acute budgets in part countered by the negative impact of NCB services, operating costs and reserves.

The forecast position has improved by £1.2m and now stands at a full year deficit of £(2.5)m. The potential for risk in acute over performance continues to be the overriding factor although the position is tempered by positive forecasts in non acute, operating costs and reserves.

Following the release of 13/14 allocations on 18 December, significant work has been undertaken to understand the reduced funding and negative bottom line impact for next year. The process is ongoing and further detail on the NCB deductions and
their true effect is expected from the PCT at the end of January. The current position is that Barnet CCG’s allocation looks extremely challenging.

6. Performance

Performance against KPI for November, 2012 has identified;

- There were 55 incidents of C.Diff, seven of which are above the threshold. The plan produced by both the Royal Free and Barnet and Chase Farm Hospitals to manage performance will be reviewed through their Infection Control Committees and discussed at the monthly Clinical Quality Review Group meetings.

- There have been 6 cases of MRSA, which is one above the threshold. Performance will be reviewed through the infection control committees and discussed at the monthly Clinical Quality Review Provider Group meetings.

- Although mixed sex accommodation breaches are down by three since last month, there have been 4 breaches of the standard, 3 at Barnet and Chase Farm (1 at Barnet site and 2 at Barnet and Chase Farm) and 1 breach at the Royal Free, as a result of bed availability. An improvement plan recovery trajectory is in place which has seen a reduction in reported Trust level breaches. Performance at Barnet and Chase Farm and The Royal Free Trusts is currently being monitored and discussed at the monthly Clinical Quality Review Group meetings.

- Maternity access at 12 weeks has again improved but still below threshold. Targeted work with Barnet & Chase Farm and local GP’s is underway to identify the root cause and resolve the issues identified.

John Morton
Barnet CCG Chief Officer
MEETING: Meeting of the Joint Boards of NHS North Central London
DATE: Thursday 31 January 2013
TITLE: Camden Emerging Clinical Commissioning Group Performance Report
LEAD DIRECTOR: David Cryer, Chief Officer (Designate), NHS Camden Clinical Commissioning Group
AUTHOR: William Roberts, Strategy and Planning
CONTACT DETAILS: david.cryer@nclondon.nhs.co.uk
07825 402 612

SUMMARY:
This paper gives the Board of Camden Primary Care Trust (PCT) a summary of the CCG monthly integrated performance report.

SUPPORTING PAPERS:
No appendices accompany this paper.

RECOMMENDED ACTION:
The Board of Camden Primary Care Trust is asked to:
• NOTE and COMMENT on CCG performance.

LINKS TO NHS NORTH CENTRAL LONDON STRATEGY
Performance management is a key part of CCGs progress towards achieving authorisation.

GOVERNANCE: Relates to internal Transition Programme governance only.

Voting: Please indicate which Board(s) has voting rights on this matter (if applicable):

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<tr>
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The Joint Boards of NHS North Central London refers to the joint meeting of the Boards of Barnet, Camden, Haringey, Enfield and Islington Primary Care Trusts.
Objective(s) / Plans supported by this paper:

To provide the Joint Boards with an overview of CCG performance.

Patient & Public Involvement (PPI): None

Equality Impact Analysis: None

Risks: The key risk of not meeting the delegated responsibility budget is being managed by close involvement with contracting and informatics colleagues at Stephenson House, and the abatement of funds used for investment. The strong governance processes in place will ensure that these are affordable, achieve value for money, and do not contribute of an undershoot of the control total.

Audit Trail: N/A

Next Steps: N/A
1. EXECUTIVE SUMMARY

This report provides an update to the PCT board on the progress that the Shadow CCG has made against the areas of delegated responsibility.

2. INTRODUCTION

A comprehensive integrated performance report has been developed for CCGs to use during the period of delegated responsibility. This report will be the vehicle on which CCGs are performance managed and will form the basis of the monthly stock take meetings between Caroline Taylor and NHS North Central London colleagues and the CCG Chair, Chief Officer and CCG team. This report provides the Camden PCT Board with a summary of the integrated performance report.

The Board of Camden PCT is asked to:

- **NOTE** and **COMMENT** on CCG performance.

3. AUTHORISATION

The CCG was left with 11 remaining red buttons after the site visit, the CCGs supplementary evidence window closes on the 23rd January and the CCG is confident that six of the red buttons can be turned green. The table below summarises the red areas and the action plan to turn the buttons green.

<table>
<thead>
<tr>
<th>Authorisation criteria reference</th>
<th>CCG’s proposed rectification plan and timescale to meet requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.3B Clear arrangements in place to enable a wider local multi professional clinical community to inform commissioning, the CCG governing Body includes nurse and secondary care doctor.</td>
<td>The nurse has not yet been appointed and we are currently interviewing for this post with the intention of having the staff member in post before March 2013</td>
</tr>
<tr>
<td>2.2B Plans, processes and resources are in place to measure and use insight from patients and carers. Systems and processes for monitoring and acting on patient feedback.</td>
<td>We are currently developing a process for sign off at the January CCG governing body meeting to collate and collect this information systematically. The Patient and Public Engagement Group (PPEG) had their first formal meeting on the 19th November and identified this as a key piece of work in their work plan. Recruitment for the support role for this group closed on the 16th November and a fixed term appointment will be made to support this work. The PPEG have developed their engagement plan for Q4 2012/13 and 2013/14.</td>
</tr>
<tr>
<td>Section</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
</tr>
<tr>
<td>3.1.1B</td>
<td>Clear and credible plans</td>
</tr>
<tr>
<td>3.1.1C</td>
<td>Clear and credible plans</td>
</tr>
<tr>
<td>4.2.1E</td>
<td>Effective system of internal controls</td>
</tr>
<tr>
<td>4.2.1F</td>
<td>Effective system of internal controls</td>
</tr>
<tr>
<td>4.2.3D</td>
<td>CCG has systems and processes</td>
</tr>
<tr>
<td>5.1A</td>
<td>Collaborative arrangements</td>
</tr>
<tr>
<td>5.3B</td>
<td>CCG collaborates with local partners</td>
</tr>
<tr>
<td>6.4F</td>
<td>Governing body fulfils national requirements</td>
</tr>
</tbody>
</table>
We have been advised by the NHS commissioning board that areas 3.1.1b and 3.1.1c will not be reviewed during the evidence window and will be assessed through the operating planning submission. Added to this we will not have recruited and have in place a chief finance officer by the 23rd but are confident that they will be successfully recruited ahead of April 2013 and have a process in place to secure the appointment. The risk share agreement is being finalised by the CCGs but may not be completed in time for the evidence window. The remaining red button for the recruitment will depend on the success of securing an appointment by the 23rd January and this is likely given the interview schedule before this date but not guaranteed.

4. **Performance against national indicators**

There have been no notable changes over the past month with the high levels of Clostridium difficile seen in the first quarter now stabilised and the new trajectories for IAPT have been submitted to NHS London for review. The three additional areas that have been highlighted for attention are:

<table>
<thead>
<tr>
<th>Measure</th>
<th>Plan</th>
<th>Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Four-hour maximum wait in A&amp;E</td>
<td>95% Q3</td>
<td>94.50% Q3</td>
</tr>
<tr>
<td>Infection control: MRSA</td>
<td>Annual threshold is 6. Threshold is calculated monthly at 2 for April – Nov.</td>
<td>5 to date – no new cases since last month.</td>
</tr>
<tr>
<td>Substance Misusers in Effective Treatment</td>
<td>1,321 substance misusers in treatment</td>
<td>1,267 in treatment (July 2012)</td>
</tr>
</tbody>
</table>

4.1 A&E four hour wait

Whilst A&E performance has improved over the past few weeks, concern remains that this level of performance cannot be sustained throughout the winter months. UCLH partly attributed underperformance during November and December to lack of bed availability at the UCLH Tower, staffing pressures and increased attendances: the combined effect of these factors has increased waiting times for assessment and treatment in A&E. UCLH has a short and medium term recovery plan that increases bed capacity; addresses the bed flow within the Tower and clarifies escalation processes within A&E. The issue has been given the highest priority within the Trust and recovery meetings are taking place 3 times a week led by the Chief Executive and Medical Director.

There was a further meeting with the Trust’s Chief Executive and leadership in December that focused on the following key areas:
It was agreed to jointly undertake a piece of work to develop a more effective model of urgent care

More work is needed to understand what impact the planned interventions will have in delivery on a sustainable basis to address the root causes of underperformance, particularly in relation to the Trust’s medium-term plan

A further look at the planned restart of elective work in January, following the holiday period, and impact on managing emergency workload to determine whether any adjustments may be needed

In an effort to support the Trust to ensure an accurate analysis of problems and planned intervention, we agreed to share further data we hold with the Trust

Latest performance suggests an increase in performance at UCLH but there will continue to be a push for the trust to implement the ECIST report recommendations. Plans for the EPRR systems under the CCG are still in development and will be finalised over the coming weeks with the CSU.

4.2 MRSA

Camden is reporting 5 MRSA bacteraemia acquisitions against an annual threshold of 6 and a YTD trajectory of 2.

The following table provides a breakdown of cases reported at each trust.

<table>
<thead>
<tr>
<th>Camden PCO MRSA Acquisition April to December 2012</th>
<th>GOSH</th>
<th>RFH</th>
<th>UCLH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attributable to Acute Trust</td>
<td>Attributable to Community</td>
<td>Attributable to Acute Trust</td>
<td>Attributable to Community</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

Action plans have been written by the reporting trusts and are being monitored via the NCL Infection Control team and the Trust Infection Control Committees. Root Cause Analysis Investigations have been carried out for all cases. The main learning appears to relate to care of CVC lines (2 cases). Further review of MRSA acquisition will be undertaken with all Providers via CQRG’s.

4.3 Substance misusers in effective treatment

This is no longer a national target, but 50% of the funding for drug treatment is based on performance against this measure. Public Health England has confirmed this measure will inform a proportion that would have been previously ring-fenced to drug treatment in the public health allowance in future.

The number of opiate and crack users in treatment has reduced steadily by 2.2% from 2010/11 baseline of 1,307 to 1,278 in 2011/12. Data for rolling 12 months period ending in July 2012 shows a 1% decrease from 2011/12 out turn (1,267), however, Camden’s actual performance at the end of July 2012 is 4.1% (54) behind the target for 2012/13.
The decrease in opiate and crack users in treatment is not a problem to Camden alone, data for London shows a considerable 6% reduction in numbers from 2010/11 to 2011/12. And a reduction in numbers of especially opiate users in treatment has also been reported nationally. The NTA has identified some possible reasons for this reduction:

a. More people are using other drugs (in Camden the proportion of non-opiate or crack users in treatment has increased 20% in 2010/11 to 23% in 2011/12).

b. Less people initiate opiate use and some people who may have been using opiates divert to other drugs amidst the opiate related health scares and overall poor quality of street drugs.

Of the estimated 2,311 opiate and crack users in Camden data shows that 80% (1,859) have treatment experience, meaning only 20% have never been to treatment. Camden’s annual treatment rate (around 59%) is also 8% higher than the London overall rate. As the estimates for opiate and crack use change annually, and for Camden this change has been considerable (from 4,444 in 2005/06 to 2,311 in 2008/09) there is a concern that the estimate is higher than the actual treatment need.

Another issue for Camden is that not enough opiate users are completing treatment, but instead remain on substitute prescribing for years. A new national indicator for successful completions shows that completions rate for opiate users in Camden (7.7% of the treatment population) is 2% behind the rate for comparable areas in England. This could be a reflection of lack of recovery options for opiate users in Camden, which might also act as a barrier for some treatment naïve opiate users from accessing treatment.

The main provider (Camden and Islington NHS Foundation Trust) underwent a significant restructure in 2011/12 and this could have had an impact on the numbers in effective treatment. However, the provider has reported that it has seen any client it could and there have been no waiting lists. Therefore the overall shift in drug use is likely to have a bigger impact on numbers reported in effective treatment than the organisational change.

5. Finance

The forecast year-end position for the CCG showed an underspend of £7,753,000. The finance report for month 08 highlighted a forecast year-end financial pressure within the acute contracts portfolio of £8M, which is a slight improvement on the previous month forecast of £8.5M.

It should be noted however, that the over-performance at in-sector hospitals as at Month 8 has worsened by £300k since last month. This does not mean the CCG will exceed its delegated budget for the year: the pressure can be off-set by forecast underspends in non-acute, investments and reserves of £15M.

Around £1M of the underspend is coming from running costs due to lower than expected staffing costs as a result of staffing levels being lower than complement in the early part of the year.

The financial position of the Business Case Investments was discussed and the Chief
Financial Officer provided a report on the latest budget and spend positions of each of the Wave 1, 2 and 3 Business Cases. This has highlighted an underspend of £6M of investment funds.

6. Contract position and planning for 13/14

The CSU and CCG are engaged in the contract negotiations with discussions progressing around the QIPP schemes for 13/14. The CCG shadow governing body signed off the strategic direction and QIPP ambition with some refinements required to agree a final QIPP target for 13.14 and 14/15 that ensure effective QIPP improvement but ensures delivery and clinical safety. The CSU have been asked to agree a local process for assuring QIPP with providers and supporting commissioner sign off of CIP plans.

Finalised operating planning guidance was issued by the NHS commissioning board over the Christmas period. The main changes are to the dates of submission and to some of the content of what needs to be submitted. This document details the changes made, progress over the past month, areas for the governing body to identify if they are sufficiently assured and the timeline for sign off.

To comply with the guidance the CCG is required to submit the following to the NHS commissioning board local area team:

- 2013/2014“Plan on a Page” including key elements of transformational change;
- Self certification of delivery of the NHS Constitution, Mandate and Clostridium difficile objective;
- Self certification of assurance of provider Cost Improvement Programmes;
- Trajectory for Dementia and IAPT;
- Trajectories for 3 locally selected priorities;
- Activity trajectories for 4 key measures – elective FFCEs, non-elective FFCEs, first outpatient attendances, A&E attendances;
- Financial information including
- Description of QIPP

The CCG is required to submit the requested items by the 25th January 2013 and a final operating plan to the NHS commissioning board London Area Team by the 5th April 2013. We are on trajectory to achieve this and have worked closely with the cluster CCGs and the CSU through a joint planning group to ensure consistency of approach, shared development where necessary and to support coordinated planning.

The NHS commissioning board has produced the following timeline for sign off of the operating plan:
Based on this timeline the suggestion is to sign off the document at the following governing body meetings and subcommittees:

<table>
<thead>
<tr>
<th>Item requiring sign off</th>
<th>Suggested meeting for sign off</th>
</tr>
</thead>
<tbody>
<tr>
<td>First draft submission</td>
<td>CCG governing body seminar 23rd January 2013</td>
</tr>
<tr>
<td>QIPP and finance plan</td>
<td>February 27th Finance and performance committee</td>
</tr>
<tr>
<td>Contract values signed off</td>
<td>February 27th Finance and performance committee</td>
</tr>
<tr>
<td>Final draft operating plan</td>
<td>CCG governing body seminar 27th March 2013</td>
</tr>
</tbody>
</table>

7 GOVERNANCE HEADLINES

7.1 Achievements of the CCG Board and other sub-committees

The governing body has met in public three times and a register of interest has been established to ensure transparency and openness. The audit committee chair has been appointed and the first shadow meeting took place in January. The shadow remuneration committee has been established.

The governing body has sign off a range of policy documents including: Information Governance Policies (including Records Management); Equality and Diversity Strategy; Conflicts of interest policy; Adult Safeguarding Policy; Children’s Safeguarding Policy; Complaints policy
The governing body are currently reviewing the constitution to ensure it remains in line with the national guidance

8. CONCLUSION

The shadow CCG has made significant progress over the last month with continued strong financial performance and clear plans in place to improve performance in areas where it is not currently sufficient. We expect to be authorised with limited conditions in the coming month and are confident of discharging any condition ahead of April 2013.
MEETING: Meeting of the Joint Boards of NHS North Central London
DATE: 31 January 2013
TITLE: Enfield Clinical Commissioning Group Performance Report
LEAD DIRECTOR: Liz Wise, Chief Officer
AUTHOR: Keith Spratt
CONTACT DETAILS: Keith.spratt@nclondon.nhs.uk
0208 238 3730

SUMMARY:

This paper provides the Board of Enfield Primary Care Trust (PCT) with an updated summary of Enfield Clinical Commissioning Group (CCG) monthly integrated performance report.

SUPPORTING PAPERS:

None

RECOMMENDED ACTION:

The Board of Enfield Primary Care Trust is asked to:

• NOTE and COMMENT on progress towards Authorisation and progress in relation to key performance targets

LINKS TO NHS NORTH CENTRAL LONDON STRATEGY

Performance management is a key aspect of progress towards achieving Authorisation.
**GOVERNANCE:** Transition Programme

**Voting:** Please indicate which Board(s) has voting rights on this matter (if applicable)

<table>
<thead>
<tr>
<th>Barnet</th>
<th>Camden</th>
<th>Enfield</th>
<th>Haringey</th>
<th>Islington</th>
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<tr>
<td>Paula Kahn</td>
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<tr>
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<td>Caroline Rivett</td>
<td>Karen Trew</td>
<td>Cathy Herman</td>
<td>Anne Weyman</td>
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<td>Andrew Howe</td>
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<td>Joanne Wickens</td>
<td>Abedi</td>
<td>Helen</td>
<td>Bev Evans</td>
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<td>Jennie Hurley</td>
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</table>

**Objective(s) / Plans supported by this paper:**

To provide an overview of Enfield CCG performance

**Patient & Public Involvement (PPI):** None

**Equality Impact Analysis:** Not required

**Audit Trail:** None
1. INTRODUCTION

1.1 Enfield Clinical Commissioning Group (Enfield CCG) successfully achieved Delegated Responsibility on 1 October 2012 and is working towards Authorisation to take over its statutory commissioning responsibilities from 1 April 2013.

NHS North Central London has a duty to ensure that in passing over the statutory responsibility to Enfield CCG it has evidence across six domains to support the authorisation process. This includes performance reporting and in particular, ensuring that performance is understood and where there are concerns that Enfield CCG is addressing those concerns through robust action plans to tackle areas of poor performance. Leading on performance reporting is a key aspect of attaining delegated responsibility and authorisation. This reporting regime provides the evidence and assurance that performance standards are in place, are understood and where deficient, are being addressed.

2. PERFORMANCE OF DELEGATED BUDGETS

2.1 NHS Enfield CCG has achieved Delegated Responsibility for all commissioned services for which it will have a statutory responsibility for from 1st April 2013.

NHS Enfield CCG continues to work with the cluster team in respect of issues relating to:

- Barnet Enfield Haringey Mental Health NHS Trust operational and quality issues
- Acute over-performance
- QIPP unidentified gap
- Possible cost of retrospective claims for Continuing Health Care
- Forecast PCT overspend of £5.3m
- BEH Clinical Strategy approval and implementation

2.2 Enfield CCG is pleased to share the following achievements:

2.2.1 The PCT forecast year-end deficit has been on a decreasing trend for the last quarter and currently stands at £5.3m.

The month 8 cumulative results show a deficit of £1.898M against a break even position. The shortfall is primarily made up of acute over-performance and unidentified QIPP. The forecast to the end of the year shows a deficit of £5.038M with acute over-performance £1.87M and unallocated QIPP deficit of £6.107M the key items. These are partially offset by the acute reserve of £5.4M and contingency of £2.4M.

2.2.2 Performance against the Prescribing budget is now showing an underspend of £400K for the year to date with a forecast underspend of £600K by year-end. October 2012 prescribing data shows a -2.3% reduction on October 2011 and cumulative spend of -7.1% (April-October 12 vs. April-October 11). This compares well with a reduction in spend for London of -5.6%. Current full year forecast outturn from PPA is £35.3m, indicating that QIPP increased target of £3.3m will be exceeded.
2.2.3 The acute performance continues to be the prime area of concern with over performance of £800K to date and a forecast of £1.9M.

2.2.4 NCB Shadow budgets were overspent by £787K (1.4%). The key impact comes from specialist commissioning and reduced income in primary care.

2.2.5 Operating costs show a saving against budget of £1,517K to date, primarily from estates costs (under budget by £703K) and capital charges (depreciation for owning assets) – a saving of £572K for the eight months.

2.2.6 ‘Reserves and contingencies’ show an over spend against budget of £2.5M. This relates to unallocated QIPP of £4.1M offset by £1.6M of contingency, the total available at month 8. The CCG continues to develop QIPP programmes to reduce the unallocated sums; however implementation timescales largely preclude impact in the current year.

2.2.7 The Enfield QIPP target is £31.6M, of which £6.5M has been addressed through non-recurrent support, leaving a target of £25.1M. The QIPP schemes identified have been successful, though currently there is still an unallocated QIPP target of £6.1M.

2.2.8 Ten of the local QIPP schemes are set up and delivering financial savings with the remaining 12 local schemes at varying stages of planning. Enfield FR&Q Committee this month approved a business case to commence admission avoidance and Early Supported Discharge at North Middlesex University Hospital with Enfield as well as a new community cardiology service with expected savings of £400k in 2013/14.

2.2.9 Planning is well underway for the 2013/14 - 2015/16 programme with initial PIDs now meeting the proposed target of £25m for 2013/14 and £20m for 2014/15 with an expected delivery of £15m and £12m respectively.

2.2.10 The Fracture Liaison Nurse commenced on 3rd December 2012. Wider Falls development work has identified a number of key areas of focus; early identification and management of people susceptible to falls, setting up a single point of access and comprehensive and multi factorial Falls service, and Risk stratification and setting up a Falls register.

2.2.11 A Learning Disabilities Work Plan Strategy is being scoped to particularly focus on Transition and planning services for the projected increase in the Enfield population who are predicated to have a moderate or severe learning disability.

2.2.12 Apart from a vacancy for a Mental Health Nurse Assessor the continuing care assessment team is fully recruited. Forecast outturn as at November indicates a £96k over performance, indicating that the service continues to make progress against the stretch target of £120k in addition to achieving the £300k QIPP.
2.2.13 All Enfield practices are sent reports from the CCG on their referral and admission rates benchmarked against other practices in Enfield, London and England averages. Practices have formed peer groups to review under QoF their referral rates, A&E attendances and Emergency admissions and are on track to report back to the CCG in March.

2.2.14 In respect of performance targets;

- Both Referral to Treatment (RTT) targets remain ‘green’ this month. 90% Admitted performance stands at 94.5% for October and 95% non-Admitted is 98.7%
- Four-hour maximum wait in A&E has dropped below the target of 95% in November to 94.9%
- All Cancer waits are meeting targets with the exception of the 85% Cancer waits – 62 days to referral treatment target which stands at 73.5%
- Infection control targets for Clostridium Difficile and MRSA are both within target.

The CCG is closely monitoring targets with Providers in particular targets concerning A&E waits and Cancer waits.

3. GOVERNANCE HEADLINES

The Enfield CCG has on 16th January held its second public Governing Body Meeting. Minutes are currently being approved. The Governing Body Meeting Agendas, papers and minutes will be available on the Public website which will be available from the end of February.

3.1 Enfield CCG Governing Body (16th January 2013): Teri Okoro, Lay member with lead on patient and public engagement has been appointed. Professor Robert Elkeles, secondary care consultant has been appointed. Dr Mo Abedi has been appointed as Medical Director Integrated Care. The following policies were adopted/ratified by the Governing Body;

- Code of Practice on Openness in the NHS
- Standards for Members of NHS Boards and Clinical Commissioning Group Governing Bodies in England
- Standards of Business Conduct for NHS Staff
- Code of Conduct for NHS Managers
- Policy for Declaration of Interest and Resolution of Conflict
- Gifts, Hospitality and Commercial Sponsorship Policy
- Risk Management Strategy
- Information Governance Policy
- E-mail Security Policy
- Information Security Policy
- Safeguarding Children Policy
- Safeguarding Adults Policy
- Mental Capacity and Deprivation of Liberty Policy
3.2 In progressing towards authorisation Enfield CCG has established or recently recruited to the following Governing body roles:

<table>
<thead>
<tr>
<th>Roles</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chief Officer (Designate)</td>
<td>Liz Wise – commenced 1st October 2012</td>
</tr>
<tr>
<td>CCG Chair</td>
<td>Alpesh Patel - in post since July 2011</td>
</tr>
<tr>
<td>Chief Finance Officer and Director of Commissioning</td>
<td>Richard Quinton took up substantive contract 1 January 2013.</td>
</tr>
<tr>
<td>Lay Member (x2)</td>
<td>Karen Trew appointed Lay Vice chair with lead in governance</td>
</tr>
<tr>
<td></td>
<td>Teri Okoro appointed Lay Member with Lead in public and patient engagement</td>
</tr>
<tr>
<td>Registered Nurse</td>
<td>Recruitment completed – start February.</td>
</tr>
<tr>
<td>Secondary Care Doctor</td>
<td>Professor Robert Elkeles appointed</td>
</tr>
<tr>
<td>Patient Representative</td>
<td>Interim Recruitment process commenced on 19th November based on PPGs in practices</td>
</tr>
</tbody>
</table>

4. PROGRESS TOWARDS AUTHORISATION

4.1 Progress against plan

4.1.1 Enfield has completed the first two phases of the authorisation process and is currently in phase three. The NHS Commissioning Board carried out its Site Visit on Monday 7 January 2013 and was very complimentary on the results.

4.1.2 The site visit report was received Tuesday 15 January. The NHS Commissioning Board site visit report/letter and the CCG’s outline considered response will be tabled at Governing Body meeting.

4.1.3 The final CCG considered response was sent to the NHS Commissioning Board by Thursday 17 January 2013.

4.1.4 The NHS Commissioning Board will provide its’ final decision to Enfield CCG on 7 March 2013. The high level project plan is attached at Annex 1.

5. SUMMARY

In summary, Enfield CCG remains on track to achieve submission requirements for authorisation and associated organisational development including recruitment to organisational structure. The Board of Enfield Primary Care Trust is asked to note this report on the CCG’s progress towards authorisation and progress in relation to key performance targets.
Annex 1:

Our progress against our Authorisation Plan

Information collected on: 20 December 2012

NHS North Central London is a collaborative working arrangement between Barnet, Camden, Haringey, Enfield and Islington Primary Care Trusts.

The Joint Boards of NHS North Central London refers to the joint meeting of the Boards of Barnet, Camden, Haringey, Enfield and Islington Primary Care Trusts.
MEETING: Meeting of the Joint Boards of NHS North Central London
DATE: 31 January 2013
TITLE: Haringey Emerging Clinical Commissioning Group Performance Report
LEAD DIRECTOR: Sarah Price, Chief Officer
AUTHOR: Sarah Price, Chief Officer
CONTACT DETAILS: Sarah.price@nclondon.nhs.uk

SUMMARY:
This paper gives the Board of Haringey Primary Care Trust (PCT) a summary of the CCG monthly integrated performance report.

SUPPORTING PAPERS:
None.

RECOMMENDED ACTION:
The Board of Haringey Primary Care Trust is asked to:
• NOTE and COMMENT on CCG performance.

LINKS TO NHS NORTH CENTRAL LONDON STRATEGY
Performance management is a key part of CCGs progress towards achieving authorisation.

GOVERNANCE: Relates to internal Transition Programme governance only.

Voting: Please indicate which Board(s) has voting rights on this matter (if applicable)

NHS North Central London is a collaborative working arrangement between Camden, Camden, Haringey, Camden and Islington Primary Care Trusts.
The Joint Boards of NHS North Central London refers to the joint meeting of the Boards of Camden, Camden, Haringey, Camden and Islington Primary Care Trusts.
Objective(s) / Plans supported by this paper:

To provide the Joint Boards with an overview of CCG performance.

Patient & Public Involvement (PPI): None

Equality Impact Analysis: None

Risks: As described in report

Audit Trail: None

Next Steps: The NHSCB Authorisation Board will meet on 15 February 2013, with Haringey CCG receiving the authorisation status and number of conditions on 18 February 2013.
Performance Report – Joint Boards

This report provides a summary of performance for Haringey shadow Clinical Commissioning Group. This report was produced using information provided by NHS North Central London acting as the Commissioning Support Unit.

The CCG Governing Body receives regular reports covering:
- General Performance and KPIs (Key Performance Indicators)
- Quality
- Finance

The attached is a composite of such reports. National performance measures cover a wide range of quality and performance standards as set out in the Operating Framework for the NHS in England 2012/13. Some indicators appear in more than one area as they are applicable to multiple organisations and the data collection period also varies depending on the indicator.

Acute Performance

Generally in month performance has improved from October 2012. There is continued good performance overall against the referral to treatment time, with all North Central London Trusts meeting national measures for admitted and non-admitted treatments, incomplete pathways and diagnostic tests.

a) While the overall Haringey four hour A&E performance target remains green and Whittington Health performance has recovered to 95.30%, there has been deterioration at NMUH and UCLH this month with attainment at 94.40% and 93.70% respectively. Each of these providers have provided action plans, which have been strengthened in light of discussions, to recover and sustain the A&E waiting times standard. For NMUH the actions focus on additional staffing to support both department throughput and admissions avoidance work, e.g. additional therapies staff, additional nursing resource to support peak times for paediatric attendances and A&E consultant cover at weekends.

b) Cancer waits have improved this month and all measures are now within target range.

c) A mixed sex accommodation breach has been highlighted for a Haringey resident at Kings College Hospital NHS Foundation Trust. Additional details are being sought via the NHS NCL team as the trust is located outside of the routine reporting area and patient-specific details are therefore not routinely provided.

d) There was an increase in Clostridium difficile (C diff) cases in month at UCLH, which means the Trust is now over the cumulative infection control target for C diff. Whittington Health remain with one reported case of MRSA bacteraemia in the year to date, which is their annual target threshold. However, both the Haringey level targets (across all providers) remain within threshold limits.
e) Norovirus infection incidence rates and consequent bed closures for November have been experienced across North Central London – of note are BCF, UCLH and Whittington Health. The effect of seasonal pressures such as this and the monitoring of capacity demands are discussed with providers during regular teleconferences with acute providers, currently held three times per week over the winter period.

Non Acute Performance

a) GP survey opening hours satisfaction has improved by 0.6% to 75% but is still below target and will remain a key area of focus for the Primary Care Strategy

b) Quarter 2 performance on Improving Access to Psychological Therapies (IAPT) across the cluster reveals that only Haringey is currently achieving its plan (and the Department of Health target) for the percentage of people with depression accessing IAPT services.

c) The number of Health Visitors is now reported as a Haringey-only figure, rather than combined with Islington, and stands at 87.2% (staffing against NHS London target).

Public Health

Many Public Health KPIs have not changed in month as data collection periods have not been updated. The Board is asked to note the following;

a) Quarter 2 immunisations rates have reduced for two counts –

- DTaP/IPV/Hib or the 5-in-1 vaccine, this protects against: diphtheria, tetanus, pertussis (whooping cough), polio and Hib (*Haemophilus influenzae* type B) and is given in 3 doses before the age of 1 year.
- Pneumococcal (PCV) – this protects against some types of pneumococcal infection and is given in 3 doses the last being at just over 1 year of age.

Potential causes for the dip have been investigated by Public Health colleagues and in discussion with other Boroughs. No dominant cause has been identified and a similar decrease in uptake has been recorded in other Boroughs across the same period. Overall target attainment remains on trajectory as quarter 1 figures were high and indicative rates for quarter 3 in Haringey have improved, which would indicate that this is not a downward trajectory. The work continues with getting accurate data from GP practices.

b) Quarter 2 smoking cessation figures show a large increase, although the figures remain under trajectory for Haringey. There has been a significant improvement which is in line with the usual target attainment profile and an action plan has been agreed with the service provider, Innovision. Key actions include targeting mental health (both capturing status recording and training of staff in mental health units), marketing and communications strategies and improved web-based IT systems.

c) A new measurement included this month shows the number of drug users in treatment as significantly higher than target (879 v 549).

d) Haringey achieved the quarter 2 year to date plan for NHS Health Checks, both offered and received.
Governance headlines

The Clinical Commissioning Group’s inaugural Governing Body (GB) meeting in public was held on 22 November 2012. The GB noted the progress against authorisation, including the recent site visit on 13 November 2012. The GB agreed to delegate final approval of the plans regarding how best to use the 2012/13 allocations for Social Care and Reablement to the Finance and Performance Committee. The GB noted that the forecast out-turn at Month 7 was again an improvement on the previous month. The GB received progress updates on the Integrated Commissioning Plan and the Primary Care Strategy.

The GB formally adopted a range of Governance Codes and Standards to mark the fact that it is now meeting in public. The GB also adopted the NHS NCL PALS and Complaints Policy. The GB reviewed the Risk Register and BAF and recommended them to the NHS NCL Joint Boards. The GB noted the standing Performance and Quality Reports.

The GB also held a seminar on 13 December 2012. Detailed updates were provided on Continuing Health Care and the authorisation process. Discussions took place concerning recruiting to the Medical Director post and the third Lay Member on the Governing Body. Future organisational development was discussed, including the pressing need to ensure that people’s skills and time are used effectively. Volunteers were sought for the two clinical members of the Audit Committee. Updates were also provided on the implementation of the Primary Care Strategy and the current QIPP position.

Haringey has four committees which report directly to the governing body. All are chaired by clinicians or lay members. The Quality Committee is chaired by the Nurse Member who has the governing body lead for quality. The Director of Quality and Integrated Governance will take up post in January providing much-needed capacity. She will be the executive lead on the Quality Committee and will also attend the Finance and Performance Committee where issues of wider governance will be discussed and where she will be able to ensure quality remains at the centre of financial decision making.

The Quality Committee meets monthly, receiving minutes and supplementary reports from the clinical quality review groups of Whittington Health; Barnet, Enfield and Haringey Mental Health trust; North Middlesex Hospital; the Professional Executive Committee; the Medicines Management Committee and the Communications and Engagement Group. In the new year a serious incident panel will be established to monitor the incidence, trends and learning from serious incidents occurring in commissioned services.

Complaints

Haringey Clinical Commissioning Group approved the NHS North Central London complaints policy on November 22nd 2012 and has begun work on a policy to reflect the organisational position from April 2013.

Of the 103 complaints and concerns received in Quarters 1 and 2, 67 of these related to appointments at GP practices and how issues of access were dealt with. Access to GP practices in the morning and evening were the key issues raised, along with difficulty accessing practices by phone.

Quality Assurance of Trusts of interest to Haringey Clinical Commissioning Group
Background

Haringey’s local trusts are Whittington Health Integrated Care Organisation which provides secondary care services for the west of the borough and community services across the whole borough; North Middlesex Hospital which provides secondary care services for the east of the borough and Barnet, Enfield and Haringey Mental Health Trust which provides mental health services. It is likely that from early next year Haringey will host the Clinical Quality Review Group of North Middlesex Hospital.

All local Clinical Quality Review Groups are attended by Haringey Clinical Commissioning Group clinicians.

North Middlesex Hospital

Patient Experience

Concerns regarding various aspects of quality, especially the patient survey, led to NHS North Central London convening a quality summit earlier this year, which Haringey Clinical Commissioning Group’s Nurse Member attended along with other clinicians. Actions agreed as a result of that summit are being monitored through the Clinical Quality Review Group.

The hospital performed poorly in the National Cancer Patient Survey being the 10th worst NHS trust and at 60% had a lower than average response rate. The action plan is being monitored by the Clinical Quality Review Group.

The Clinical Commissioning Group Nurse Member is developing good relationships with the senior nursing staff and has attended the senior nurse professional forum. There is impressive work in progress within the maternity unit to rapidly identify areas of both good and unacceptable practice. Good practice is rewarded and poor practice is addressed with the individual immediately.

Serious Incidents

North Middlesex Hospital reported 13 Serious Incidents 1st July 2012 and 30th September 2012. This is an increase from quarter 1 where 8 were reported. Two particular areas of concern were:

<table>
<thead>
<tr>
<th>Category of Incident</th>
<th>Description</th>
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<tbody>
<tr>
<td>Screening</td>
<td>Failsafe processes discovered that the photographs of a patient who was screened for diabetic retinopathy and had background diabetic retinopathy (R1) had not been put through for secondary grading and that the patient was send an automated result letter with an incorrect grade. This was immediately escalated to the central IT supplier as it appeared to be an IT issue. A reply was given and the Trust was assured that the configuration was adjusted and the problem resolved. An urgent check to ascertain if other patients had been involved was requested and it was reported that there were 360 patients involved.</td>
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</table>

NEVER EVENTS
Retained foreign object  Retained foreign object post-operation.

Infection Control

North Middlesex Hospital had a peer review visit to the Trust in January 2012. The report noted that they have most of the actions required to reduce healthcare associated infections (HCAIs) in place. The desire to create much stronger local accountability, assurance and governance processes was noted as an important component of sustainable reductions in HCAI. There was nothing new to recommend in terms of the understanding of methicillin-resistant staphylococcus aureus (MRSA) and clostridium difficile infections (CDI) and their control. The report recommended that the focus should continue to be on: antibiotic stewardship; prompt diagnosis and isolation; competent clinical practice and cleaning and environmental hygiene. The action plan continues to be monitored through the Clinical Quality Review Group.

Whittington Health

Cancer Patient Experience

Performance in this area has improved since the last survey, but some areas remain low. The experience of being able to identify and contact the clinical nurse specialists were particularly poor in addition to feeling listened to and getting understandable answers from this particular group. A more detailed analysis will be presented to the Clinical Quality Review Group as part of the patient experience report, along with an action plan addressing the areas where performance is poor.

Community Podiatry

Concerns were raised with the Trust about the long waits for patients using the podiatry service. A service planning meeting has been held, and the underlying capacity and demand issues are now being reviewed by Haringey and Islington Clinical Commissioning Groups. An update will be provided to the Clinical Quality Review Group with the outcome of the reviews.

New Birth Visits

It has been acknowledged that although there have been improvements it is likely that the year-end target will be missed. The trust has been asked to submit an improvement trajectory, and will undertake this once the number of trainees joining the service has been identified.

Serious Incidents

Whittington Health reported 35 incidents which occurred between 1st July 2012 and 30th September 2012. This represents an increase of 40% from quarter 1. This data includes community serious incidents that happen within Whittington Health.

The most frequent types of incidents reported by Whittington Health this quarter are:

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Maternity Services
6 – Including 1 unplanned maternal admission to Intensive Care Unit and 5 unexpected admissions to Neonatal Intensive Care Units (NICU).

Pressure Ulcers
22 - This includes community acquired pressure ulcers and hospital acquired.

Confidential Information leaks
2 – The theft of a community midwife's bag; inappropriate disposal of children’s school nursing records.

Unexpected Death
2 – 1 Post operative death; 2. Community acquired MRSA bacteraemia.

The Trust presented a report to the Clinical Quality Review Group on 3rd October 2012 which provided detailed analysis of the pressure ulcer incidents, and their plans to reduce the incidence of grade 3 and 4 pressure ulcers. The trust has set reduction targets of 70% for inpatient pressure ulcers (although this is starting from an already low base) and 30% for community pressure ulcers. This will be continued to be monitored at the Clinical Quality Review meetings.

Barnet, Enfield and Haringey Mental Health Trust

Serious Incidents

There has been a 53% increase in the number of serious incidents reported in quarter 2 (23) from the previous quarter (15). These include 10 incidents of suspected suicide/ suicide/ attempted suicide, 2 homicides by outpatients not in receipt and 3 unexpected deaths.

Following this apparent increase in patient suicide a review is being undertaken by Barnet, Enfield and Haringey Mental Health Trust. This review will include a look back over the last two years, and a report will go to the trust board in November, after which it will be shared with commissioners.

Financial Position as at Month 8

As at the end of November, the CCG was overspent against its delegated budget by £4.9m. The overspend against the overall PCT budget was £4.3m, which represented an in-month worsening in the financial position of £1.0m. The forecast outturn is an overspend of £6.2m; this is broadly in line with the position reported at month 7.

The overspend is primarily driven by over-performance in our acute SLAs, in particular at UCLH; at month 8 the SLA with ULCH had over-performed by £5.1m (which represents 28% of contract). The in-month position against the UCLH SLA was an overspend of £1.0m. A key element of the over-performance is critical care activity; at month 8 this accounted for £1.5m of the over-performance. The current performance of the UCLH contract was discussed in detail at the CCG Finance and Performance Committee in December, where a number of joint actions for the Trust, CSU and CCG were agreed. An update regarding these actions is being brought to the February meeting of the Committee.

QIPP Position as at Month 8

The annual QIPP plan for Haringey is £21.049m.
Delivery against the QIPP plan for the year to date was £9.523m. QIPP delivery for the year is forecast to be £15.420m, representing an under achievement against the plan of £5.629m. The equivalent position as at month 7 was under-delivery of £6.256m, so the forecast ouput has improved by £0.63m.

The movement in the position is largely a result of:

- An improvement in the delivery of the acute new to follow up metric of £0.5m. This is largely a result of work to identify the impact of this metric at the North Middlesex Hospital. Given that the 2012/13 SLA is a block contract, this does not impact upon the CCG’s financial position for this year but does positively impact upon the exit run-rate.

- An improvement in the delivery of the primary care medicines management QIPP.

**CCG Authorisation**

Haringey CCG worked on a number of areas and held three development sessions with the Governing Body members prior to and in readiness for its authorisation visit on 13 November 2012.

The Desk Top Summary report showed 56 red authorisation criteria Key Lines Of Enquiries (KLOEs) and by the end of the Site Visit, this number had been reduced to 16/17. This has subsequently been reduced post-Moderation Panel to 12 outstanding KLOEs and additional evidence will be submitted at the next opportunity to turn the remaining reds to green and will be resolved by the end of January 2013.

The final decision for all Wave 3 CCGs will be made by the NHS CB sub-committee on 15 February 2103.
MEETING: Meeting of the Joint Boards of NHS North Central London
DATE: 31 January 2013
TITLE: Islington Clinical Commissioning Group Performance Report
LEAD DIRECTOR: Alison Blair, Chief Officer - Islington Clinical Commissioning Group
AUTHOR: Jacky Kutner – Interim Director of Performance and Information
CONTACT DETAILS: Jacky.kutner@nclondon.nhs.uk

SUMMARY:

This paper provides the Board of Islington Primary Care Trust (PCT) with a summary of the CCG monthly integrated performance report.

SUPPORTING PAPERS:

None.

RECOMMENDED ACTION:

The Board of Islington Primary Care Trust is asked to:

- NOTE and COMMENT on CCG performance.

LINKS TO NHS NORTH CENTRAL LONDON STRATEGY

The CCG is currently progressing with authorisation in line with Cluster plans.

GOVERNANCE: Relates to internal Transition Programme governance only.

Voting: Please indicate which Board(s) has voting rights on this matter (if applicable)

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<tr>
<th>Barnet</th>
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<th>Islington</th>
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<td>Penny Bevan</td>
<td>Shahed Ahmed</td>
<td>Jeanelle De</td>
<td>Bev Evans</td>
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<tr>
<td>Philippa Curran</td>
<td>Marek Koperski</td>
<td>Mohammed</td>
<td>Gruchy</td>
<td>Bev Evans</td>
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<tr>
<td>Alison Pointu</td>
<td>Joanne Wickens</td>
<td>Abedi</td>
<td>Helen</td>
<td>Penny Bevan</td>
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<td>S. Gillian</td>
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Objective(s) / Plans supported by this paper:

To provide the Joint Boards of NHS North Central London with an overview of CCG performance.

Patient & Public Involvement (PPI): None

Equality Impact Analysis: None

Risks:
The ability to make effective investments in 2012/13 will be impacted by:

- Delivery of the QIPP plan for both local and NCL-wide schemes. The CCG Governing Body has approved an approach of phasing investment in line with delivery of the QIPP savings plan for 2012/13
- Local capacity to implement agreed service developments, with this being addressed through additional posts and resources being identified in the Islington CCG team aligned to the delivery of schemes.

The key risk to delivering the QIPP savings target for 2012/13 accrues from delivery of metrics for productivity and PoLCE in acute contracts and reducing referral rates into acute services.

Risk around performance lies in the Providers’ ability to deliver to the contracted targets and standards specified in the contract. There are action plans in place to maintain grip on these key areas this month.

- A&E four hour target
- Maternity access at 12 weeks
- Number of health visitor posts vacant
- Cancer waiting times
- C-Diff

Audit Trail: This report has been signed off by the relevant CCG directors

Next Steps: Islington CCG continues to develop its performance reporting framework, is responding to the NHS Commissioning Board Planning and Assurance development and the incorporation of the National Outcomes Framework into its planning.
INTRODUCTION

1.1 A comprehensive integrated performance report has been developed for CCGs to use during the period of delegated responsibility. This report will be the vehicle on which CCGs are performance managed and forms the basis of the monthly stock take meetings between the NHS Commissioning Board, Caroline Taylor (Chief Executive, North Central London Cluster), NHS North Central London colleagues and the CCG Chair, Chief Officer and CCG team. The next meeting is planned for 30 January 2013.

1.2 This report provides the Islington PCT Board with a summary of the integrated performance report.

1.3 The Board of Islington PCT is asked to:

NOTE and COMMENT on CCG performance.

2. PROGRESS TOWARDS ACHIEVING DELEGATED RESPONSIBILITY

2.1 Progress against plan

2.1.1 Islington CCG achieved full delegated responsibility in March 2012.

3. HEADLINES FROM THE LAST MONTH – FINANCIAL POSITION

3.1 At the end of November 2012 (Month 8), Islington CCG’s financial position:

- Recorded an in-month surplus of £0.33m, £0.43m below plan.

- Increased the cumulative surplus to £11.6m, £5.6m above the £6m planned surplus.

- Delegated budgets recorded a £338k overspend this month and are forecast to be £4.34m underspent by the year-end.

- QIPP savings of £694k were delivered this month. For the eight months of the year, £5.4m of savings have been achieved. The forecast remains to deliver £9.2m for the full year.

- A mitigated forecast, bringing forward investment opportunities and allowing for an element of winter pressure on acute contracts, reduces the forecast to within 1.9% of plan. The plan remains to deliver a position as close to budget as possible.

3.2 IN MONTH FINANCIAL PERFORMANCE

3.2.1 In-month performance variance of £0.33m, £0.43M adrift of plan as a result of:

- The acute category of expenditure recorded an adverse variance of £0.9m for month 8, with both inner and outer sector contracts showing adverse variances of £0.5m and £0.1m respectively. In addition, adverse variances were also
recorded against Service Level Agreement excluded items (£0.2m), the London Ambulance Service and In-Health (£0.1m) contracts and non-contracted activity (£0.1m) i.e. where Islington registered patient activity is delivered by providers with whom we do not hold contracts.

- Reviewing the Public Health accrual (revision of £0.4m) within operating costs to reflect a more accurate assessment of expenditure.
- Additional capital charges of £0.2m to reflect the new Goswell Road lease.
- Review of the prescribing position, resulting in a £0.4m favourable variance.
- Continuation of the mental health and continuing care plan underspends.

3.2.2 The table below summaries the current position

<table>
<thead>
<tr>
<th>Month Variance</th>
<th>Rating</th>
<th>Budget £k</th>
<th>Actual £k</th>
<th>YTD Variance £k</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>£k</td>
<td>%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revenue Resource Limit</td>
<td>0</td>
<td>0.0%</td>
<td>GREEN</td>
<td>(316,443)</td>
<td>(316,443)</td>
</tr>
<tr>
<td>Acute &amp; Integrated Care</td>
<td>(931)</td>
<td>(4.5)%</td>
<td>RED</td>
<td>163,342</td>
<td>162,919</td>
</tr>
<tr>
<td>Non Acute</td>
<td>594</td>
<td>7.8%</td>
<td>GREEN</td>
<td>63,920</td>
<td>62,583</td>
</tr>
<tr>
<td>CCG delegated budgets total</td>
<td>(338)</td>
<td>(1.2)%</td>
<td>RED</td>
<td>227,262</td>
<td>225,502</td>
</tr>
<tr>
<td>NCB shadow budgets - Primary Care</td>
<td>160</td>
<td>2.2%</td>
<td>GREEN</td>
<td>57,916</td>
<td>57,539</td>
</tr>
<tr>
<td>Public Health</td>
<td>(3)</td>
<td>(0.3)%</td>
<td>AMBER</td>
<td>6,021</td>
<td>5,974</td>
</tr>
<tr>
<td>Operating Costs</td>
<td>(432)</td>
<td>(18.5)%</td>
<td>RED</td>
<td>17,697</td>
<td>15,819</td>
</tr>
<tr>
<td>Other (QIPP, Reserves and contingencies)</td>
<td>186</td>
<td>100.0%</td>
<td>GREEN</td>
<td>1,491</td>
<td>0</td>
</tr>
<tr>
<td>Total Expenditure</td>
<td>(426)</td>
<td>(1.1)%</td>
<td>RED</td>
<td>310,386</td>
<td>304,833</td>
</tr>
<tr>
<td>Net Surplus / (Deficit)</td>
<td>(426)</td>
<td>(56.3)%</td>
<td>RED</td>
<td>6,057</td>
<td>11,610</td>
</tr>
</tbody>
</table>

3.3 ACUTE, INTEGRATED CARE AND NON-ACUTE EXPENDITURE

3.3.1 Overall acute performance remains as previously reported, with the Royal Free and Bart’s Health contracts being the two main contributors to the cumulative underspend. The Bart’s Health position is being driven by underspends on critical care bed costs (£2m), based on prior year activity. These favourable variances have been offset by adverse variances for UCLH (£0.9m) and Moorfield’s Eye Hospital (£0.4m).
3.3.2 Mental health (£0.2m) services are underspent in month due to lower expenditure on Child and Adolescent Mental Health Services (CAMHS) spot placements, children's joint agency panel costs and on general levels of activity with the East London & City NHS Foundation Trust and South London and Maudsley NHS Foundation Trust. CAMHS has a relatively low level of activity due to only 2 inpatients to date.

3.3.3 Additionally, lower than planned continuing healthcare costs (£0.1m) are also contributing to the non-acute underspend.

4.0 QIPP PERFORMANCE

4.1.1 Over the first 8 months, the QIPP programme has delivered £5.4m against a plan of £8.6m (62.79%) for the year to date. The most notable areas of underperformance are with the PoLCE and referral management schemes and the element of QIPP which remains unidentified. This unidentified target relates to those acute stretch targets set which were not matched by QIPP schemes to ensure activity did not go into Acute. Mitigation to meet the stretch gap non-recurrently has been considered in the forecast analysis.

4.1.2 Forecast QIPP savings for the year remain in line with previously reported amounts, £9.2m. This is £4.2m adrift of our plan and is a result of slippage across the programmes affecting the current position.

5.0 HEADLINES FROM LAST MONTH – SERVICE PERFORMANCE

5.1.1 Overall the CCG continues to perform well against key performance areas, though there are some areas of pressure which the CCG is addressing. The following performance targets are of note this month.

- There is a recent improvement in the performance at both UCLH and Whittington Health in achieving the 4 hour maximum A&E wait. UCLH failed to meet the November target however, achieving 93.7%. RFH failed to meet the target w/c 25th November and 9th December, but both UCLH and Whittington Health have met the target for the last four consecutive weeks. The CCG are closely monitoring the situation and working closely with key stakeholders to improve performance and manage winter pressures.

- **Cancer Waits - 2 week symptomatic** target performance has improved since September (91.5%) to 92.5% but there appears to be an issue specific to Whittington Health who have a recorded performance of 87.2% which is currently being investigated.

- **Cancer waits - 31 days diagnosis, subsequent drug treatment** has dropped from 100% to 95%. This was due to patient choice. Overall performance at all providers is within target.

- **GP Survey – satisfaction with opening hours** continues to be low with Q2 figures (74.8%) showing no improvement on Q1 (75%). The CCG is working with GP
Practices to improve access through a number of schemes in line with the primary care strategy.

- **C-Diff** continues to be carefully monitored. The CCG has 50 reported cases against a threshold of 46 as of November 2012. This includes both community and hospital acquired infections. UCLH have reported 16 cases attributed to Islington and are exceeding their overall respective threshold, but are working to rectify the position with an investment in line with an action plan. Whittington Health is performing under its allocated threshold in acute settings. In respect of community acquired infections, work is being undertaken with GPs and medicines management colleagues in the CCG on anti-biotic stewardship.

- **MRSA** cases now number 3 against a threshold of 2 for the CCG.

- **Immunisations**: Quarter 2 figures show some slight movement in performance. All targets remain above threshold, with the exception of 2 years Hib/MenC which has moved from 90.28% in Q1 to 90.10%, but still remains ‘amber’

### 6.0 GOVERNANCE HEADLINES

#### 6.1 Achievements of the CCG Board and other sub-committees

6.1.1 Islington CCG’s governance and structures are now well established and have been operating throughout 2012. The following headlines can be reported for the groups that met recently:

- The Governing Body meets on a monthly basis and has recently considered the work of the groups (identified below) as well as considering the results of a review of its governance structures in preparation for authorisation in April. Meetings in public continue to be well attended by members of the public.
- **Finance & Performance** – Month 8 financial position and risks related to delivery of the year’s financial plans particularly in regard to this year and next year’s investment portfolio.
- **Service Improvement** – Approved more proposals for QIPP and investment in the current year as well as in preparation for next. Individual commissioners continue to identify further investment opportunities to support the achievement of strategic outcomes.
- **Public & Patient Participation** – Progress continues to be made against annual work plan with patients/members of the public being appointed for all key CCG committees and groups nearly complete.
- **Governance and Quality** – Reports from the Commissioning Quality Review Groups for Moorfields Eye Hospital and University College Hospitals were received. Risk Management and the risk register have been discussed and there have been reports on patient experience, adult safeguarding and learning difficulties.
- **Integrated Care Programme Board** – Continues to receive highlight reports on progress against plan and from established task and finish groups. Lord Victor Adebowale, a non-executive director of the NHS Commissioning Board attended the Programme Board to learn about the implementation of the integrated care strategy.

### 7 PROGRESS TOWARDS AUTHORISATION
7.1 Progress against plan

7.1.1 The CCG was given full Authorisation with one condition remaining in December 2012. The condition relates to Collaborative Commissioning (criteria 5.1A) which is currently being worked on across North Central London CCGs with a draft collaboration agreement prepared for approval.
This paper gives the Joint Boards an overview of the progress made on the NHS North Central London (NCL) Transition Programme since the previous update.

The NHS NCL Transition Programme has now commenced the phased handover of functions to the new organisations that will manage and commission healthcare services from 1 April 2013. This handover follows comprehensive planning and extensive preparation, and is underpinned by robust assurance processes and governance structures.

The purpose of this report is to articulate the changes to the healthcare system relevant to this final phase of transition, outline the key activities underway to support functional handover and manage risk, and to highlight the implications for NHS North Central London.

SUPPORTING PAPERS:
Appendix A: Detail of Risks and Mitigating Actions V1.0

RECOMMENDED ACTION:
The Joint Boards are asked to:
- NOTE and COMMENT on the Transition Programme update

LINKS TO NHS NORTH CENTRAL LONDON STRATEGY
This paper supports Principal Objective 3 aligned to the Board Assurance Framework.
GOVERNANCE: Relates to internal Transition Programme governance only.

Voting: Please indicate which Board(s) has voting rights on this matter (if applicable)

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<td>Bernadette Conroy</td>
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<td>Marek Koperski</td>
<td>Shahed Ahmad</td>
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<td>Joanne Wickens</td>
<td>Mohammed Abedi</td>
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<td>Philippa Curran</td>
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<td>Helen Pelendrides</td>
<td>S. Gillian</td>
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<td>Alison Pointu</td>
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<td>Karen Baggaley</td>
<td>Greenhough</td>
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</table>

Objective(s) / Plans supported by this paper: This paper supports Principal Objective 3 within the Board Assurance Framework.

Patient & Public Involvement (PPI): None

Equality Impact Analysis: None

Risks: The Transition Programme for NHS North Central London is taking a risk-based approach to delivery. This approach places a strong emphasis on early identification, proactive management and resolution of risks and issues, with rapid escalation when necessary. Risks and mitigating actions are documented and monitored using a dedicated Transition Programme risk register and Legacy, Handover and Closedown risk register. In addition, relevant risks are reflected in the Board Assurance Framework and organisational risk registers. The Transition Programme has also instituted a weekly issue resolution process supported by an Escalations Log, facilitating rapid Chief Executive and Director level intervention to resolve issues if necessary.

The specific detail of relevant risks and mitigation actions is provided at Appendix A. At a high-level, these risks and actions relate to:

- **NHS North Central London maintaining a firm grip on delivery of QIPP, financial turnaround and delegated responsibilities during the transition period 31 March 2013.** Mitigating actions include a robust performance management approach, governance structure and assurance process for this period, during which accountability for delivery rests with NHS North Central London.
- **Achieving a safe handover of functions, corporate knowledge and skills, and assets and liabilities from the old to the new system.** Mitigating actions include the deployment of a comprehensive handover and assurance process developed in partnership with receiving organisations. This process is designed to ensure clarity
and completeness of functional handover and is underpinned by a comprehensive suite of legal and functional documentation. The handover will have oversight and sign-off at Chief Executive, Chief Officer and Director level.

- **Ensuring the safety and stability of the healthcare system during the transition**, including the continuity of commissioning and delivery of healthcare services. Mitigating actions include the development of a comprehensive handover approach, robust assurance and the introduction of transitional governance arrangements.

**Resource Implications:** Programme management resources are in place to lead the Transition Programme and individual workstreams including Clinical Commissioning Group Development, Public Health and Legacy, Handover and Closedown. A 2012-13 transition budget has been set aside by NHS London and is being controlled and managed by the Director of Finance.

**Audit Trail:**

- Joint PCT Boards (26 January 2012) - Transition Report to the Joint Boards including high level Transition plan.
- NHS NCL Senior Leadership Team (9 March 2012) and Joint PCT Boards (29 March 2012) - Transition work stream updates and approval for the introduction of the Legacy, Handover and Closedown work stream.
- Joint PCT Boards Seminar (26 April 2012) – Transition progress update and break-out sessions focusing on development of high level process maps for the development of receiving organisations and debate around how existing NCL Committees will work with CCGs going forward.
- FRQ Committee (19 June 2012) – Transition programme risk review shared with the Committee.
- Joint Overview and Scrutiny Committee (10 September 2012) – Transition programme progress update focusing on emerging receiving organisations and changes expected from 1 October 2012.
- Audit Committee (20 September 2012) – Presentation on Transition programme progress with a specific focus on Legacy, Handover and Closedown.
- Audit Committee (22 November 2012) – Presentation on the progress of the Interim Operating Model implementation from 1 October.
- Transition Committee – (21 November 2012) – Draft paper outlining the present position of transition in North Central London and planned next steps.
- Transition Committee – (15 January 2013) – A suite of papers setting out the present position of transition in North Central London and planned next steps.

**Next Steps:** Regular Transition Programme progress updates are being shared with the Transition Committee and the Joint Boards of NHS North Central London throughout the period of transition.
1. INTRODUCTION

The NHS North Central London (NHS NCL) Transition Programme has now commenced the phased handover of functions to the new organisations that will manage and commission healthcare services in the future.

The PCT cluster is working in partnership with receiving organisations to enable a smooth transition to the new system. This handover of functions was preceded by extensive joint planning and preparation. The handover process involves meetings at functional level supported by comprehensive documentation, followed by meetings at Chief Executive, Chief Officer and Director level to provide oversight and sign-off.

NHS North Central London will remain accountable for delivery until April 2013. The handover approach is therefore underpinned by robust assurance processes and governance structures, both within the cluster and pan-London.

During the final transition period there remains a core cluster team at NHS North Central London ensuring the delivery of statutory PCT functions including quality and safety, finance and supporting local governance arrangements until 31 March 2013.

2. UPDATE ON READINESS OF RECEIVING ORGANISATIONS

2.1 NHS Commissioning Board (NHS CB)

As previously reported, the NHS Commissioning Board (NHS CB) was formally established as an independent body, at arm's length to the Government, on 1 October 2012. It is continuing the preparatory work begun by the NHS Commissioning Board Authority on reforming the healthcare commissioning landscape, whilst also taking on initial statutory responsibilities. These responsibilities include the authorisation of Clinical Commissioning Groups (CCGs) which are the drivers of the new, clinically-led commissioning system introduced by the Health and Social Care Act.

Locally, NHS North Central London and the NHS Commissioning Board London (NHS CBL) have developed a robust approach to handover and assurance of statutory responsibilities. A detailed plan for ‘take-on’ of functions has been developed and agreed. The handover of delivery from ‘sending’ to ‘receiving’ organisations will involve detailed functional meetings supported by comprehensive documentation, including operating models, readiness assessments, handover certificates and legal transfer schemes. These functional meetings will be complemented by Chief Executive, Chief Officer and Director level meetings to sign-off readiness for transfer and the interim operating model, and to agree governance and assurance to April 2013.

The handover process commenced 10 January 2013. Functional handover meetings are scheduled to take place during the month of January. Chief Executive, Chief Officer and Director level sign-off of handover will take place in late January and early February.

The NHS Commissioning Board London will assure the new and existing systems for in-year delivery during the final phase of transition. This will be done through governance arrangements designed to ensure the healthcare system remains safe as the new system begins to take on greater responsibility.

2.2 NHS Trust Development Authority (NHS TDA)
The NHS Trust Development Authority (NHS TDA) aims to provide leadership and support to the remaining NHS (non-Foundation) Trusts to deliver high quality, sustainable services. As previously reported, the organisation was launched on 1 October 2012. Following the abolition of Strategic Health Authorities (SHAs), the NHS TDA will be responsible for overseeing the performance management and governance of NHS Trusts, including clinical quality, and managing their progress towards foundation trust status.

NHS TDA is engaging with NHS Trusts to determine how best the new organisation can support these providers. The NHS TDA executive team has been meeting with Finance Directors, Directors of Nursing and Medical Directors across the health system, consulting on ways of working and how best to support NHS trusts. The NHS TDA has also published a suite of guidance documents regarding future arrangements, new support structures and planning and reporting requirements.

The NHS TDA will be fully operational by April 2013. In October 2012, the NHS TDA took on responsibility for non-executive appointments to NHS Trusts and for overseeing the 2013/14 planning round. Prior to 1 April 2013, the Department of Health and Strategic Health Authorities will retain responsibility for the Foundation Trust pipeline, performance management of NHS Trusts and appointments of non-executive members to NHS Trusts and NHS Charities.

2.3 Public Health

NHS North Central London is working closely with Local Authorities and Public Health England (PHE) to plan and manage the transition of public health services. There have been a number of key developments since the Joint Board in November:

- **The budget allocations for Local Authorities have been announced by the Department of Health.** This announcement provided Local Authorities with definitive allocations for Public Health for 2013/14 and 2014/15, which will support detailed service planning.

- **All local staff consultations are complete and the majority of staff have been matched to roles in the new structures.** Julie Billett was successfully appointed as the Joint Director of Public Health for the shared Camden and Islington Public Health service. This appointment will take effect from 1 February 2013. There are now substantive appointments for all Directors of Public Health (DsPH) within North Central London.

- **The five boroughs are seeking Cabinet ratification of their transition arrangements:** The Haringey Public Health team transition paper, including details on contracts, and plans for the service, was approved by their Cabinet in December 2012. The remaining four boroughs are presenting similar papers to their respective Cabinets during February and early March 2013.

- **All contracts for Public Health services have been identified and included in the transfer scheme submissions.** Provisional breakdown of the contract values have been shared with all involved parties and will inform contract negotiations for 2013/14. In each borough, local teams (comprised of Councils and Clinical Commissioning Groups) have met with representatives from NHS North Central
London and North and East London Commissioning Support Unit to discuss approaches to contract management in the future.

In addition, NHS North Central London and Local Authorities have agreed the approach to handover and assurance of Public Health functions. This approach was agreed by Chief Executives 11 January 2013, and involves functional handover meetings supported by detailed documentation, followed by Chief Executive, Chief Officer and Director level sign-off meetings.

2.4 North and East London Commissioning Support Unit (NCEL CSU)

Commissioning Support Units (CSUs) are a key element of the new commissioning landscape. As Members are aware, Clinical Commissioning Groups can choose whether they appoint internal commissioning staff, source support from the independent or voluntary sectors, or engage new NHS commissioning support units (CSUs). The North and East London Commissioning Support Unit (NEL CSU) offers an ‘end-to-end’ service that will provide an extensive range of commissioning support to the five CCGs of North Central London.

Nationally, the NHS Commissioning Board (NHS CB) will host the emerging CSUs. The NHS Business Services Authority (NHS BSA) is acting as employment partner. As previously reported, this arrangement will continue to 2016, positioning the NHS CB to provide oversight and direction to CSUs, whilst allowing a degree of autonomy and independence for CSUs as they move along the path to externalisation over the next three years. The NHS CB is currently developing their strategy and approach to enabling externalisation in consultation with health system stakeholders.

Locally, NEL CSU is on track in delivery of key preparatory activities for 1 April 2013. NEL CSU successfully underwent a detailed review and risk assessment of its business plans and strategies by NHS CB last year, known as ‘Checkpoint 3’. This month, NEL CSU will commence ‘Checkpoint 4’, a self-assessment, which will further assure their business plans in terms of scale, staffing and financial due diligence. These checkpoints are key steps toward securing a formal ‘licence to operate’ by the NHS CB in April 2013.

NEL CSU and the NHS North Central London are working collaboratively to ensure a smooth transition. This includes the transfer of staff and functions for those staff joining the CSU from roles with the PCT Cluster. NEL CSU has appointed staff to over 70% of positions within the organisation and is aiming to complete recruitment by 28 February 2013.

2.5 Clinical Commissioning Group (CCG) Development

All Clinical Commissioning Groups CCGs in North Central London are on track to achieve authorisation (with minimal conditions) by 31 March 2013. Each has successfully submitted an authorisation application to the NHS Commissioning Board and is progressing in the authorisation process:

- **Islington CCG is the first within North Central London to achieve authorisation.** Authorisation was awarded by the NHS Commissioning Board Sub-Committee Decision Panel for all Wave One applications on 5 December. One remaining condition is attached to the authorisation, namely the need to establish written agreements detailing the scope of collaboration with other CCGs. The NCL
Collaboration Agreement is currently in draft and will be finalised over the next two months. This agreement will address the outstanding condition.

- **Haringey, Camden and Barnet CCGs submitted their applications in Wave Three.** Site visits by NHS CB took place during November 2012. These CCGs will be subject to Moderation and Conditions Panels this month, following which they will have a 10 day opportunity to submit additional evidence or provide comment regarding identified risks or issues. The NHS CB Sub-Committee Decision Panel for Wave 3 applications will be held on 15 February 2013 and the CCGs will receive their decision letter shortly after this date.

- **Enfield CCG submitted its authorisation application as part of Wave 4.** The NHS CB undertook a site visit on 7 January 2013. Following the Moderation Panel and Conditions Panel, the NHS CB Sub-Committee Decision Panel for Wave Four CCGs will take place on 6 March 2013. CCGs will receive their decision letter stating their authorisation status shortly after this date.

Each of the five emerging CCGs in North Central London is in the process of recruiting and appointing the final members of their governing bodies and leadership teams. The majority of appointments to senior leadership posts (Chair, Chief Officer and Chief Financial Officer) in all five CCGs in North Central London have been made, and work is continuing to secure appointees to a few key outstanding posts.

### 3. TRANSITION PROGRAMME ENABLING WORKSTREAMS

NHS London has established four enabling workstream to support the effective transition of people and functions from the current Cluster operating model to emerging receiving organisations: People Transition; Stakeholder Engagement and Communications; Transition Governance; and Transition Finance. These workstreams are discussed in turn below.

#### 3.1 People Transition

Significant progress has been made in planning the redeployment of staff, with approximately 75% of North Central London staff matched to a future role and employer. The People Transition workstream is working closely with colleagues across the system and within the DH to clarify arrangements regarding remaining staff. Examples of areas requiring further clarity include PALs and Complaints staff, Clinical Advisors and GP Appraisers.

The People Transition workstream has taken a comprehensive and systematic approach to communicating job matching outcomes to staff. Throughout December and January, the workstream team have been writing to staff on an individual basis and working closely with the Communication Teams to ensure this activity is complemented by extensive employee engagement and updates.

Case management of displaced staff is an ongoing priority activity. As previously reported, this commenced in September. It includes providing support and guidance to staff on finding suitable alternative employment; contacting individuals to arrange 1:1 sessions with a dedicated HR support specialist to define individual requirements, and providing a facility for discussion of ad hoc queries and concerns.
The People Transition workstream continues to work closely with receiving organisations and North Central London management. This is to facilitate identification of the most appropriate organisational and role matches and assist in competitive matching and resolving legal difficulties, such as the application of TUPE. In addition, they are supporting North Central London managers in transferring staff to new locations and ensuring that interim support is arranged where required to support the transitional period.

3.2 Stakeholder Engagement and Communications

Supporting and informing our staff during this transition is a key priority. The North Central London Communications Team continues to work closely with Human Resources and members of the North Central London Transition Programme Board to ensure that key messages are shared through managers, the intranet and newsletters.

Internal communications have been strengthened. Face-to-face staff briefings, led by the CEO, are held at least twice per month. There is a weekly staff e-newsletter and the extensive communication updates via the intranet. The Communications Team is also ensuring that “business as usual” communications and engagement continues at pace during the transition and closedown period.

Phased transition of responsibility for stakeholder engagement and communications to the new organisations has commenced. In summary:

- **North and East London Commissioning Support Unit** has taken full responsibility for its own internal and external communications;
- **CCGs, Local Public Health and the NHS Commissioning Board** are working in partnership with the NCL communications team;
- **NHS Property Services Limited** will take responsibility for communications from 31 March 2013. Until that point, the NCL Communications team is supporting the NCL Estates team to plan and undertake communications activities.

3.3 Transition Governance

Cluster governance arrangements have been refined to provide clear routes for escalation and streamlined reporting. Local progress on transition is reported to the Core Cluster Executive Team and the Transition Committee (a sub-Committee of the Joint PCT Boards) as well as the existing Joint PCT Boards. The Local Delivery Director for the NHS Commissioning Board will act as a non-voting member of the Joint PCT Boards, as an integral mechanism for assuring both the sending and receiving systems.

A register of all assets and liabilities has been developed to inform transfer schemes. The third in an iterative series of submissions of the register to the Department of Health is taking place on 17 January. From this point, the submissions will be baselined and subject to a change control process, as lawyers work to translate the submissions into legal transfer schemes.

Board sign-off of the transfer must take place in March. During January and February Accountable Officers in sending organisations will meet with nominated officers in receiving organisation and agree the assets and liabilities to transfer. A formal statement of the assets and liabilities to be transferred must be signed by sending and receiving organisations at a Board meeting not later than 27 March 2013. This documentation will form part of the information for agreement at the Joint Boards final meeting in March.
3.4 Transition Finance

The cutover plan detailing activity through to July 2013, for production of year end accounts and audit completion was submitted to NHS London and signed off in October 2012. The plan is aligned to NHS North East London Cluster’s plan and details activity to support robust implementation to manage delivery to 31st March 2013, ensure progress to clear debtor and creditor balances, and facilitate function handover to receiving organisations, and support preparation and sign off of Year End Accounts and Annual Report.

As described in the previous updates to the Boards, the draft 2012-13 transition budget is currently being used for urgent transitional costs. The Cluster was advised to seek savings of approximately 15% of the estimated total spend on Transition, following which a comprehensive cost savings exercise was undertaken. This target has been met. This forms part of the overall 2% non-recurrent funding held by NHS London.

The Integrated Single Financial Environment Project is progressing on schedule to establish a new finance system for the CCGs. This will replace the current finance system Agresso. As previously reported, this is a national project to move all commissioning organisations to the Shared Business Services (SBS) operating a standard General Ledger on 1 April 2013.

NHS North Central London are ensuring staffing and controls are in place to enable ongoing operation during the transition period and ensure financial grip is maintained. Internal Audit are working closely with CCG and CSU colleagues, and with the current Cluster team in support of this activity, which focuses on invoice processes, claims management, QIPP monitoring and financial reporting.

4. LEGACY, HANOVER AND CLOSEDOWN

As the programme enters the final stage of transition, sender and receiver organisations are focussed on completing all handover activities in advance of 31 March 2013. Key activities include:

- Working in close partnership with receiving organisations, to confirm handover lead contacts, develop take on plans and ensure all required meetings are scheduled;
- Continuing to work to ensure that senders have been identified for all outstanding functions. Queries in relation to the drafting of certificates have been responded to as-and-when they have arisen; feedback has been provided to senders in relation to submitted certificates, to ensure that certificates contain all relevant information and meet the expected standards. Quality and Safety certificates are also being quality assured by NHS London.
- Reviewing and finalising all handover documentation. This includes Handover Certificates for each function, and also Handover Frameworks to support each operational discussion and ensure that all wider contextual information is shared;
- Ensuring that the handover and assurance process is followed for each function: This process involves functional handover meetings, and Chief Executive, Chief Officer and Director level sign-off meetings. The programme monitors whether meetings are scheduled, take place and result in handover.
• Capturing, monitoring and reporting all handover activities via the ‘PCT Functions Tracker’, which is being used to track progress, identify gaps and issues, and provide assurance of delivery to the wider programme.

The programme is maintaining a particular focus on ensuring the quality and safety of NHS services during transition, and making certain that information about quality is not lost. NHS North Central London is using a nationally determined process with enhanced monitoring and guidance provided by the Department of Health National Quality Board and the Cluster Regional Health Authorities.

Handover documents for all quality and safety functions have been produced and quality assured by the Director of Quality and Safety, Alison Pointu. The quality and safety function handover documents have used a format which provides more information than the handover documents used for other functions and have been designed to cover the areas highlighted by the National Quality Board in their latest guidance (How to Maintain Quality during the Transition: Preparing for handover. May 2012).

Feedback has been received on the quality and safety handover documents, which as reported to the Boards in November, were provided to NHS London in October for quality assurance. This quality assurance assessment has provided NHS North Central London with additional guidance on improving the documents that will be used for handover. The Quality and Safety Directorate has agreed actions to address the areas of improvement.
The Transition Programme for NHS North Central London is taking a risk-based approach to delivery. This approach places a strong emphasis on early identification, proactive management and resolution of risks and issues, with rapid escalation when necessary. Risks and mitigating actions are documented and monitored using a dedicated Transition Programme risk register and Legacy, Handover and Closedown risk register. In addition, relevant risks are reflected in the Board Assurance Framework and organisational risk registers. The Transition Programme has also instituted a weekly issue resolution process supported by an Escalations Log, facilitating rapid Chief Executive and Director level intervention to resolve issues if necessary.

This Appendix sets out the specific detail of relevant risks and mitigation actions.

<table>
<thead>
<tr>
<th>Risk Description</th>
<th>Assurance of Mitigation</th>
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<tbody>
<tr>
<td><strong>Board Assurance Framework level risks</strong></td>
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<tr>
<td><strong>685 – Loss of grip on delivery</strong></td>
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<tr>
<td><strong>Current risk assessment: 15 / Red</strong></td>
<td></td>
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<tr>
<td>Following the delegation of responsibility to Clinical Commissioning Groups, and during the period of shadow running and transition to March 2013, there is a risk that the cluster loses grip on the delivery of QIPP and financial turnaround.</td>
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<tr>
<td>• Islington CCG is now authorised with only one condition which relates to collaborative commissioning and is being addressed</td>
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<tr>
<td>• All CCGs have had their NHS Commissioning Board site visits and are in the process of addressing remaining risks.</td>
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<tr>
<td>• Clinical Commissioning Group (CCG) Integrated Performance management approach in place</td>
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<td>• Regular review of Clinical Commissioning Group budget management by CCG Finance Committees</td>
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<tr>
<td>• Regular review of transition programme progress by Weekly Leadership Team through Transition dashboard</td>
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<tr>
<td>• NHS Commissioning Board London Local Area Director appointed for North Central and North East London. Attendance at Joint PCT Board meetings as part of assurance approach.</td>
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<tr>
<td>• Monthly assurance meetings between the Cluster and the NHS Commissioning Board</td>
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<tr>
<td>642 – Management of delegated responsibility</td>
<td>642 – Management of delegated responsibility</td>
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<tr>
<td><strong>Current risk assessment: 12 / Amber</strong></td>
<td><strong>Current risk assessment: 12 / Amber</strong></td>
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<tr>
<td>There is risk that CCGs are not sufficiently developed to manage delegated responsibility and achieve authorisation due to:</td>
<td><strong>Islington CCG is now authorised with only one condition which relates to collaborative commissioning and is being addressed</strong></td>
</tr>
<tr>
<td>• Capacity and capability of CCGs;</td>
<td>• All CCGS have had their NHS Commissioning Board site visits and are in the process of addressing remaining risks.</td>
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<td>• Ownership of the agenda;</td>
<td>• Robust transition and authorisation plans are in place, which are reviewed at peer group meetings and Pan-London Cluster Working Group</td>
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<tr>
<td>• Underlying financial position of the Cluster.</td>
<td>• Minutes of CCG Boards and GP Cabinet evidence decision making</td>
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<td></td>
<td>• Transition reports to Joint Boards</td>
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<td></td>
<td>• RSM Tenon Internal Audit of CCG development activity, management and support. Positive report now received.</td>
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<tr>
<td></td>
<td>• Integrated performance reporting is being continuously improved based on feedback.</td>
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<tr>
<td></td>
<td>• CCG Integrated Performance management approach in place</td>
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<td></td>
<td>• Regular review of CCG budget management by CCG Finance Committees</td>
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<th>643 – System misalignment</th>
<th>643 – System misalignment</th>
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<tr>
<td><strong>Current risk assessment: 15 / Red</strong></td>
<td><strong>Current risk assessment: 15 / Red</strong></td>
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<tr>
<td>There is a risk of dislocation between or misalignment of different elements of the commissioning system leading to:</td>
<td><strong>Close working with the CSU and CCGs regarding take-on plans and functional handover</strong></td>
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<tr>
<td>• Gaps in delivery</td>
<td>• Weekly Sender / Receiver forum established to facilitate identification and resolution of risks.</td>
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<td>• Differences in expectations between parts of the system (e.g. Commissioning Support Unit (CSU) offer does not align to CCG need)</td>
<td>• Transition reports to Joint Boards</td>
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<td>• Ineffective commissioning partnerships</td>
<td>• High level North Central London Transition plan</td>
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<td></td>
<td>• CSU take-on plans developed and reviewed</td>
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<td>• Transition Programme Plan</td>
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<td>• 'Learning by Doing' Event (October 2012)</td>
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<th>431 – Corporate memory loss</th>
<th>431 – Corporate memory loss</th>
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<td><strong>Current risk assessment: 16 / Red</strong></td>
<td><strong>Current risk assessment: 16 / Red</strong></td>
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<tr>
<td>The scale and complexity of forthcoming changes means there is a risk that functions or knowledge may not be adequately transferred to receiving organisations or that the statutory organisations are not safely closed down.</td>
<td><strong>Dedicated Legacy, Handover and Closedown (LHC) programme team meeting</strong></td>
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<td>• Handover assurance approach agreed, which will involve both functional meetings and Chief Executive, Chief Officer and Director level meetings</td>
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<td>• Handover certificates developed in support of handover, which document all information pertinent to each function</td>
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<td></td>
<td>• Detailed handover framework being developed and tailored for each handover meeting</td>
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Minutes and outputs from meetings including:

• System Transition Group minutes
• North Central London Transition plan
- CSU Programme plan
- Notes from Clinical Cabinet
- Minutes of CCG Boards
- Joint Boards Minutes
- Commissioning Support Stock-take
- Weekly Leadership Team Minutes
- Transition reports

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<tr>
<th>644 – Alignment of resourcing</th>
<th>NCL 818 – Delivery of core business</th>
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<tr>
<td>Current risk assessment: 12 / Amber</td>
<td>Current risk assessment: 10 / Amber</td>
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There is a risk that ineffective alignment of resources during the transition period (1 October 2012 - 31 March 2013) will impact the delivery of key cluster objectives and reduces organisational effectiveness.

- Transition Plans regularly refreshed throughout the Transition period to date to ensure appropriate activity is reflected; resources aligned to priority areas accordingly
- Transition programme governance and management arrangements shared with Major Projects Authority team as part of wider transition programme review (October 2012)

- Robust governance arrangements have been put in place to support safe operating during the remaining transition period
- The governance arrangements include meetings to review and monitor progress and risk through the following: Joint PCT Boards, Audit Committee, Transition Committee, Quality and Safety Committee, Financial Recovery and QIPP Committee, Workforce and Remuneration Committee and Core Executive Team.

**Programme level risks**

Safety and stability of the healthcare system:
There is a risk that lack of synchronisation of the development of receiving organisations could impact the continuity of commissioning and delivery of healthcare services, resulting in a disjointed and destabilised healthcare system, both across the Capital and in North Central London.

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<tr>
<td>• Misalignment of expectations of senders and receivers regarding ‘who does what’ and functions to be transferred</td>
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<tr>
<td>• Delivery of Cluster statutory obligations may be impeded</td>
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<td>• Limited recruitment pools due to poor staff retention</td>
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<tr>
<td>• Complex governance arrangements required during transition period</td>
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<td>• Low staff morale may result</td>
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<tr>
<th>Mitigation</th>
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<tr>
<td>• Collaborative working between senders and receivers, specifically around governance and functional transfer.</td>
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</table>
**Safe transfer of assets and liabilities from the old to new system:**

There is a risk that instructions issued to count assets within sending organisations will cause duplication and provide an inaccurate view of assets.

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<tr>
<th>Impact:</th>
<th>Lack of clarity, inaccuracy or duplication within the instructions for transfer of assets and liabilities to receivers could result in:</th>
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<tbody>
<tr>
<td></td>
<td>- Delay to the transfer of assets and liabilities from senders to receivers</td>
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<td></td>
<td>- Receivers having an inaccurate or incomplete view of the assets and liabilities that will be transferred</td>
</tr>
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<td></td>
<td>- Receivers having insufficient insurance arrangements in place to take on liabilities from senders</td>
</tr>
</tbody>
</table>

**Mitigation:**

- Cluster attended Department of Health workshop on Transfer Schemes on 7 January
- Updated Transfer Schemes submitted to Department of Health on 17 January
- Cluster followed up through Governance and Finance teams for further clarity and information on transfer schemes
- Cluster Director of Finance progressing queries through NHS London lead for Handover and Closure who in turn is part of weekly monitoring with DH
- Under weekly review by Governance and Finance Leads
- Potential resource implications and competing demands across work streams under regular
<table>
<thead>
<tr>
<th>Issue</th>
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<tbody>
<tr>
<td>Loss of knowledge and skills within the sending system:</td>
<td>• Insufficient capability to maintain business continuity through transition period</td>
</tr>
<tr>
<td>As appointments are made to receiving organisations, skills, talent and knowledge will leave the Cluster, reducing capacity and capability to deliver.</td>
<td>• Lack of clearly defined roles in different parts of the system</td>
</tr>
<tr>
<td>Mitigation:</td>
<td>• Confirmation that the new system will lead in-year delivery from October 2012 and planning for 2013-14</td>
</tr>
<tr>
<td></td>
<td>• Localised map of any Cluster gaps and put plans in place to manage release of staff ensuring handover of any key business critical activity</td>
</tr>
<tr>
<td></td>
<td>• Functional handover approach involves review and discussion of any Interim Operating Model in place up to 31 March 2013, including review of resources, risks and issues.</td>
</tr>
</tbody>
</table>

review
• Transition Committee established for North Central London
MEETING: Meeting of the Joint Boards of NHS North Central London  
DATE: 31 January 2013  
TITLE: Legacy Report  
LEAD DIRECTOR: Alison Pointu, Director of Quality and Safety  
AUTHOR: Peta Birch, Interim Head of Corporate Governance  
CONTACT DETAILS: Peta.birch@nclondon.nhs.uk

SUMMARY:

As part of the transition to the new NHS landscape, as set out in the Health and Social Care Act 2010/12, NHS North Central London is required to develop a legacy document to support the smooth handover to the receiving organisations. The purpose of this is to help maintain organisational memory, to ensure continuity of service during the transitional period, and to assist with maintaining quality and safety.

This legacy document and accompanying Library of Knowledge have been produced in line with the National Quality Board’s Phase One report ‘Maintaining and Improving Quality during the transition: safety, effectiveness, experience’, and are intended to provide a repository of information regarding the history and combined learning of the five PCTs. The documents will be a core element of the handover process, and will aid future organisations that will lead the NHS. This will include the NHS Commissioning Board, the Commissioning Support Unit, Local Authorities and Clinical Commissioning Groups, among others.

The Legacy report is a living document and a further iteration will be presented to the Joint Boards in March 2013.

SUPPORTING PAPERS:

- None.

RECOMMENDED ACTION:

The Joint Boards are asked to:

- NOTE the report.

LINKS TO NHS NORTH CENTRAL LONDON STRATEGY

Principal Objective 3: To deliver key organisational objectives and a secure transition to the commissioning landscape in line with the Health and Social Care Act 2012.

Strategic Objective 3.5: To ensure the safe hand over of knowledge, responsibilities and
accountability, and secure the successful closedown of the statutory organisations.

GOVERNANCE:

Voting: Please indicate which Board(s) has voting rights on this matter (if applicable)

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Objective(s) / Plans supported by this paper: This paper relates to the following sections of the NHS North Central London Objectives for 2012-13:

Principal Objective 3: To deliver key organisational objectives and a secure transition to the commissioning landscape in line with the Health and Social Care Act 2012.

Strategic Objective 3.5: To ensure the safe hand over of knowledge, responsibilities and accountability, and secure the successful closedown of the statutory organisations.

Patient & Public Involvement (PPI): None associated with this paper.

Equality Impact Analysis: None associated with this paper.

Risks: This report mitigates against NCL Risk 431 on the Board Assurance Framework; that the scale and complexity of forthcoming changes means there is a risk that functions or knowledge may not be adequately transferred to receiving organisations or that the statutory organisations are not safely closed down.

Resource Implications: None associated with this paper.

Audit Trail: the NHS North Central London Senior Management Team submitted the first version of this Legacy Report to NHS London on 30 August following approval. The Joint Boards of NHS North Central London reviewed the report on 27 September 2012. The Director of Finance, the Director of Quality & Safety and the Interim Head of Communications sent this second iteration of the report to NHS London on 13 January 2013 following review.

Next Steps: The document presented is the third of four iterations of the Legacy Report, which will be updated throughout the transition period to 31 March 2013.
EXECUTIVE SUMMARY

The Legacy Report and Library of Knowledge are iterative documents intended to inform new NHS organisations of the history, key risks, and finance and quality performance across PCT areas and quality performance across providers.

Both documents were have been subjected to review by NHS London and were presented to the Joint Boards on 27 September 2012.

1. INTRODUCTION

2.1 The Legacy Report, covering all NHS North Central London PCT areas is required by NHS London to support the smooth handover to future NHS Organisations. Its purpose is to help maintain corporate memory, to ensure continuity of service during the transitional period and to assist with maintaining quality and safety. The document is written in narrative form to provide the reader with an overall picture of the NHS in North Central London.

2.2 Some sections list key documents in blue boxes pointing to the evidence pertinent to that section. All publicly available documents will be available on NHS North Central London website under the publications section and confidential documents will be made available on request. The appendices at the end of the report list all key documents and resources.

2.3 The Library of Knowledge provides a detailed list of documents agreed as required across London. The Library logs the document; the name of the current owner and contact details; the electronic and/or hard copy location and the name of the receiving organisation. In this way records management can ensure that the information is appropriately archived for retrieval.

Both documents are iterative and will be revised once more before close down on 31 March 2012.

3. Legacy Report

3.1 The Report includes the following areas:
   b. Demographic data across the cluster and at borough level.
   c. An explanation of the CCGs and the position on CCG delegation and authorisation.
   d. Provision of services by provider.
   e. Quality across provider services including effectiveness and patient experience; safety.
   f. Performance including a summary of current and historic performance against national core standards.
   g. Financial history by PCT including: summary of current organisational budgets; current high-risk financial issues and identified management strategies to manage the risks.
   h. Provider capacity including: summary of historic service capacity issues and outstanding issues; planned procurement of services.
   i. Workforce, including: Summary of workforce issues as at 31 July 2012.
j. Summary of key planned changes – NHS North Central London Commissioning Strategic Plans and QIPP documents. risk assessments relating to handover; risk and control framework; risk profile on the Board Assurance Framework and other significant risks on the PCTs’ risk register.

k. Organisational assets and liabilities.

l. Stakeholder map – communications and engagement both current and anticipated from 1 October; CCG delegation and authorisation; arrangements for corporate risk registers at the point of handover; records management to enable safe transfer of records to receiving organisations.

m. Governance.

3.2 Library of Knowledge

3.2.1 NHS London provided all PCT clusters with a list of key documents to be transferred as part of the legacy and handover work. Cluster organisations were then asked to populate the proforma with the current owner and contact details, location of records and the name of the receiving organisation. The documents include serious incident reports, committee minutes; medico-legal cases; risk registers ands risk profiles; financial and performance reports.

3.2.2 The continuation of this work, between January 2013 and March 2013 will be conducted within the records management function of corporate governance to ensure that all documents are retrieved and archived effectively for retrieval.

4. CONCLUSION

NHS North Central London continues to ensure robust governance in readiness for handover to receiving organisations as they become ready to assume accountability in March 2013.

The Legacy Report and Library of Knowledge provide a wealth of information and signposting for all new organisations.
### MEETING:

Meeting of the Joint Boards of NHS North Central London

### DATE:

31 January 2013

### TITLE:


### LEAD DIRECTOR:

Caroline Taylor, Chief Executive

### AUTHOR:

Nadine Hammett, Risk Manager

### CONTACT DETAILS:

caroline.taylor@nclondon.nhs.uk

### SUMMARY:

The Board Assurance Framework outlines NHS North Central London’s principal objectives, the risks to achieving those objectives, key controls and assurances, and gaps in controls and assurances. The Risk Register contains a mixture of strategic and operational risks at organisational and directorate level as well as the arrangements in place to mitigate these.

The maintenance and monitoring of the Board Assurance Framework and the Risk Register is essential to provide Board assurance that the organisation has robust risk management arrangements and that these arrangements are subject to appropriate scrutiny and therefore the Joint Boards can be confident their objectives can be achieved. This is particularly pertinent as we move into the next stage of transition and the new organisations take on their lead responsibilities albeit within the Cluster governance arrangements.

### SUPPORTING PAPERS:

- Appendix 1 - Board Assurance Framework 2012/13
- Appendix 2 - Extreme Risk Report (rated 15 - 25)

### RECOMMENDED ACTION:

The Joint Boards are asked to:

- **REVIEW** and **DISCUSS** the risks, controls and assurances in the NHS North Central London Board Assurance Framework and Extreme Risk Report;
- **NOTE** the current risk profile of NHS North Central London
- **APPROVE** planned actions to mitigate the risks, and gaps in controls and assurance.

### LINKS TO NHS NORTH CENTRAL LONDON STRATEGY

This paper supports effective governance within NHS North Central London to enable the organisation to focus on delivery of its objectives despite the significant organisational changes that is faces over the next six or so months.

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NHS North Central London is a collaborative working arrangement between Barnet, Camden, Haringey, Enfield and Islington Primary Care Trusts.
The Joint Boards of NHS North Central London refers to the joint meeting of the Boards of Barnet, Camden, Haringey, Enfield and Islington Primary Care Trusts.
GOVERNANCE:

Voting: Please indicate which Board(s) has voting rights on this matter (if applicable)

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<td>Karen Baggaley</td>
<td>Jennie Hurley</td>
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Objective(s) / Plans supported by this paper: This paper relates to 2012/13 Strategic Objective 3.2 which relates to maintaining a clear focus on delivery through the effective alignment of staff and resources, and ensuring clarity over roles and robustness of governance arrangements.

Patient & Public Involvement (PPI): The Board Assurance Framework and extreme risks within the Risk Register will be presented at all Public meetings of the Joint Boards and will be available to members of the public via the Joint Boards papers on the NHS North Central London website.

Equality Impact Analysis: There is no direct impact of the Board Assurance Framework and Risk Register on equality and diversity but these documents will ensure that that equality and diversity issues are addressed as part of governance and risk management arrangements and the Board receives the appropriate assurances.

Risks: The Board Assurance Framework and Risk Register are key documents to ensure the Joint Boards are aware of the risks to achieving their objectives, and are assured that there are effective controls in place to manage these.

Resource Implications: The Board Assurance Framework and Risk Register reporting and monitoring will be facilitated by the Corporate Governance Team but it is acknowledged that risk management is an integral part of the management process for all managers.

Audit Trail: The Board Assurance Framework 2012/13 and a selection of directorate Risk Registers were presented to the Audit Committees on 24 January 2012.

Next Steps: The Board Assurance Framework 2012/13 and a selection of directorate Risk Registers will be presented to the March 2013 meeting of the Audit Committees.
1. INTRODUCTION AND BACKGROUND

1.1 The Board Assurance Framework outlines NHS North Central London’s principal objectives, the risks to achieving those objectives, key controls and assurances, and gaps in controls and assurances. The Risk Register contains a mixture of strategic and operational risks at organisational and directorate level as well as the arrangements in place to mitigate these.

1.2 The maintenance and monitoring of the Board Assurance Framework and the Risk Register is essential to provide Board assurance that the organisation has robust risk management arrangements and that these arrangements are subject to appropriate scrutiny and therefore the Joint Boards can be confident their objectives can be achieved.

2. BOARD ASSURANCE FRAMEWORK

2.1 The Board Assurance Framework 2012/13 is attached at Appendix 1.

2.2 There are 16 risks identified in the Board Assurance Framework; with controls in place and planned actions the residual risk in ten of these is less than 15.

2.3 There are six risks with a residual score of 15 or above (extreme risks). Two risks relate to the scale of the financial challenge across NHS North Central London and the significant QIPP stretch targets required to bring the PCTs in deficit back into run rate balance.

2.4 Three risks are transitional risks around; the cluster losing grip on delivery of QIPP and financial turnaround; the risk of dislocation between or misalignment of different elements of the commissioning system; and the risk that functions or knowledge may not be adequately transferred to receiving organisations or that the statutory organisations are not safely closed down.

2.5 The sixth risk is around alerts in relation to standards of care in nursing / care homes and capacity issues at Borough level leading to possible safety / safeguarding concerns for adult resident patients.

2.6 Figure 1 illustrates the differences between the inherent and the current risk ratings of all risks within the Board Assurance Framework 2012/13:

**Figure 1: 'Heat Maps' of inherent and current risk within the Board Assurance Framework**

![Heat Maps](image-url)
3. RISK REGISTER

3.1 There are currently 152 risks identified on the Risk Register, with 61 risks on the Corporate Risk Register (i.e. those rated 12 or above). Figure 2 below illustrates the total number of risks on the Risk Register by the risk rating:

Figure 2: Number of risks on the Risk Register by risk rating:

![Risk Register Diagram]

3.2 Figure 3 below illustrates the risk profile by directorate of all risks on the Corporate Risk Register (those rated 12 or above):

Figure 3: Risk profile of all risks on Corporate Risk Register (rated 12 or above) by directorate

![Risk Profile Diagram]
3.3 The extract of extreme risks (those rated 15 - 25) from the Risk Register is attached at Appendix 2. There are 18 extreme risks on the Risk Register.

4. DE-ESCALATED RISKS

4.1 The following risks in the Risk Register were de-escalated as a result of mitigating actions and further refining and reviewing:

<table>
<thead>
<tr>
<th>ID</th>
<th>PCT</th>
<th>Risk</th>
<th>Current Risk</th>
<th>Directorate (Lead Director)</th>
<th>Reason for De-escalation</th>
</tr>
</thead>
<tbody>
<tr>
<td>NCL</td>
<td>Barnet</td>
<td>Financial, clinical, reputational and legal risk, due to the impact of the Dept of Health closedown deadlines for retrospective claims for care costs.</td>
<td>(16) 12</td>
<td>Barnet Borough / CCG (John Morton)</td>
<td>Claim submission deadline passed. PWC team engaged and setting up Centre of Excellence to review and validate claims and liability. Aim to provide as much as possible in 12/13 accounts based on PWC work for liability as a whole.</td>
</tr>
<tr>
<td>788</td>
<td>Cluster</td>
<td>There is a risk to the implementation timetable for Barnet and Chase farm that the impact of the process to be acquired causes some delay due to capacity of management with conflicting agendas, or some other issue that may arise.</td>
<td>(12) 6</td>
<td>BEH Clinical Strategy (Siobhan Harrington)</td>
<td>Programme sighted on processes for acquisition. BCF identified management and programme resource for BEH though the development of FBC. Engagement of future partner in work once decision agreed.</td>
</tr>
<tr>
<td>784</td>
<td>Cluster</td>
<td>There is a risk that there is not sufficient capacity in the system to deliver the improvements in primary care, as being agreed in the borough primary care improvement plans. This could impact the delivery of the primary care improvements that support the transfer of clinical services.</td>
<td>(10) 6</td>
<td>BEH Clinical Strategy (Siobhan Harrington)</td>
<td>Indicators of progress of improving outcomes for people to be jointly agreed across BEH and with boroughs and local authorities. Regular communication of improvements.</td>
</tr>
<tr>
<td>ID</td>
<td>PCT</td>
<td>Risk</td>
<td>Current Risk</td>
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<td>Reason for De-escalation</td>
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<tr>
<td>NCL 821</td>
<td>Camden</td>
<td>Financial, clinical, reputational and legal risk, due to the impact of the Dept of Health closedown deadlines for retrospective claims for care costs.</td>
<td>16</td>
<td>Cameron Borough / CCG (David Cryer)</td>
<td>Claim submission deadline passed. PWC team engaged and setting up Centre of Excellence to review and validate claims and liability. Aim to provide as much as possible in 12/13 accounts based on PWC work for liability as a whole.</td>
</tr>
<tr>
<td>NCL 822</td>
<td>Enfield</td>
<td>Financial, clinical, reputational and legal risk, due to the impact of the Dept of Health closedown deadlines for retrospective claims for care costs.</td>
<td>16</td>
<td>Enfield Borough / CCG (Liz Wise)</td>
<td>Claim submission deadline passed. PWC team engaged and setting up Centre of Excellence to review and validate claims and liability. Aim to provide as much as possible in 12/13 accounts based on PWC work for liability as a whole.</td>
</tr>
<tr>
<td>NCL 688</td>
<td>Haringey</td>
<td>Financial balance is not achieved in 12/13 and future years per the 2011/12 4 year QIPP plan due to the following key risks: - acute contract over performance - Insufficient QIPP schemes are developed or delivered</td>
<td>20</td>
<td>Finance (Bev Evans)</td>
<td>Likelihood decreased as month on month increased QIPP delivery as against % plans</td>
</tr>
<tr>
<td>NCL 687</td>
<td>Islington</td>
<td>Financial balance is not achieved in 12/13 and future years per the 2011/12 4 year QIPP plan due to the following key risks: - acute contract over performance - Insufficient QIPP schemes are developed or delivered.</td>
<td>15</td>
<td>Finance (Bev Evans)</td>
<td>Control total surplus delivered. Further investment plans being implemented and any identified QIPP in year off set by increased available surplus.</td>
</tr>
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</table>
4.2 The following risks in the BAF were de-escalated as a result of mitigating actions and further refining and reviewing:

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<th>Reason for De-escalation</th>
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<td>NCL 816</td>
<td>Haringey</td>
<td>Financial, clinical, reputational and legal risk, due to the impact of the Dept of Health closedown deadlines for retrospective claims for care costs.</td>
<td>12 ▼ (16)</td>
<td>Haringey Borough / CCG (Sarah Price)</td>
<td>Claim submission deadline passed. PWC team engaged and setting up Centre of Excellence to review and validate claims and liability. Aim to provide as much as possible in 12/13 accounts based on PWC work for liability as a whole.</td>
</tr>
<tr>
<td>NCL 819</td>
<td>Islington</td>
<td>Financial, clinical, reputational and legal risk, due to the impact of the Dept of Health closedown deadlines for retrospective claims for care costs.</td>
<td>12 ▼ (16)</td>
<td>Islington Borough / CCG (Alison Blair)</td>
<td>Claim submission deadline passed. PWC team engaged and setting up Centre of Excellence to review and validate claims and liability. Aim to provide as much as possible in 12/13 accounts based on PWC work for liability as a whole.</td>
</tr>
<tr>
<td>NCL 748</td>
<td>Cluster</td>
<td>The scale and pace of the transition process may lead to the loss of key individuals before initiatives are implemented.</td>
<td>8 ▼ (16)</td>
<td>QIPP (Bev Evans)</td>
<td>Handed over to CCGs.</td>
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<tbody>
<tr>
<td>NCL 783</td>
<td>Cluster</td>
<td>Given the scale of the financial challenge, there is a risk that we do not deliver the agreed control total.</td>
<td>4 ▼ (12)</td>
<td>Finance (Bev Evans)</td>
<td>Control total achieved at both Cluster and individual PCT level.</td>
</tr>
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### 5 ESCALATED RISKS

5.1 The following risk in the BAF has been escalated:

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<tr>
<th>ID</th>
<th>PCT</th>
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<th>Current Risk (previous)</th>
<th>Directorate (Lead Director)</th>
<th>Planned Mitigating Actions</th>
</tr>
</thead>
</table>
| NCL 827 | Cluster | Given the scale of the financial challenge, there is a risk that we do not deliver the recurrent run rate balance. Escalated due to recurrent underlying run rate position for at least 2 PCTs will be deficit at exit. | 12 (16) | Finance (Bev Evans) | • PMO process established across all 5 CCGs during October 12 with support where identified being recruited to  
  • CFO roles substantially appointed - ongoing (3 appointed, 2 in hand)  
  • Month 9 hard close to secure control totals at PCT level in hand.  
  • Improve understanding of run rate at PCT level |
5.2 The following risks in the Risk Register were escalated:

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<th>Current Risk (previous)</th>
<th>Directorate (Lead Director)</th>
<th>Planned Mitigating Actions</th>
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</table>
| NCL 787 Cluster | There is a risk that the workforce changes will take longer to implement than planned; that the Trusts do not work closely enough together to mitigate risks around workforce changes and that the workforce is available in the right service at the right time. Likelihood increased due to limited time remaining for detailed workforce to be in place. | (8) 16                 | BEH Clinical Strategy (Siobhan Harrington) | • Workstream SROs in place and meetings underway  
• Deep Dives by Clinical Cabinet will monitor and assure  
• Workforce data from BCF on 1 February 13  
• NMH recruitment plan in development |
| NCL 786 Cluster | There is a risk that the transfer of services will be delayed if there is a legal challenge. Likelihood increased due to limited time remaining for the delivery of the programme and increased scrutiny. | (9) 12                 | BEH Clinical Strategy (Siobhan Harrington) | • Joint indicators monitoring progress to be developed with stakeholders.  
• Close working with Local Authority colleagues  
• Communications and engagement with all stakeholders |
| NCL 666 Camden | The office base for Camden CCG has not been finalised. Plans for the use of St Pancras Hospital have been affected by the switch of ownership to CIFT and by the increasing size of the CCG. Likelihood increased due to change to status of St Pancras Hospital increases the risk of not having suitable accommodation for CCG from 1st April 2013. | (4) 6                  | Camden Borough / CCG (David Cryer) | • Discussions with Estates and Facilities - ongoing  
• Agree timeline of actions and decision making bodies  
• Agree end stop date  
• Discussions with CIFT to be commenced if this fails |
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<tr>
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<th>Current Risk (previous)</th>
<th>Directorate (Lead Director)</th>
<th>Planned Mitigating Actions</th>
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</table>
| NCL 580 Cluster |      | Information Governance - There is a risk that NHS North Central London information and physical assets storing personal data will be prepared for moving to various locations so if not effectively managed could lead to a data loss and resultant fine as a result of transition. Likelihood increased due to staff movements, increasing movements of data to support the transition and the need for more robust leavers process. Consequence increased due to the potential that physical desktops will be moved that may hold PID that as were not previously mobile have not historically been encrypted. | 16 (9) | Corporate Affairs (Caroline Taylor) | • Director sign off of information asset registers  
• Physical IT equipment Asset registers to be reviewed by IT  
• Delivery of records management transition plans  
• Communications and web pages to be used  
• Review of all main sites with Estates and Facilities  
• IT and HR to put in a clear leavers process to return IT assets when staff move and the secure treatment of unencrypted Desktop PCs |
| NCL 760 Cluster |      | Information Governance - NHS NCL process (collect, hold, store, analyse, interpret, share, and disclose) significant levels of Personal Identifiable data, in various locations and even on the move to underpin its operational activities. There is a risk that any lack of suitable IG controls could lead to a loss of confidentiality integrity or availability of said data could lead to poor reputation, trust, ability to deliver business as usual and in some events lead to fines up to £500,000. Likelihood increased due to staff movements, increasing movements of data to support the transition and the need for more robust leavers process. | 15 (10) | Corporate Affairs (Caroline Taylor) | • >95% Staff to undertake refresher IG Training to provide assurance staff are familiar with responsibilities, currently at 40%  
• Delivery of RM transition programme  
• Data Transfer Orders and / Information Sharing Agreements to be put in place before data are transferred to receiving organisations.  
• IT and HR to put in a clear leavers process to return IT assets when staff move and the secure treatment of unencrypted Desktop PCs |
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<th>Current Risk (previous)</th>
<th>Directorate (Lead Director)</th>
<th>Planned Mitigating Actions</th>
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| NCL 761 Cluster | | The key functions of the Complaints and PALs team are being disaggregated as part of transition. The five Healthwatch organisations in NCL are taking on the PALs signposting function from April 2013. They may not all be operational from April 1st leaving residents with no information and they may then contact new NHS organisations who will not be able to provide this service. There may then be an increase in formal complaints with limited capacity to deal with these. The NCB is taking on the management of Primary Care complaints and may not be ready from April 2013. Escalated due to NCB state of readiness to receive primary care complaints and also the effect of transition of NCL staff. | (6) 12 | Quality & Safety (Alison Pointu) | - Quarterly reports on PALS and complaints activity being shared with Local Authority leads (August 2012, November 2012 and February 2013).  
- Quality Workshop with Barnet and Enfield CCGs covering complaints Jan 13  
- NCL/NELC proposal to NCB submitted Dec 12 including a breakdown of the number of complaints and the staffing resources required - response awaited |

6. **NEXT STEPS**

6.1 The Board Assurance Framework 2012/13 and a selection of directorate Risk Registers will be presented to the March 2013 meeting of the Audit Committees.
Effective risk management is a critical part of any organisation’s system of internal control and a robust Risk Management Strategy is a key enabler to sound risk management.

This paper presents the reviewed NHS North Central London Risk Management Strategy.

The Risk Management Strategy was approved by the Joint Boards in December 2011 and had been updated to reflect remaining organisational timescales, updated strategic objectives and minor amendments to roles / job titles.

**SUPPORTING PAPERS:**

Appendix 1 - NHS North Central London Risk Management Strategy

**RECOMMENDED ACTION:**

The Joint Boards are asked to:

- **APPROVE** the updated NHS North Central London Risk Management Strategy

**LINKS TO NHS NORTH CENTRAL LONDON STRATEGY**

This paper supports effective governance within NHS North Central London to enable the organisation to focus on delivery of its objectives.
GOVERNANCE:

Voting: Please indicate which Board(s) has voting rights on this matter (if applicable)

<table>
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<tr>
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Objective(s) / Plans supported by this paper: This paper relates to 2012/13 Strategic Objective 3.2 which relates to maintaining a clear focus on delivery through the effective alignment of staff and resources, and ensuring clarity over roles and robustness of governance arrangements.

Patient & Public Involvement (PPI): The Board Assurance Framework and extreme risks within the Risk Register will be presented at all Public meetings of the Joint Boards and will be available to members of the public via the Joint Boards papers on the NHS North Central London website.

Equality Impact Analysis: There is no direct impact of the Board Assurance Framework and Risk Register on equality and diversity but these documents will ensure that that equality and diversity issues are addressed as part of governance and risk management arrangements and the Board receives the appropriate assurances.

Risks: The Board Assurance Framework and Risk Register are key documents to ensure the Joint Boards are aware of the risks to achieving their objectives, and are assured that there are effective controls in place to manage these.

Resource Implications: The Board Assurance Framework and Risk Register reporting and monitoring will be facilitated by the Corporate Governance Team but it is acknowledged that risk management is an integral part of the management process for all managers.

Audit Trail: The NHS North Central London Risk Management Strategy was approved by the Joint Boards in December 2011.

# Risk Management Strategy

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### Appendices

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1. **Introduction**

1.1 NHS North Central London is a collaborative working arrangement between Barnet, Camden, Enfield, Haringey and Islington Primary Care Trusts. The NHS North Central London Governance Framework was agreed by the five Primary Care Trust Boards of in February 2011. The framework outlined the requirement for the Joint Boards to develop a Board Assurance Framework, Risk Register, Risk Management Strategy and have governance arrangements in place which operate with a single management team in accordance with Department of Health guidance.

1.2 This document outlines NHS North Central London’s approach to risk management. Specifically:

- NHS North Central London’s committee structure, detailing those committees which have responsibility for risk
- Roles and responsibilities of all staff with regards to risk management
- The process for identification, assessment and management of risk
- The process for managing, and Board review of, the organisation wide Risk Register and Board Assurance Framework
- The process for monitoring the Risk Management Strategy and ensuring it is effective

1.3 An effective Risk Management Strategy is essential to ensuring a high quality of safe services are delivered for patients within available resources and to providing a safe working environment for staff.

1.4 The draft strategy reflects current best practice, taking into account a range of governance standards including those set out in:

- [*Taking it on Trust*, (Audit Commission, 2009);]
- [*Assurance: The Board Agenda* (2002);]
- [*NHS Controls Assurance*, Risk Register Working Group 2002;]
- Department of Health guidance on the Statement on Internal Control and the Board Assurance Framework;
- The NHS Litigation Authority (NHSLA) Risk Management Standards; and
- Health and Safety Legislation.

2. **Strategy Statement**

2.1 NHS North Central London is committed to the provision of high quality care in a setting that puts the safety of patients and staff first. NHS North Central London will meet this requirement through a system of risk management and assurance that is understood and implemented at all levels of the organisation. The purpose of this document is to set out those processes and the monitoring arrangements to ensure effective implementation.

2.2 Effective risk management is best achieved in an open and honest environment where risks are identified quickly and responded to in a positive and active way.
2.3 There are a number of principles and aims that underpin the strategy and are essential for its successful implementation. An outline of the strategy principles and aims is included in Appendix 1.

3. **Scope of this Strategy**

3.1 Risk management is a central part of the organisation’s overall activities and the strategy therefore relates to all aspects of NHS North Central London’s working.

3.2 The risk management strategy by its very nature relates to a number of NHS North Central London’s policies. Policies can be located on the Intranet:

http://nww.ncl.nhs.uk/Docs/default.aspx

3.3 However it is recommended that the strategy be read in conjunction with the following policies which directly relate to NHS North Central London’s risk management functions:

- Incidents and Serious Untoward Incident Reporting Policy
- Complaints Policy
- Claims Handling Procedures
- Health and Safety Policy
- Staff Induction Policy
- Essential Training Policy
- Safeguarding Policies

3.4 The strategy relates directly to the strategic objectives of NHS North Central London. These objectives are updated on an annual basis and are included in Appendix 2.

3.5 NHS North Central London will ensure all principal risks to the achievement of the strategic objectives are identified and effectively managed. This will form the basis of the Board Assurance Framework. The Board Assurance Framework sets out the key controls for managing specific risks; assurances, including any gaps in assurance and agreed action plans.

4. **Who this Strategy Applies to**

4.1 This strategy applies to all staff, teams and activities managed by NHS North Central London.

4.2 This strategy applies to all activities and functions of NHS North Central London. There are committees reporting into NHS North Central London Joint Boards with specific responsibilities which are detailed further in this document.

4.3 The strategy relates to the management of risks faced by NHS North Central London. Its scope therefore relates to resources directly managed by NHS North Central London. However, the activities of primary care practitioners, and the actions of organisations outside NHS North Central London but acting on its behalf, involve risks which can have an impact on whether NHS North Central London achieves its objectives and should be managed accordingly.
5. **Definitions used in this Document**

5.1 **Risk** is the chance that something will happen that will have an impact on the achievement of objectives. It is measured in terms of likelihood (frequency or probability of the risk occurring) and consequence / severity (impact or magnitude of the effect of the risk occurring). Risk can be defined as the possibility of incurring harm or loss, and may be associated with people (patients, staff, visitors etc), buildings and estates, systems, finance and equipment.

5.2 **Risk management** is a key element of the governance framework and is the identification, assessment and management of risks so as to minimise their potential consequences and likelihood of occurrence. Risk Management is the culture, processes and structures that are directed towards the effective management of potential opportunities and adverse effects.

5.3 **Risk assessment** is the process for identifying, analysing, evaluating, controlling, monitoring and communicating risk.

5.4 **Risk rating** is the severity assigned to a risk. This is determined by multiplying the consequence of the risk by the likelihood of occurrence, as outlined in section 7.2 of this strategy.

5.5 **Risk Register** is a ‘log of risks of all kinds that threaten an organisation’s success in achieving its declared aims and objectives. It is a dynamic living document, which is populated through the organisation’s risk assessment and evaluation process. This enables risk to be quantified and ranked. It provides a structure for collating information about risks that helps both in the analysis of risks and in decisions about whether or how these risks should be treated.’ (Risk Register Working Group 2002, NHS Controls Assurance).

5.6 **Controls** - in the context of this strategy the term ‘control’ refers to that which is place to prevent a risk from occurring, or to reduce the potential consequences and likelihood. Examples of possible controls include:

- Implementation of policies and guidance
- Management structure and accountabilities
- Corporate and clinical governance processes
- Statutory frameworks e.g. Standing Orders, Standing Financial Instructions, Scheme of Delegation
- Incident reporting, complaints, and patient and public feedback procedures
- Staff recruitment, retention and training

5.7 **Risk appetite** refers to the level of risk which the organisation is prepared to accept or tolerate. NHS North Central London’s risk appetite is outlined in section 7.3.

6. **Roles and Responsibilities**

This section outlines the roles and responsibilities of key individuals and committees with responsibility for risk management. A committee structure is included in Appendix 3, outlining how all the committees with specific responsibility for risk management report up to the Joint Boards.
6.1 NHS North Central London Joint Boards

The Joint Boards have overarching responsibility for gaining assurance that NHS North Central London has effective processes in place for managing risk, meeting all statutory requirements and adhering to guidance issued by the Department of Health in respect of risk management and governance.

An effective Board monitors that principal objectives are being achieved and that it receives regular reports on risks to the principal objectives and the processes in place to manage them. It also needs to assure that:

- the Board Assurance Framework and Risk Register are reviewed, updated and monitored regularly; and
- it is satisfied with the controls in place and progress is being made in completing mitigating actions

6.2 Audit Committees

The Audit Committees have overall delegated responsibility for ensuring NHS North Central London establishes and maintains an effective system of governance, risk management and internal control. The committees will provide regular updates to the Joint Boards of NHS North Central London and report any exceptional issues.

6.3 Remuneration Committee

The Remuneration Committee is a Non-Executive Committee and is responsible for remuneration and terms of service for senior managers, including performance related pay or terms of service.

6.4 Professional Executive Committees

The Professional Executive Committees assist the development of strategy and policies, monitor clinical standards and advise on quality and clinical governance.

6.5 Quality and Safety Committee

The Quality and Safety Committee develops quality and safety indicators and reviews clinical quality of health providers. It ensures that quality and safety is integral to the commissioning function and that clinical risk is managed.

6.6 Financial Recovery and Quality, Innovation, Productivity and Prevention (QIPP) Committee

6.7 Clinical Commissioning Groups

As Clinical Commissioning Groups take on delegated responsibility for budgets and become Committees of the Joint Boards, they will be responsible for the effective management of all risk within their delegated area, working with the NHS North Central London risk management arrangements.

6.8 There are a number of other committees with specific responsibility for risk management that report into the Joint Boards or committees of the Boards. These include: Senior Wider Leadership Team, Information Governance Committee; Health and Safety Committee, Quality & Safety Policy Review Group - see Appendix 3 for further information.

6.9 Chief Executive

The Chief Executive has overall responsibility for ensuring an effective risk management system is in place across NHS North Central London.

6.10 Senior Wider Leadership Team / Directors

The Senior Wider Leadership Team has responsibility for ensuring risks are identified and managed at an appropriate level across NHS North Central London. Specifically:

- Risks are identified, assessed and actions agreed;
- Managers and staff under their management are aware of this strategy and their responsibilities for implementing it;
- Risks are reported and recorded in accordance with this strategy; and
- That staff attend appropriate training.

6.11 Non-Executive Directors

All Non-Executive Directors are required to assure themselves that NHS North Central London has robust and effective systems for risk management and internal control. Through membership on the Joint Boards and NHS North Central London committees Non Executive Directors will receive, review and comment on regular risk management updates and ensure satisfactory progress is made against action plans.

6.12 Head of Corporate Governance

The Head of Corporate Governance is responsible for the development and implementation of effective risk management arrangements and systems of internal control, including in particular the development of the Board Assurance Framework.

6.13 Risk Manager

The Risk Manager is responsible for facilitating risk management processes and activity across NHS North Central London.
This will include:

- Assisting with the development and review of relevant policies;
- Assisting with the implementation of the Risk Management Strategy; and
- Maintaining the Risk Register and Board Assurance Framework.

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<tr>
<th>6.14 Risk Corporate Governance Facilitator and Health and Safety Co-ordinator</th>
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<td>The Risk and Health and Safety Co-ordinator Corporate Governance Facilitator is responsible for taking the organisational lead for Health and Safety issues across NHS North Central London. This will include:</td>
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<tr>
<td>- Organising the Health and Safety Committee</td>
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<td>- Ensuring compliance around health and safety requirements</td>
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<td>- Responsibility for Health and Safety Policy</td>
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<tr>
<td>- Responsibility for provision and organisation of health and safety training including monitoring, bookings etc</td>
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<td>- Responsibility for recording of training</td>
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<tr>
<td>- Responsibility for Fire Policy</td>
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<tr>
<td>- Responsibility for fire training provision</td>
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<td>- Responsibility for building / property risk assessments</td>
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<td>- Responsibility for fire alarm testing and fire drills</td>
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<td>All managers are responsible for:</td>
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<tr>
<td>- Familiarising themselves with the Risk Management Strategy and raising awareness and understanding of risk management processes within their work area;</td>
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<td>- Reviewing their areas of work to identify risks, agree appropriate actions and escalate risks as necessary;</td>
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<td>- Fostering a supportive work environment to facilitate the reporting of risks; to investigate risks reported to them by staff;</td>
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<td>- Developing and implementing any local policies necessary to the effective implementation of risk management;</td>
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<tr>
<td>- Ensuring staff have access to opportunities for training and development; and</td>
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<td>- Ensuring that risk management is a regular agenda item at directorate and team meetings.</td>
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6.18 **All Staff are Responsible for:**

- Attending mandatory and statutory training;
- Co-operating with arrangements for minimising risk;
- Working to NHS North Central London policies;
- Taking reasonable care for their own safety and that of others;
- Taking care of NHS North Central London’s buildings, equipment and other assets; and
- Reporting risks, incidents and near misses.

6.19 **All Committees are Responsible for:**

- Ensuring all risks raised either through committee papers or during discussion are assessed and included on the Risk Register as appropriate.
- Receiving, reviewing and commenting on papers submitted to the committee regarding areas of risk relevant to the committee’s remit. Sections 8.6 and 8.7 below outline the review of risk by the Committees of the Joint Boards.

7 **Process for the Management of Risk**

This section outlines NHS North Central London’s processes for identifying, assessing and managing risk. This includes both arrangements within corporate headquarters and borough offices.

7.1 **Identification of Risk**

Risks can be identified through a variety of ways. The following are examples of some of the ways in which NHS North Central London identifies risks, although this is not intended to be exhaustive.

7.1.1 **Incidents, Complaints and Claims**

All incidents, complaints and claims must be reported and managed in line with the respective policies (referenced in section 3). Any risks identified as part of these processes must be assessed and managed in line with this strategy, as indicated in the relevant policies.

7.1.2 **Policies**

NHS North Central London has a process for ensuring that all necessary policies and procedures are in place and up to date, easily accessible to those who need them and implemented effectively. All risks identified through the development and implementation of policies must be assessed and managed in line with this strategy.

7.1.3 **Committee Reports**

All reports to NHS North Central London Committees must be submitted in the relevant committee report template. This template includes a requirement to highlight any risks identified in relation to the content of the report.
All NHS North Central London Committees also have identification and submission of new risks to the Risk Register as a regular agenda item. All risks identified and reported in this way must be assessed and managed in line with this strategy.

7.1.4 External Assessments

NHS North Central London is required to undertake a number of external assessments and audits every year. All risks identified in relation to the requirements of an external assessment must be assessed and managed in line with this strategy.

7.1.5 National Guidance / Safety Alerts

NHS North Central London has processes in place for managing the dissemination and implementation of relevant NICE guidance, national guidance, and safety alerts. All risks identified in relation to implementation of such guidance must be assessed and managed in line with this strategy.

7.1.6 Internal Audit

NHS North Central London’s internal auditors will provide an independent and objective opinion on the effectiveness of risk management and governance within the organisation. All risks identified through in the internal audit process must be assessed and managed in line with this strategy.

7.2 Risk Assessment

All identified risks must be assessed to determine the likelihood and the consequence or severity of the risk. Risk assessment is a systematic and effective method of determining the level of risks and most cost-effective means to minimise or remove them.

This is completed using a risk assessment matrix to calculate an overall risk rating. The risk rating is calculated by combining the likelihood and the consequence / severity of the risk.

Risk Rating = Likelihood of Occurrence x Consequence / Severity of Hazard

Table 1 should be used to assess the consequence and obtain a consequence score.
Table 1 - Risk Consequence Score

<table>
<thead>
<tr>
<th>Category</th>
<th>1 Negligible</th>
<th>2 Minor</th>
<th>3 Moderate</th>
<th>4 Major</th>
<th>5 Catastrophic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adverse publicity / reputation / perception</td>
<td>Coverage in media, little effect on public confidence / staff morale</td>
<td>Local Media – short term. Minor effect on public attitudes / staff morale</td>
<td>Local Media – long term. Impact on staff morale &amp; public perception of organisation</td>
<td>National media &lt;3 days Public confidence in organisation undermined. Usage of services affected</td>
<td>National media &gt;3 days. MP Concern (questions in House)</td>
</tr>
<tr>
<td>Business objectives / projects</td>
<td>Insignificant cost increase/schedule slippage</td>
<td>Less than 5 per cent over project budget. Schedule slippage.</td>
<td>5 to 10 per cent over project budget. Schedule slippage.</td>
<td>Non-compliance with national 10-25 per cent over project budget. Schedule slippage. Key objectives not met.</td>
<td>Incident leading to over 25 per cent over project budget. Schedule slippage. Key objectives not met.</td>
</tr>
<tr>
<td>Finance including claims</td>
<td>Small loss. Risk of claim remote.</td>
<td>Loss of 0.05 – 0.125 per cent of budget per PCT. Claim less than 10,000 GBP.</td>
<td>Loss of 0.125 - 0.25 per cent of budget per PCT. Claim(s) between 10,000 GBP and 100,000 GBP.</td>
<td>Uncertain delivery of key objective/loss of 0.25 - 0.5 per cent of budget per PCT. Claim(s) between 100,000 GBP and 1 million GBP. Purchasers failing to pay on time.</td>
<td>Non-delivery of key objective/loss of over 0.5 per cent of budget per PCT. Failure to meet specifications /slippage. Loss of contract/payment by results. Claim(s) of over 1 million GBP.</td>
</tr>
<tr>
<td>HR / organisational development / staffing / competence</td>
<td>Short/term low staffing level that temporarily reduces service quality (less than 1 day).</td>
<td>Low staffing level that reduces the service quality.</td>
<td>Late delivery of key objective/service due to lack of staff. Unsafe staffing level or competence (greater than 1 day). Low staff morale. Poor staff attendance for mandatory/key training.</td>
<td>Uncertain delivery of key objective/service due to lack of staff. Unsafe staffing level or competence (greater than 5 days). Very low staff morale. No staff attending mandatory/key training.</td>
<td>Non-delivery of key objective/service due to lack of staff. Ongoing unsafe staffing levels or service. Loss of several key staff. No staff attending mandatory training/key training on an ongoing basis.</td>
</tr>
<tr>
<td>Impact on the safety of patients, staff or public</td>
<td>Minimal injury requiring nonminimal intervention or treatment. No time off work.</td>
<td>Minor injury or illness requiring minor intervention. Requiring time off work for over 3 days. Increase in length of hospital stay by 1-3 days.</td>
<td>Major injury requiring professional intervention. Requiring time off work for 4-14 days. Increase in length of hospital stay by 4-15 days. RIDDOR/agency reportable incident. An event which impacts on a small number of patients.</td>
<td>Major injury leading to long-term incapacity/disability. Requiring time off work for over 14 days. Increase in length of hospital stay by over 15 days. Mismanagement of patient care with long-term effects.</td>
<td>Incident leading to death. Multiple permanent injuries or irreversible health effects. An event which impacts on a large number of patients.</td>
</tr>
<tr>
<td>Service business / Environmental impact</td>
<td>Loss/interruption of over 1 hour. Minimal or no impact on the environment.</td>
<td>Loss/interruption of over 8 hours. Minor impact on environment.</td>
<td>Loss/interruption of over 1 day. Moderate impact on environment.</td>
<td>Loss/interruption of over 1 week. Major impact on environment.</td>
<td>Permanent loss of service or facility. Catastrophic impact on environment.</td>
</tr>
</tbody>
</table>
### 7.2.1 The likelihood of the consequence occurring must then be measured. Table 2 should be used to assess the likelihood and obtain a likelihood score. When assessing the likelihood it is important to take into consideration the controls (i.e. mitigating factors that may prevent the risk occurring) already in place.

**Table 2 - Risk Likelihood Score**

<table>
<thead>
<tr>
<th>LIKELIHOOD</th>
<th>1 Rare</th>
<th>2 Unlikely</th>
<th>3 Possible</th>
<th>4 Likely</th>
<th>5 Almost Certain</th>
</tr>
</thead>
<tbody>
<tr>
<td>of hazard realised</td>
<td>Negligible (1)</td>
<td>Minor (2)</td>
<td>Moderate (3)</td>
<td>Major (4)</td>
<td>Catastrophic (5)</td>
</tr>
<tr>
<td>Rare (1)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Unlikely (2)</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>Possible (3)</td>
<td>3</td>
<td>6</td>
<td>9</td>
<td>12</td>
<td>15</td>
</tr>
<tr>
<td>Likely (4)</td>
<td>4</td>
<td>8</td>
<td>12</td>
<td>16</td>
<td>20</td>
</tr>
<tr>
<td>Almost Certain (5)</td>
<td>5</td>
<td>10</td>
<td>15</td>
<td>20</td>
<td>25</td>
</tr>
</tbody>
</table>

7.2.2 The consequence and likelihood scores must then be multiplied and plotted on table 3 to establish the overall level of risk and necessary action. The bold line depicts the level of acceptable risk detailed in section 7.3.

**Table 3 – Risk Assessment Matrix (level of risk)**

<table>
<thead>
<tr>
<th>LIKELIHOOD</th>
<th>CONSEQUENCE severity / impact of hazard being realised</th>
</tr>
</thead>
<tbody>
<tr>
<td>of hazard realised</td>
<td>Negligible (1)</td>
</tr>
<tr>
<td>Rare (1)</td>
<td>1</td>
</tr>
<tr>
<td>Unlikely (2)</td>
<td>2</td>
</tr>
<tr>
<td>Possible (3)</td>
<td>3</td>
</tr>
<tr>
<td>Likely (4)</td>
<td>4</td>
</tr>
<tr>
<td>Almost Certain (5)</td>
<td>5</td>
</tr>
</tbody>
</table>

1-3 Low Risk  
4-6 Moderate Risk  
8-12 High Risk  
15-25 Extreme Risk

Solid line indicates threshold of risk acceptability (see risk appetite in 7.3)
7.3 Risk Rating and Risk Appetite

7.3.1 NHS North Central London is a transitional commissioning organisation. It has emerged from the first phase of transition which saw the clustering together of five Primary Care Trusts with a 54% reduction in management costs. The organisation is currently embarking on the next phase of transition which, subject to legislative change, will deliver the changes set out in *Equity and Excellence: liberating the NHS* (July 2010). It is acknowledged that any transition is a process with inherent risk. Similarly, the scale of the financial challenge in North Central London and pace of transformational change needed to bring the health economy back into balance makes effective risk management essential. This includes the need to mitigate risk and to maximise opportunities which in themselves may require a degree of risk taking. A consideration of the organisation’s risk appetite is key.

7.3.2 Significant management effort is required to ensure the effective alignment of resources behind delivery of key programmes of work. In doing this, the organisation may need to accept a level of risk so it is important to determine where the threshold for risk acceptance sits. It should also be acknowledged that it is not always possible to show continuous improvement in all risk ratings or eliminate risk completely. For those risks that cannot be removed / reduced entirely, the risks must be mitigated to a level which the organisation is willing to tolerate.

7.3.3 This section provides a breakdown of what level of risk is regarded as acceptable and how risks should be managed once an appropriate score is identified (in other words the organisation’s risk appetite).

7.3.4 When assessing individual risks, the following questions should be considered to assist in determining whether a risk is acceptable:

- What is the level of risk we think we are facing?
- What is the impact?
- Can we tolerate the possibility of that risk actually happening?
- If not, do we want or need to do more?
- Will the cost of managing this risk outweigh the benefit?

7.3.5 NHS North Central London risk appetite is as outlined below:

- **Low and moderate risks (1 - 6)** are regarded as acceptable and should be managed locally or within the relevant directorate areas. Services should review low risks on a regular basis at relevant directorate and team meetings.

- **High risks (8 - 10)** are regarded as acceptable and risks rated 12 and above should be included on the Corporate Risk Register. Risks rated 12 and above are regarded as unacceptable. Relevant departmental managers / heads of service must be assigned as the overall risk owner with responsibility for overseeing management of the risk.

- **Extreme risks (15 - 25)** are regarded similarly as unacceptable and should be included on the Corporate Risk Register and reported to the Joint Boards. Relevant Directors must be assigned as the overall risk owner with responsibility for overseeing management of the risk.
7.3.6 Appropriate controls and actions need to be agreed and taken to reduce all risks to an acceptable level, or where it is not possible to reduce the level of risk ensure that it is managed appropriately.

8 Monitoring and Reporting

8.1 It is essential that Boards are properly informed about risk, and are able provide evidence that they have identified their objectives systematically, managed the principal risks to achieving them through systems of internal control and obtained assurances that risk management arrangements are effective. The Board Assurance Framework and the Risk Registers are designed to fulfil this purpose.

8.2 The Board Assurance Framework outlines NHS North Central London’s principal objectives, the risks to achieving those objectives, key controls and assurances, and gaps in controls and assurances. The Risk Register contains a mixture of strategic and operational risks at organisational and directorate level as well as the arrangements in place to mitigate these.

The Board Assurance Framework provides NHS North Central London with a simple but comprehensive method for the effective and focused management of the principal risks to meeting objectives. It also provides a structure for the evidence to support the Statement on Internal Control. This simplifies Board reporting and the prioritisation of action plans, which, in turn, allow for more effective performance management.

8.3 The Risk Register includes the following information:

- A description of the risk - detailing Cause Event Effect
- An assigned risk owner
- Key Controls - what controls / systems we have in place to mitigate the risk
- Assurance on Controls - where can we gain evidence that shows we are reasonably managing our risk?
- Positive Assurances - what evidence have we received that shows we are reasonably managing our risks?
- Gaps in Controls - where are we failing to put controls / systems in place? Where are we failing in making them effective?
- Gaps in Assurance - where are we failing to gain evidence that our controls / systems are effective?
- Inherent / Original Risk - risk rating when risk first identified
- Planned Actions – to mitigate risk and to manage gaps including risk register action plan

8.4 The maintenance and monitoring of the Board Assurance Framework and the Risk Register is essential to provide assurance that the organisation has robust risk management arrangements, that these arrangements are subject to appropriate scrutiny and that the Joint Boards can be confident their objectives can be achieved.
8.5 NHS North Central London has a structured approach in place for completion of its Assurance Framework and Risk Register and the Joint Boards will draw assurance from the following arrangements for ensuring that both the Risk Register and Board Assurance Framework are proactively monitored so that the processes are embedded within the organisation and link to key business, planning and investment decisions.

8.6 These arrangements are as follows:

**Directorate Risk Registers**
- contain all potential risks identified within the directorate
- monitored and reviewed at the Directorate Management Team meeting on a monthly basis
- monitored at the Senior-Wider Leadership Team meeting on rolling monthly basis
- high and extreme risks (rated 12 and above) escalated to Corporate Risk Register

**Corporate Risk Register**
- contains high (rated 12 and above) and extreme (rated 15 - 25) risks identified within the Directorate Risk Registers
- monitored at all meetings of Audit Committees
- extreme risks (rated 15 - 25) at all Board meetings
- monitored at Senior-Wider Leadership Team meeting on monthly basis

**Board Assurance Framework**
- contains risks to principal and strategic objectives
- monitored at all meetings of Audit Committees
- reviewed at all Board meetings
- monitored at Senior-Wider Leadership Team meeting on a monthly basis

These reporting and monitoring arrangements are outlined in Appendix 4.

8.7 The Quality and Safety, Financial Recovery and Quality, Innovation, Productivity and Prevention (QIPP) Committee and the Clinical Commissioning Groups (CCGs) also review relevant sections of the Risk Register regularly.

9 **Training**

9.1 Training will be delivered to all staff (including board members and senior management) in line with the trust training needs analysis. Mandatory training will be given to all new starters at the corporate induction. This will include a briefing on risk assessment and using the risk registers.

9.2 Regular risk management updates will be provided at relevant committees on an ongoing basis which will include training on new requirements or changes to existing requirements.
10 Dissemination and Implementation

10.1 This strategy will be disseminated throughout NHS North Central London via the newsletter, relevant managers and directorate meetings. It is also available on the Intranet, in the following location:

http://nww.ncl.nhs.uk/Docs/default.aspx

10.2 Generic risk management responsibilities are included in the job descriptions of all members of staff. Specific responsibilities for risk management will be outlined in the job descriptions of relevant members of staff.

11 Review

11.1 This strategy will be reviewed in 1 year, or earlier if there are changes to national guidance or significant changes to the management of risk across the organisation.
APPENDIX 1

Risk Management Strategy - Principles and Aims

The following key principles are essential for the successful implementation of this strategy:

- There is Board and management commitment to, and leadership of, the total risk.
- There is widespread employee participation and consultation in risk management processes, which will operate in a fair blame culture.
- There are management systems in place that provide safe practices, premises and equipment in the working environment. Systems of work must be designed to reduce the likelihood of human error occurring.
- The risk management process must be applied to contract management especially when acquiring, expanding or outsourcing services, equipment or facilities. Contracts must be reviewed and written to ensure that only reasonable risks are accepted.
- On all NHS North Central London premises, whether owned or shared, safe systems of work must be in place to protect patients, visitors and staff.
- NHS North Central London maintains an effective system of emergency preparedness, emergency response and contingency planning.
- NHS North Central London provides realistic resources to implement and support effective risk management throughout the organisation.

The aims of managing risks effectively are to:

- Ensure the management of risk is consistent with and supports the achievement of NHS North Central London strategic and corporate objectives.
- Commission and provide a high quality service to patients.
- Initiate action to prevent or reduce the adverse effects of risk.
- Minimise the financial and other negative consequences of losses and claims, for example, poor publicity, loss of reputation.
- Minimise the risks associated with new developments/activities.
- Meet statutory and legal obligations and improve compliance with the ongoing requirements of best practice governance standards.
- Protect patients, visitors and staff from risks where reasonably practicable.
APPENDIX 2

NHS North Central London Principal and Strategic Objectives

**Principal Objective 1:** To ensure we commission services which are safe and of increasing quality for the people we serve

**Strategic Objectives:**

1.1 To understand the quality and safety of all commissioned services and agree action plans to address any shortfalls.
1.2 To establish quality and safety markers for all commissioned services and agree improvement trajectories.
1.3 To improve patient experience in all commissioned services.
1.4 To contribute to the London-wide Quality and Safety review and embed its recommendations.

**Principal Objective 2:** To deliver the NHS North Central London Commissioning Strategy and QIPP plan.

**Strategic Objectives:**

2.1 To achieve agreed milestones within all implementation plans.
2.2 To further develop the Commissioning Strategy and QIPP delivery plans, focusing on transformational change to secure a sustainable health economy (including the Primary Care Strategy, BEH Clinical Strategy, Integrated Care, Prevention, and the Cost and Clinical Effectiveness Programme).
2.3 To achieve the cluster control total.
2.4 To achieve individual PCT run-rate balance in 2012/13.
2.5 To support NHS trusts to develop service strategies with wide engagement and confirm their routes to Foundation Trust.

**Principal Objective 3:** To deliver key organisational objectives and a secure transition* to the commissioning landscape in line with the Health and Social Care Act 2012.

**Strategic Objectives:**

3.1 To work in partnership with communities, patients and other key stakeholders to reduce health inequalities, and improve health and health services in North Central London.
3.2 To maintain a clear focus on delivery through the effective alignment of staff and resources, and ensuring clarity over roles and robustness of governance arrangements.
3.3 To support the development of the new commissioning system by:
   - Developing the Commissioning Support Service with a robust business model to deliver high quality commissioning support;
   - Supporting the development of Clinical Commissioning Groups to deliver within their delegated responsibilities and achieve authorisation by April 2013; and
   - Building effective commissioning partnerships with the NHS Commissioning Board, Local Authorities and Public Health England.
3.4 To invest in staff development, and maintain effective staff communication to prepare the workforce to transfer successfully to new organisations.
3.5 To ensure the safe hand over of knowledge, responsibilities and accountability, and secure the successful closedown of the statutory organisations.

*It is acknowledged that the transition element of this objective is subject to national policy direction and legislative change. We will monitor these changes closely to ensure that the objectives of the five Primary Care Trusts are aligned appropriately.*
NHS North Central London Cluster Board structure from 1 October 2012

Overall Transition Accountability & Assurance

Joint PCT Boards

Previous Committees of the Joint PCT Boards

- Audit Committee
- Financial Recovery and QIPP Committee
- Quality and Safety Committee

New / Adapted Committees of the Joint PCT Boards

- Adapted ToRe: Remuneration and Workforce Committee
- New: Transition Committee

Day-to-Day Management Groups

- Transition Delivery Group (Project Managers)
- Core Cluster Executive Team
APPENDIX 3

Senior-Wider Leadership Team (WSLT)

- Service Prioritisation & Review Group
- Health and Safety Committee
- Information Governance Steering Group
APPENDIX 4

Illustration of Risk Reporting and Monitoring Arrangements

Board Assurance Framework
Principal and Strategic Objectives
Reported to:

- At all Board meetings
- At all Audit Committee meetings
- At Senior-Wider Leadership Team meeting on a monthly basis

Responsible Director:
Director of Transition and Corporate Affairs

Risks to Principal and Strategic Objectives included

Corporate Risk Register
Strategic and Operational Objectives
Reported to:

- Extreme risk at all Board meetings
- Full Register at all Audit Committee meetings
- Full Register at Senior-Wider Leadership Team meeting on a monthly basis

Responsible Director:

Extreme and High Risks escalated

Directorate Risk Register
Directorate Objectives
Reported to:

- Full Register at Directorate Management Team on a monthly basis
- Full Register at Senior-Wider Leadership Team meeting on rolling basis

Responsible Director:
This paper updates the Boards on the activities of the Audit Committees from November 2012 and January 2013.

The Joint Boards are asked to:
- REVIEW the activities of the Committees

**GOVERNANCE:**
Voting: Please indicate which Board(s) has voting rights on this matter (if applicable)

<table>
<thead>
<tr>
<th>Barnet</th>
<th>Camden</th>
<th>Enfield</th>
<th>Haringey</th>
<th>Islington</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paula Kahn</td>
<td>Paula Kahn</td>
<td>Paula Kahn</td>
<td>Paula Kahn</td>
<td>Paula Kahn</td>
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<tr>
<td>David Riddle</td>
<td>Karen Trew</td>
<td>Karen Trew</td>
<td>Cathy Herman</td>
<td>Anne Weyman</td>
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<tr>
<td>Caroline Rivett</td>
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<tr>
<td>Robert Sumerling</td>
<td>Deborah Fowler</td>
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<td>Anne Weyman</td>
<td>Sorrel Brookes</td>
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<tr>
<td>Karen Trew</td>
<td>Cathy Herman</td>
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<td>Marek Koperski</td>
<td>Shahed Ahmad</td>
<td>Mohammed</td>
<td>S. Gillian</td>
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<td>Mohammed</td>
<td>Gruchy</td>
<td>Greenough</td>
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<tr>
<td>Penny Bevan</td>
<td>(vacant)</td>
<td>Helen</td>
<td>Penny Bevan</td>
<td>Penny Bevan</td>
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<tr>
<td></td>
<td></td>
<td>Pelendrides</td>
<td></td>
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</tbody>
</table>
Objective(s) / Plans supported by this paper:
Principal Objective 3: To deliver key organisational objectives and a secure transition* to the commissioning landscape set out in the white paper *Equity and Excellence: Liberating the NHS (July 2010).

Audit Trail: The Boards review the activity of the Audit Committees at each meeting. The approved minutes of the Audit Committees are submitted to the Joint Boards as a standard item for information.

Patient & Public Involvement (PPI): There has been no patient and public involvement for this paper.

Equality Impact Assessment: No Equality Impact Assessment is planned or has been undertaken for the report.

Risks: This paper identifies risks arising from the review of internal and external audit reports.

Resource Implications: There are no direct resource implications for this paper.

Next Steps: The Audit Committees Report will be a standing item on future Board agendas.
1 SUMMARY

The Audit Committees of Barnet, Camden, Enfield, Haringey and Islington Primary Care Trusts met jointly on 22 November 2012. The Committee reflected on its position until year end and the work-plan for the additional meeting of the Committee at the end of March 2013.

2. Audit Committees Meeting – 20 September 2012

Key matters arising

2.1 FINANCIAL RECOVERY AND QIPP COMMITTEE UPDATE
The Director of Finance gave a high level update on the month 7 position; an overview of the challenge of QIPP delivery and the work that had been undertaken to identify QIPP and QIPP stretch within contracts. The focus was now on working with the Clinical Commissioning Groups to facilitate the delivery of local plans and recurrent savings.

It was anticipated that there would not be a difficulty in reaching the year end control total, but that the challenge would be in the individual Clinical Commissioning Groups attaining run rate balance.

Discussions were continuing between the Chief Financial Officers on agreeing a risk share arrangement across a five year period, which would be agreed at the local board level.

2.2 CLINICAL COMMISSIONING GROUP AUDIT COMMITTEE TRANSITION
The Committees were given an update by representatives of each of the borough Clinical Commissioning Groups on progress in establishing audit committees, Islington and Enfield had their inaugural meetings, and internal audit had attended.

The Committees discussed in depth the possible models for future delivery and agreement of the audit plans across the Clinical Commissioning Groups, and the mechanisms for how to receive assurance, streamlining the process across the audit providers, using the contractual arrangement with the Clinical Support Unit to drive delivery.

2.3 BOARD ASSURANCE FRAMEWORK AND RISK REGISTER
The Committees continued their in-depth review of transitional risks, receiving updates on estates and facilities, non-clinical contract, transition and IT risks.

Risks related to the transfer of property were reviewed, it was felt that the ‘lift and shift’ of function would mitigate some risk. Assurance was given on plans to mitigate risk and work being undertaken with receiving organisations. It was recognised that work on the flow of funds into receiving organisations was a work in progress.

Current value of assets had been determined, with a full revaluation feeding into the Month 9 hard close. Transfer orders were being completed, and discussions ongoing with primary care tenants which had resulted in a national initiative to produce a legally binding obligation on accommodation to transfer with ownership.
Assurance was received that all facilities contracts had been comprehensively identified for novation, extension or cancellation. Receivership had been confirmed, and contracts had been extended where necessary.

An update was received on IT transition risks, and progress against audit recommendations, the risk of receivership of the IT service was highlighted along with the risks associated with the disaggregation of the shared service.

2.4 LEGACY HANDOVER AND CLOSEDOWN

The Committees were informed that a Transition Committee had been established looking at key issues of human resources, handover certification and sender and receiver readiness.

2.5 ACCOUNTS RECEIVABLE AND PAYABLE

A report on the level of cleared invoices was received, with the timelines for clearing aged debt. The process for signing of invoices had been streamlined and budget holders had been reminded of their responsibilities for resolving disputes. The Committee approved the debt write off proposals submitted.

2.6 CONCLUSION

The Committees also received an update on transition issues and a report on the progress made against the Croydon Assurance Checklist in Part 2 of the meeting; confirming that the approach satisfied the Committees on NHS North Central London’s progress against action plan to ensure safe financial handover.

The Committees will be receiving the following items at the next meeting, being held on 24 January 2013.

- The last items in the cycle of risk review including Transition, Public Health, Quality and Safety and Communications and Governance risks
- The draft governance statements for each borough
- Clinical Commissioning Group Audit Committee minutes
- Finance transition and QIPP updates including risks and opportunities
- An update on accounts payable and receivable
- Ernst and Young report

The Joint Boards are asked to:

- **REVIEW** the activities of the Committees.
**MEETING:** Meeting of the Joint Boards of NHS North Central London  
**DATE:** Thursday 31 January 2013  
**TITLE:** Report of the Charitable Fund Committees of Barnet and Camden Primary Care Trusts  
**LEAD DIRECTOR:** Bev Evans, Director of Finance  
**AUTHOR:** Tilly Vivek, Financial Controller  
Matt Hopkinson, Board Secretary  
**CONTACT DETAILS:** Tilly.vivek@nclondon.nhs.uk  
Matthew.hopkinson@nclondon.nhs.uk  

**SUMMARY:**

This report provides an update on the activity of the Charitable Fund Committees of Barnet and Camden Primary Care Trusts, which last met on 14 December 2012.

On 21 June 2011 part of the North Central London Charitable Funds were transferred by Statutory Instrument to The Whittington Hospital NHS Trust and to Barnet, Enfield & Haringey Mental Health Trust. On the 15 November 2011 the remaining funds were transferred to Central and North West London NHS Foundation Trust. Transfer by Statutory Instrument of the Barnet Primary Care Trust General Charity to Central London Community Healthcare NHS Trust, was also carried out on 16 July 2012.

There are no charitable funds now held by any of the five North Central London Primary Care Trusts. Accordingly, the Charitable Fund Committees of the two Primary Care Trusts will cease to operate.

Barnet Primary Care Trust remained the corporate trustee of the Barnet PCT General Charity in 2011-2012, and is responsible for the submission of annual accounts to the Charities Commission for that year. The audited accounts for 2011-2012 were approved by the Barnet Charitable Fund Committee on 14 December 2012 and are submitted here for approval by the PCT Board.

The Joint Board are asked to note a difference in the 2010-11 comparative figures by £1,000 where the fund total on the Statement of Financial Activites was stated as £90,000 and the Balance Sheet as £89,000. The 2011-12 accounts reported the same difference as these were the final audited accounts for 2010-11 and hence cannot be adjusted for.

The Committees noted the excellent work supported by the Charitable Funds over the last 18 months; in particular the Dr William Scholl Podiatric Research and Development Endowment Fund, which supported the research project ‘Advancing care for children with obesity: an evaluation of foot and lower limb musculoskeletal pathology and characteristics of motor function’. The Committees also commended the Arts Projects at the Mary Rankin Dialysis Unit and the Conference Centre at St Pancras Hospital, which had been of significant benefit to patients and members of staff.
The Committees also expressed their thanks and commendation to the Finance Team for their work in preparing the Annual Accounts for both Camden and Barnet Charitable Funds.

The Boards of Barnet and Camden Primary Care Trusts are also asked to formally note the cessation of operations by the Charitable Funds Committees as the committees have now concluded their business.

SUPPORTING PAPERS:

Appendix A – Barnet Primary Care Trust Charitable Fund Annual Accounts and Annual report 2011-2012.
Appendix B – External Audit Opinion on Annual Accounts

RECOMMENDED ACTION:

The Board of Barnet Primary Care Trust is asked to:

- **ADOPT** the Charitable Fund Annual Accounts 2011-2012; and
- **NOTE** the cessation of operations by the Barnet Primary Care Trust Charitable Fund Committee.

The Board of Camden Primary Care Trust is asked to:

- **NOTE** the cessation of operations by the Camden Primary Care Trust Charitable Fund Committee.

LINKS TO NHS NORTH CENTRAL LONDON STRATEGY

Strategic Objective 3.2: To maintain a clear focus on delivery through the effective alignment of staff and resources, and ensuring clarity over roles and robustness of governance arrangements.

GOVERNANCE:

**Voting:** Please indicate which Board(s) has voting rights on this matter (if applicable)

<table>
<thead>
<tr>
<th>Barnet</th>
<th>Camden</th>
<th>Enfield</th>
<th>Haringey</th>
<th>Islington</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paula Kahn</td>
<td>Caroline Rivett</td>
<td>Karen Trew</td>
<td>Caroline Rivett</td>
<td>Catherine Herman</td>
</tr>
<tr>
<td>David Riddle</td>
<td></td>
<td>Deborah Fowler</td>
<td></td>
<td>Anne Weyman</td>
</tr>
<tr>
<td>Bernadette Conroy</td>
<td>Robert Sumerling</td>
<td>Ellen Schroder</td>
<td>Cathy Herman</td>
<td>John Baker</td>
</tr>
<tr>
<td>Caroline Taylor</td>
<td>Bev Evans</td>
<td>Caroline Taylor</td>
<td></td>
<td>Caroline Taylor</td>
</tr>
<tr>
<td>Bev Evans</td>
<td>Penny Bevan</td>
<td>Bev Evans</td>
<td></td>
<td>Bev Evans</td>
</tr>
<tr>
<td>Andrew Howe</td>
<td>Joanne Wickens</td>
<td>Shahed Ahmad</td>
<td>Mohammed Abedi</td>
<td>Jeanelle De Gruchy</td>
</tr>
<tr>
<td>Philippa Curran</td>
<td></td>
<td></td>
<td></td>
<td>Helen Pelendrides</td>
</tr>
<tr>
<td>Alison Pointu</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Objective(s) / Plans supported by this paper: Strategic Objective 3.2: To maintain a clear focus on delivery through the effective alignment of staff and resources, and ensuring clarity over roles and robustness of governance arrangements.

Patient & Public Involvement (PPI): None associated with this report.

Equality Impact Analysis: None associated with this report.

Risks: There are no outstanding risks associated with the Charitable Funds, as all duties as trustees have been transferred out of the Primary Care Trusts.

Resource Implications: None.

Audit Trail: None

Next Steps: None.
STRATEGIC OBJECTIVES AND ACTIVITIES

Under the terms of the Governing Document, the object of the fund is to apply income for any charitable purpose relating to hospital and health services provided by the Barnet Primary Care Trust. These funds are used for:
* the relief of those who are ill or disabled and;
* the advancement of education.

ACHIEVEMENT AND PERFORMANCE

Total income for the Barnet PCT General Charity for 2011/12 amounted to £2k.
The total amount of money spent during the year in pursuing the Trust fund objectives was £13k
Net assets amounted to £79k.

The Corporate Trustees for the Barnet PCT are as follows:

Paula Kahn – Chair
David Riddle – Vice Chair
Bernadette Conroy – NED
John Carrier – NED
Robert Sumerling – NED
Caroline Rivett – Audit Chair
Caroline Taylor – Chief Executive
Ann Johnson - Director of Finance
Philippa Curran – PEC Chair
Andrew Burnett – Director of Public Health
Alison Pointu – PEC Nurse

The Charitable Funds Committee members are:
Robert Sumerling - Non Executive Director
Ann Johnson - Director of Finance

The Barnet Charitable funds will be transferred to Central London Community Healthcare Trust as these remaining funds relates to provider activities. The transfer documents were submitted to Department of Health in March 2012. The administration of these funds were taken over by Central London Community Healthcare Trust in April 2012.
The accounts of the Funds Held on Trust by Barnet Primary Care Trust

FOREWORD

These accounts for the year ended 31 March 2012 have been prepared by the Trustees in accordance with Part VI of the Charities Act 1993 and the Charities Accounts Regulations 2005.

STATUTORY BACKGROUND

The Barnet Primary Care Trust is the corporate trustee of the funds held on trust under paragraph 16c of Schedule 2 of the NHS and Community Care Act 1990

The Barnet Primary Care Trust charitable funds held on trust are registered with the Charity Commission and include funds in respect of the Edgware and Finchley Memorial Hospitals.

MAIN PURPOSE OF THE FUNDS HELD ON TRUST

The main purpose of the charitable funds held on trust is to apply income for any charitable purpose relating to the National Health Service wholly or mainly for the services provided by the Barnet Primary Care Trust.
Statement of trustees’ responsibilities

The trustees are responsible for:

- keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the funds held on trust and to enable them to ensure that the accounts comply with requirements in the Charities Act 1993;
- establishing and monitoring a system of internal control; and
- establishing arrangements for the prevention and detection of fraud and corruption.

The trustees are required under the Charities Act 1993 to prepare accounts for each financial year. The Trustees are required to ensure these accounts give a true and fair view of the financial position of the funds held on trust, in accordance with the Charities Act 1993. In preparing those accounts, the trustees are required to:

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The trustees confirm that they have met the responsibilities set out above and complied with the requirements for preparing the accounts. The financial statements set out on pages 9 to 18 attached have been compiled from and are in accordance with the financial records maintained by the trustees.

By Order of the Trustees
Independent examiner’s report to the trustees of Barnet Primary Care Trust General Charity

I report on the accounts of Barnet Primary Care Trust General Charity for the year ended 31 March 2012, which are set out on pages 5 to 12. This report is made solely to the trustees, as a body, in accordance with the regulations made under Section 44 of the Charities Act 1993, as amended by Charities Act 2006. My work has been undertaken so that I might state to the charity's trustees those matters I am required to state to them in an independent examiner's report and for no other purpose. To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the charity and the charity's trustees, as a body, for my work, for this report, or for the opinions I have formed.

Respective Responsibilities of Trustees and Examiner

The charity's trustees are responsible for the preparation of the accounts. The charity's trustees consider that an audit is not required for this year (under section 43(2) of the Charities Act 1993 (the Act)), that an independent examination is needed.

It is my responsibility to:

- examine the accounts under section 43 of the Act;
- to follow the procedures laid down in the general Directions given by the Charity Commission under section 43(7)(b) of the Act; and
- to state whether particular matters have come to my attention.

Basis of independent examiner’s statement

My examination was carried out in accordance with the general Directions given by the Charity Commission. An examination includes a review of the accounting records kept by the charity and a comparison of the accounts presented with those records. It also includes consideration of any unusual items or disclosures in the accounts, and seeks explanations from you as trustees concerning any such matters. The procedures undertaken do not provide all evidence that would be required in an audit, and consequently no opinion is given as to whether the accounts present a 'true and fair' view and the report is limited to those matters set out in the statement below.

Independent examiner’s statement

In connection with my examination, no matter has come to my attention:

i) which gives me reasonable cause to believe that in any material respect, the requirements;
   - to keep accounting records in accordance with section 41 of the Act; and
   - to prepare accounts which accord with the accounting records and to comply with the accounting requirements of the Act;
   have not been met; or

ii) to which, in my opinion, attention should be drawn in order to enable a proper understanding of the accounts to be reached.

Signature:………………………………………………………………………… Date:…………………

Name:

GRANT THORNTON UK LLP
Chartered Accountants
Grant Thornton House
Melton Street
Euston Square
London
NW1 2EP
## Statement of Financial Activities for the year ended 31.03.12

<table>
<thead>
<tr>
<th>Note</th>
<th>Unrestricted Funds £'000</th>
<th>Endowment Funds £'000</th>
<th>Total Funds £'000</th>
<th>Total Funds £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>2012</td>
<td>2011</td>
</tr>
<tr>
<td><strong>Incoming Resources</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Incoming resources from generated funds</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Voluntary income</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Grants from other NHS Charities</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Investment income</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other incoming resources</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total incoming resources</strong></td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td><strong>Resources expended</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Charitable activities</strong></td>
<td></td>
<td>3.1</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Governance costs</td>
<td>3.2</td>
<td>7</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Other resources expended</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total resources expended</strong></td>
<td>3.3</td>
<td>12</td>
<td>0</td>
<td>12</td>
</tr>
<tr>
<td><strong>Net incoming/outgoing resources before transfers and other recognised gains and losses</strong></td>
<td></td>
<td>4</td>
<td>(10)</td>
<td>0</td>
</tr>
<tr>
<td><strong>Transfers</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gross transfers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Net incoming resources before other recognised gains and losses</strong></td>
<td></td>
<td>(10)</td>
<td>0</td>
<td>(10)</td>
</tr>
<tr>
<td><strong>Other recognised gains/losses</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gains on revaluation of fixed assets for charity's own use</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gains/losses on investment assets</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Actuarial gains/losses on defined benefit pension schemes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Net movement in funds</strong></td>
<td></td>
<td>(10)</td>
<td>0</td>
<td>(10)</td>
</tr>
<tr>
<td><strong>Reconciliation of Funds</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total funds brought forward</td>
<td>78</td>
<td>12</td>
<td>90</td>
<td>97</td>
</tr>
<tr>
<td>Total funds carried forward</td>
<td>68</td>
<td>12</td>
<td>80</td>
<td>90</td>
</tr>
</tbody>
</table>

The notes at pages 7 to 10 form part of this account.
## Balance Sheet for the year ended 31.03.12

<table>
<thead>
<tr>
<th>Note</th>
<th>Unrestricted Funds £'000</th>
<th>Endowment Funds £'000</th>
<th>Total Funds 2012 £'000</th>
<th>Total Funds 2011 £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Current Assets:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Debtors</td>
<td>6.1</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Short term investments and deposits</td>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cash at bank and in hand</td>
<td></td>
<td>70</td>
<td>12</td>
<td>82</td>
</tr>
<tr>
<td><strong>Total current assets</strong></td>
<td></td>
<td></td>
<td>70</td>
<td>12</td>
</tr>
<tr>
<td><strong>Liabilities:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creditors: Amounts falling due within one year</td>
<td>7.1</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td><strong>Net Current Assets or Liabilities</strong></td>
<td></td>
<td></td>
<td>68</td>
<td>12</td>
</tr>
<tr>
<td><strong>Total assets less current liabilities</strong></td>
<td></td>
<td></td>
<td>68</td>
<td>12</td>
</tr>
<tr>
<td><strong>The funds of the charity:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endowment funds</td>
<td>8.1</td>
<td>0</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>Unrestricted income funds</td>
<td>8.4</td>
<td>68</td>
<td>0</td>
<td>68</td>
</tr>
<tr>
<td><strong>Total Charity funds</strong></td>
<td></td>
<td>68</td>
<td>12</td>
<td>80</td>
</tr>
</tbody>
</table>

The notes at pages 5 to 10 form part of this account.

Signed: Director of Finance

Date:
Notes to the Account

1 Accounting Policies

a) Basis of Preparation

The financial statements have been prepared under the historic cost convention, as modified for the revaluation of certain investments, and in accordance with Accounting and Reporting by Charities: Statement of Recommended Practice (SORP 2005) issued in March 2005 and applicable UK Accounting Standards and the Charities Act 1993.

b) Incoming Resources

All incoming resources are included in full in the Statement of Financial Activities as soon as the following three factors can be met:

i) entitlement - arises when a particular resource is receivable or the charity's right becomes legally enforceable;

ii) certainty - when there is reasonable certainty that the incoming resource will be received;

iii) measurement - when the monetary value of the incoming resources can be measured with sufficient reliability.

c) Resources expended and irrecoverable VAT

The funds held on trust accounts are prepared in accordance with the accruals concept. All expenditure is recognised once there is a legal or constructive obligation to make a payment to a third party. Irrecoverable VAT is charged against the category of resources expended for which it was incurred.

d) Short term investment and deposits

The Charitable Trust Fund have an RBS and Citi Bank account with a balance of £. The accounts numbers RBS 0012303132 and Citibank account 8012303132 were on the 29th November 2012 and the balances were transferred to Central London (Healthcare Trust on the 6th December 2012.
e) **Charitable activities**

Costs of charitable activities comprise all costs incurred in the pursuit of the charitable objects of the charity. These costs comprise direct costs.

f) **Governance costs**

Governance costs comprise of all costs identified as wholly or mainly attributable to ensuring the public accountability of the charity and its compliance with regulation and good practice. These costs are accounted for on an accruals basis and are recharges of appropriate proportions of overhead and support costs from Barnet Primary Care Trust.

g) **Structure of funds**

Where there is a legal restriction on the purpose to which a fund may be put, the fund is classified either as an endowment fund, where the donor has expressly provided that only the income for the fund may be applied, or as a restricted income fund where the donor has provided for the donation to be spent in furtherance of a specified charitable purpose.

Funds where the capital is held to generate income for charitable purposes and cannot itself be spent are accounted for as endowment funds.

Other funds are classified as unrestricted funds.

Funds which are not legally restricted but which the Trustees have chosen to earmark for set purposes are designated funds. The major funds held within these categories are disclosed in notes 8.2 and 8.4.
### Analysis of voluntary income 2012

<table>
<thead>
<tr>
<th>Category</th>
<th>2012</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Donations</td>
<td>£2</td>
<td>£7</td>
</tr>
<tr>
<td>Others</td>
<td>£0</td>
<td>£0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>£2</td>
<td>£7</td>
</tr>
</tbody>
</table>

### Details of Resources Expended 3.1

<table>
<thead>
<tr>
<th>Category</th>
<th>Unrestricted Funds</th>
<th>Endowment Funds</th>
<th>Total Funds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funds</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Patients welfare and amenities</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Staff welfare and amenities</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>5</td>
<td>0</td>
<td>5</td>
</tr>
</tbody>
</table>

### Governance Costs 3.2

<table>
<thead>
<tr>
<th>Category</th>
<th>Unrestricted Funds</th>
<th>Endowment Funds</th>
<th>Total Funds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funds</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Governance costs</td>
<td>7</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>7</td>
<td>0</td>
<td>7</td>
</tr>
</tbody>
</table>

### Analysis of Charitable Objectives 3.3

<table>
<thead>
<tr>
<th>Category</th>
<th>Other Costs</th>
<th>Governance Costs</th>
<th>Total Costs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auditors remuneration:</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Audit fee</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Other fees</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Bought-in services from NHS</td>
<td>0</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Other significant amounts</td>
<td>0</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>0</td>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>

### Analysis of Staff Costs 3.4

The Trust Fund does not employ any staff directly.
### CHARTABLE TRUST ACCOUNT- BARNET PCT-2011/2012

<table>
<thead>
<tr>
<th>Changes in Resources</th>
<th>Unrestricted Funds</th>
<th>Endowment Funds</th>
<th>Total 2012</th>
<th>Total 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Available for Charity Use</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Net movement in funds for the year</td>
<td>(10)</td>
<td>0</td>
<td>(10)</td>
<td>0</td>
</tr>
<tr>
<td>Net movement in tangible fixed assets:</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Net movement in funds available for future activities</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Analysis of gross income from investments</td>
<td>Held £000</td>
<td>Held £000</td>
<td>Total 2012 £000</td>
<td>Total 2011 £000</td>
</tr>
<tr>
<td>Cash held as part of the investment portfolio</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

### Analysis of Debtors

<table>
<thead>
<tr>
<th>Amounts falling due within one year:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trade debtors</td>
</tr>
<tr>
<td>Total debtors falling due within one year</td>
</tr>
</tbody>
</table>

### Analysis of Creditors

<table>
<thead>
<tr>
<th>Amounts falling due within one year:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other creditors</td>
</tr>
<tr>
<td>Total creditors falling due within one year</td>
</tr>
</tbody>
</table>
### Analysis of Funds

**8.1 Endowment Funds**

<table>
<thead>
<tr>
<th>Name of fund</th>
<th>Description of the nature and purpose of each fund</th>
<th>Balance 31 March 2011</th>
<th>Balance 31 March 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>FMH Samaritan</td>
<td>For the benefit of Staff &amp; Patients at Finchley Memorial Hospital</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Gen Patient Fund</td>
<td></td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>12</strong></td>
<td><strong>12</strong></td>
</tr>
</tbody>
</table>

### Details of material funds - endowment funds

- **A FMH Samaritan**
  - For the benefit of Staff & Patients at Finchley Memorial Hospital

### There are no restricted funds.

### Details of material funds - restricted funds

### Unrestricted funds

<table>
<thead>
<tr>
<th>Name of fund</th>
<th>Description of the nature and purpose of each fund</th>
<th>Balance 31 March 2012</th>
<th>Balance 31 March 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Fund</td>
<td>For the benefit of Staff &amp; Patients</td>
<td>48</td>
<td>58</td>
</tr>
<tr>
<td>Children's Fund</td>
<td></td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>Day Hospital Trust Fund/ Parkinson</td>
<td>For the benefit of Patient</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>68</strong></td>
<td><strong>78</strong></td>
</tr>
</tbody>
</table>
CHARITABLE TRUST ACCOUNT- BARNET PCT-2011/2012

Contingencies (9) The Charitable Trust Fund has no contingent gains or losses.

Commitments, Liabilities and Provisions (10) The trusts have no commitments in the year with regard to Charitable projects, Capital or other. The charitable funds of the PCT have transferred to Central London Community Healthcare Trust (CLCH) in the new year as the management of Provider services (Barnet Community Services) transferred to CLCH on 1st April 2011.

Trustee and Connected Persons Transactions (11) There were no trustee and connected persons transactions in the year.

Related party transactions (12) Related party transactions

During the year none of the Trustees or members of the key management staff or parties related to them were beneficiaries of the Charity.
Independent examiner's report to the trustees of The Funds Held on Trust by Barnet Primary Care Trust

I report on the accounts of The Funds Held on Trust by Barnet Primary Care Trust for the year ended 31 March 2012, which are set out on pages 8 to 14.

This report is made solely to the trustees, as a body, in accordance with the regulations made under Section 154 of the Charities Act 2011. My work has been undertaken so that I might state to the charity's trustees those matters I am required to state to them in an independent examiner's report and for no other purpose. To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the charity and the charity's trustees, as a body, for my work, for this report, or for the opinions I have formed.

Respective responsibilities of trustees and examiner

The charity's trustees are responsible for the preparation of the accounts. The charity's trustees consider that an audit is not required for this year (under section 144(2) of the Charities Act 2011 (the Act)) and that an independent examination is needed.

It is my responsibility to:
- examine the accounts under section 145 of the Act;
- to follow the procedures laid down in the general Directions given by the Charity Commission under section 145(5)(b) of the Act; and
- to state whether particular matters have come to my attention.

Basis of independent examiner's statement

My examination was carried out in accordance with the General Directions given by the Charity Commission. An examination includes a review of the accounting records kept by the charity and a comparison of the accounts presented with those records. It also includes consideration of any unusual items or disclosures in the accounts, and seeks explanations from you as trustees concerning any such matters. The procedures undertaken do not provide all the evidence that would be required in an audit, and consequently no opinion is given as to whether the accounts present a 'true and fair' view and the report is limited to those matters set out in the statement below.

Independent examiner's statement

In connection with my examination, no matter has come to my attention,

i) which gives me reasonable cause to believe that in any material respect, the requirements:
   - to keep accounting records in accordance with section 133 of the Act; and
   - to prepare accounts which accord with the accounting records and to comply with the accounting requirements of the Act;

have not been met or to which, in my opinion, attention should be drawn in order to enable a proper understanding of the accounts to be reached.

Andy Mack, CFPA
GRANT THORNTON UK LLP
Chartered Accountants
Grant Thornton House
Melton Street
Euston Square
London
NW1 2EP

17/01/12