AGENDA

1. Apologies for Absence

2. Declaration of Members' Interests

In accordance with the Council’s Constitution, Members are asked to declare any interest they may have in any matter which is to be considered at this meeting.

3. Minutes - To confirm as correct the minutes of the meeting held on 13 April 2016 (Pages 3 - 10)

4. Referral to Treatment Issues in Barking, Havering and Redbridge University Hospitals NHS Trust (Pages 11 - 46)

5. Joint Health Overview & Scrutiny Committee (Pages 47 - 60)

6. Any other public items which the Chair decides are urgent

7. To consider whether it would be appropriate to pass a resolution to exclude the public and press from the remainder of the meeting due to the nature of the business to be transacted.
Private Business

The public and press have a legal right to attend Council meetings such as the Health and Adult Services Select Committee, except where business is confidential or certain other sensitive information is to be discussed. The list below shows why items are in the private part of the agenda, with reference to the relevant legislation (the relevant paragraph of Part 1 of Schedule 12A of the Local Government Act 1972 as amended). **There are no such items at the time of preparing this agenda.**

8. **Any other confidential or exempt items which the Chair decides are urgent**
Our Vision for Barking and Dagenham

One borough; one community; London’s growth opportunity

Encouraging civic pride

- Build pride, respect and cohesion across our borough
- Promote a welcoming, safe, and resilient community
- Build civic responsibility and help residents shape their quality of life
- Promote and protect our green and public open spaces
- Narrow the gap in attainment and realise high aspirations for every child

Enabling social responsibility

- Support residents to take responsibility for themselves, their homes and their community
- Protect the most vulnerable, keeping adults and children healthy and safe
- Ensure everyone can access good quality healthcare when they need it
- Ensure children and young people are well-educated and realise their potential
- Fully integrate services for vulnerable children, young people and families

Growing the borough

- Build high quality homes and a sustainable community
- Develop a local, skilled workforce and improve employment opportunities
- Support investment in housing, leisure, the creative industries and public spaces to enhance our environment
- Work with London partners to deliver homes and jobs across our growth hubs
- Enhance the borough’s image to attract investment and business growth
MINUTES OF
HEALTH AND ADULT SERVICES SELECT COMMITTEE

Wednesday, 13 April 2016
(6:00 - 8:05 pm)

Present: Cllr Eileen Keller (Chair), Cllr Peter Chand (Deputy Chair), Cllr Abdul Aziz, Cllr Edna Fergus, Cllr Adegbuyega Oluwole and Cllr Hardial Singh Rai

Apologies: Cllr Sanchia Alasia

52. Declaration of Members' Interests

Councillors Keller and Chand both declared a non-pecuniary interest in item 9 of the agenda (Update on Pilot Projects to Build Resilience) as they were both members of the Citizen's Advice Bureau Board.

53. Minutes - To confirm as correct the minutes of the meeting held on 10 February 2016

The minutes of the meeting held on 10 February 2016 were confirmed as correct.

54. Update from Children's Services

Members noted an update report from Children’s Services outlining how the Service intended to implement a recommendation to make every contact count and introduce a scheme to encourage and possibly incentivise parents to arrange an eye test for their child prior to starting school, which arose from the Health and Adult Services Select Committee’s (HASSC) scrutiny review on local eye care services last year.

55. Update from Public Health

The HASSC noted a report setting out the Council’s plans to undertake a public health campaign to raise local residents’ awareness of the importance of having regular eye tests, whilst also delivering other important eye care messages, in response to a recommendation made by the HASSC's scrutiny review on local eye care services.

56. Urgent and Emergency Care Services

Carla Morgan, Project Manager, and Melissa Hoskins, Communications and Engagement Manager for the Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups (BHRCCGs), presented a report which provided the background to an initiative to transform urgent and emergency care (UEC) services across the three boroughs. This was being lead by a “BHR Systems Resilience Group”, a partnership of NHS and local authority representatives. In 2015 the NHS invited individual organisations and partnerships to apply to become ‘vanguards’ for the new care models programme, one of the first steps towards delivering the NHS Five Year Forward View and supporting improvement and integration of services. In late July 2015, the BHR Systems Resilience Group was announced as one of eight vanguards in the third wave of the funding programme.
Members noted that the way UEC services were currently delivered was complicated and the aim of this transformation work would be to fundamentally shift the way these services were provided, remove the barriers between health and social care and between organisations, and create a simplified, streamlined urgent care system, using the latest technology to personalise services.

Ms Hoskins summarised the wide ranging engagement activity undertaken by the BHRCCGs to ensure that patients and carers would be at the heart of the changes to service delivery, including an urgent care conference, research into local people’s understanding of services, a telephone survey of 3000 people across BHR, plans to collate the views of high users, input from the local Healthwatch organisations in designing and carrying out survey questionnaires, and engagement work with local GPs.

Members asked whether plans to personalise UEC services included the possibility of communicating with and providing information to people via their smart mobile phones or electronic tablets, and whether patients would be able to view their own medical records whilst having confidence that their confidentiality would be respected. The BHRCCG representatives stated that currently, research was being undertaken on what technological systems could be used to deliver better UEC services to local people; no one model had been agreed upon. They added that patient confidentiality would remain a fundamental principle in the design of new services, as required by law, and that the engagement so far with local people indicated that there was strong support for the use of new technologies to deliver future services.

In response to a question, Ms Morgan stated that the local vanguard was awarded £1.3 million in the last financial year to support the transformation work and that a business case for funding for the programme in 2016/17 was submitted to NHS England on 8 February 2016. BHRCCGs were bidding for a share of a £12 million funding allocation that all eight UEC vanguards had bid for. An announcement was expected from NHS England soon to confirm the allocation that BHR would receive, and the HASSC would be kept updated on this.

The Committee thanked Ms Morgan and Ms Hoskins for their update.

57. Barking, Havering and Redbridge University Trust’s Improvement Plan Update

Barking, Havering and Redbridge University Trust’s (BHRUT) Chief Operating Officer, Sarah Tedford, delivered a presentation to the HASSC on progress against the Trust’s Improvement Plan since a re-inspection by the Care Quality Commission (CQC) in March 2015 of its services, which covered the following points:

- Delivering our potential: a quick recap
- Progress against our ‘must do’ actions
- Executive sponsors – ‘must do’ actions
- Recent key highlights
- National early warning scoring (news)
- Dementia screening
• Improvement walks
• How are we doing?
• Progress against our 24 ‘should do’ actions.

Councillor Rai asked whether the Trust had started using text messaging to remind people of their appointments. He stated that he was recently sent a text reminder for an upcoming appointment from the Royal London Hospital which included the amount it would cost the NHS if he failed to turn up and felt that this would work as an incentive to many people to ring in if they could no longer make their appointment. Ms Tedford stated that a text messaging service was not provided consistently across all BHRUT services, costs for “no show” appointments were not cited in text messages currently, and that the Trust had currently put this service out to tender so that a consistent and effective text messaging service could be provided in future.

Members asked whether the Trust had a view on whether it would be out of “special measures” by the end of its next CQC inspection. Ms Tedford stated that the Trust was continuously working to remove its special measures status and it hoped that after the next inspection, it would be out of special measures. She added that the Trust regularly met with representatives of the CQC and NHS England and sent them updates on various aspects of its progress regularly.

In response to a question Ms Tedford stated the improvement walks taking place at the Trust’s hospitals involved senior members of staff of the executive team, including herself, the Chief Nurse and the Chief Executive. She emphasised, in response to comments, that all staff were on board with the improvement plan, and played an active role in shaping the Trust’s way forward.

In response to comments, Ms Tedford stated that resolving estates and environmental issues such as dealing with clutter and general presentation was a part of the improvements being made to ensure that the Trust’s premises appeared welcoming and tidy.

Ms Modhvadia, representing Barking and Dagenham Healthwatch, asked whether an update could be provided on the investigation by NHS Improvement (previously Monitor) into the BHRCCGs’ decision to select BHRUT as the provider of elective care services at the North East London Treatment Centre. Ms Tedford stated that there was no outcome to report as of yet and provided assurance that other providers were being utilised to deliver elective care services pending the outcome of the investigation. Sharon Morrow, the Chief Operating Officer for Barking and Dagenham CCG (BDGCC), stated that the BHRCCGs had undertaken much work to assist NHS Improvement with its investigation and that she expected the findings of the investigation to be available in a few weeks’ time.

58. Update from Barking and Dagenham Clinical Commissioning Group

Richard Clements, Programme Lead for Service Transformation for the BDCCG, presented a report providing an update on the BDCCG’s progress in implementing three recommendations which arose from the HASSC’s scrutiny review on local eye care services.

Members noted that in response to one of the recommendations, the BDCCG had sought to offer optometrists direct referral to its community eye care service. Through the natural expiration of the current contract, the BDCCG had joined with the Redbridge CCG to re-procure community ophthalmology - direct referral was included in the service specification which stated that optometrists were to directly refer for a range of eye conditions. Members further noted that the procurement process was concluded in March 2016, but it had not resulted in the CCGs’
awarding a contract. The possible reasons would be investigated and would inform the commissioning plan for ophthalmology.

Mr Clements stated, with regards to the recommendation that the BDCCG commission an Eye Care Liaison Officer, that this service was currently provided through some secondary care providers commissioned by the BDCCG and used by Barking and Dagenham patients. The BDCCG was planning a review of major pathways using the RightCare approach (an approach to address unwarranted variation in local healthcare). The planning for pathway reviews was currently underway and it was expected that ophthalmology commissioning would be reviewed in 2016/17.

Mr Clements stated that the HASSC also recommended that the BDCCG make cost-effective improvements to local low vision services. The BDCCG currently commissioned a low vision service, which supported the delivery of low vision assessments for the borough’s residents who experienced sight problems even after having had an eye test and worn the right contact lenses or glasses. The service operated out of both King George and Queen’s hospitals. The opportunity to review and potentially extend this service could be included as part of the BDCCG’s pathway review of ophthalmology.

An update on the re-procurement of community ophthalmology and the pathway review of ophthalmology, particularly in relation to the recommendations of the Local Eye Care Services Scrutiny Review, was requested by the HASSC for a future meeting.

59. Update on Pilot Projects to Build Resilience

The Health and Social Care Integration Manager (HSCIM) presented a report which provided an update on two pilot projects which had arisen as a result of the cessation of the Local Emergency Support Service. The pilots were designed to run from November 2015 to May 2016, and were as follows:

- The Debt Counselling and Mentoring Service, which would provide 50 residents with debt management support and 25 people (who were 18 - 35 years old, non-priority homeless with additional needs) with intensive debt management support, counselling and mentoring, and,
- A Fuel Poverty Service, which would impact around 700 homes in the Ibscott Close neighbourhood, which had a high prevalence of fuel poverty.

Members noted the challenges in identifying the metrics for the cohorts for the Debt Management and Mentoring Scheme. The number of people identified for the intensive ‘18 – 35, non-priority homeless’ cohort was stated within the service specification as being 25. In the period between November 2015 and February 2016 there had been a significant amount of work to gather 25 people who fit the criteria. Initial triage work carried out had been positive but 12 of the 25 had expressed a wish to be moved to the less intensive Debt Management Service project. Early indications did not anticipate this movement across the cohorts and there was now a need to replace those who were initially identified for the 18 -35 year old intensive Mentoring Scheme. The provider was now approaching the requisite numbers to commence the programme for both cohorts within the project. 18 people had now been triaged for the intensive Mentoring Scheme and similar triaging work had been undertaken for the 50 people to take part in the Debt
Counselling part of the Scheme. The changes within the cohort had created slippage on the timeline for the project, and the pilot was now scheduled to be completed by the end of August.

In response to questions from members, the HSCIM stated that these pilot projects would not be re-commissioned after their conclusion; however, the findings from their evaluation would be incorporated into future services to help build resilience in the community.

Councillor Chand asked whether the pilots could help more people than the initially identified cohorts per project. The Project Manager stated that it was not envisaged that a person would stay on a pilot programme for its entire six month duration and therefore, as people came off the programme, more people could be taken on, although at this stage it would not possible to say exactly how many.

Members asked how the learning from the pilot projects would be incorporated into mainstream services and whether, for example, it would include staff training. The HSCIM stated that the Council had commissioned external bodies to undertake the pilots, as described in the report, and so the learning from the projects would not be relayed directly via training of Council staff. However, the pilot projects would be evaluated at the conclusion of six months and the principles around prevention and building resilience would feed into future approaches to service design, as part of the Council’s transformation programme, Ambition 2020.

The HSCIM confirmed, in response to further questions, that the pilot projects were only funded to provide services for six months, at the end of which the services offered by them would cease.

60. Proposed Relocation of Sexual Health Clinics

The Council’s Director of Public Health (DPH) and Gary Bradshaw, Service Manager, Sexual Health, BHRUT, presented a report detailing proposals to relocate two sexual health clinics to Barking Hospital in Upney Lane from 1 June 2016, as a result of considerable financial pressures presented by reductions to the Public Health Grant, which meant that the Council needed to find more efficient ways of delivering local sexual health services. The two clinics which were subject to the proposals were in Oxlow Lane in Dagenham and Vicarage Field in Barking.

Members noted that a new contract for integrated sexual health services in Barking and Dagenham was awarded to BHRUT in October 2015. Under the new agreement BHRUT was to achieve efficiencies of five per cent of the initial contract value (£79,500) in each year of the three year contract. The costs to BHRUT of maintaining services at several sites were significant. The Trust had concluded that the service was making a considerable and unsustainable loss and had itself proposed consolidating the two clinics into one site at Barking Community Hospital in order to bring its costs in line with its income.

The DPH and Mr Bradshaw explained that the consolidated service at Barking Hospital would provide access to a wider range of sexual health services under one roof. The report described what would be a ‘one stop shop’ sexual health service at Barking Hospital, with more frequent and longer opening times for appointments and walk-in sessions. Service users would also benefit from better transport links, as the Hospital was located right next to car parking facilities, and
was less than five minutes’ walk from Upney train station. Several bus routes also passed through the Hospital, enabling easier access to the services from all wards in the borough. The relocation of sexual health services to Barking Hospital would also present the opportunity to improve access to evening and weekend services not currently available at Oxlow Lane and Vicarage Field health centres. The consolidated service would be available for a minimum of 40 hours per week, offer a dedicated young person’s clinic and have clinics on at least three evenings per week and potentially, Saturday mornings.

The DPH stated that he hoped to receive advice from the Council’s legal services shortly as to whether the proposals would amount to a “substantial reconfiguration” which would necessitate the Council carrying out a formal public consultation on the proposals before a decision was made. Mr Bradshaw stated that whatever this advice may be, it would be extremely important to inform the local community of the changes proposed and ensure that any feedback was considered seriously.

In response to questions, the DPH stated that there would a Communications Strategy that would specify how local people would be engaged in regards to the proposals and that he was happy to share it with the Committee, once it was drafted.

Members asked whether the sexual health clinics in Havering were prepared to absorb people from Dagenham, who may prefer to attend a clinic there, rather than go to Barking Hospital, if the proposals were implemented. The DPH and Mr Bradshaw stated that as these proposals had been drafted jointly between the Council and BHRUT, who provided sexual health services across both boroughs, thought had been given to the impacts of these proposals on clinics in Havering.

Members asked whether Barking and Dagenham’s teenage pregnancy rate had declined. The DPH stated that there had been the most significant fall in the borough’s teenage conception rate recently; however, it was still above the national average. He believed the reasons for the recent decrease locally was work taking place within schools and the changing attitudes of young people towards their aspirations. However, he cautioned that the rate of repeat abortions was an issue for the borough and emphasised that targeted work was yet to take place on understanding the reasons for this.

Ms Modhvadia stressed the need to engage particularly with young people around the proposals within the report and asked to see the communications strategy for the proposals, once drafted.

The HASSC indicated overall support for the proposals and noted that the Health and Wellbeing Board would be asked to make a decision on the proposals later in the year.

61. Barking and Dagenham Healthwatch’s Latest Reports

Ms Modhvadia delivered a presentation which summarised two of Healthwatch’s ‘enter and visit’ reports and two projects it had carried out between September 2015 and January 2016, as listed below:

- Enter and visit to five Elms General Practice;
- Enter and visit to Mental Health Assessment and Support Facility,
With regards to the ‘enter view and visit’ to Morris Ward in Sunflower Court, members noted that people from the borough were staying longer in the Ward than people from other boroughs. They noted that the service provider had stated that appropriate accommodation was readily available within the borough but that an embargo by the Council was delaying discharge for a number of patients. The Council’s Divisional Director, Adult Social Care (DDASC), clarified that the embargo was not on housing; there was a ‘3 out, 2 in’ restriction on placing people requiring a period of residential care following a stay in hospital. This ‘embargo’ was lifted on 31 March 2016 and work was underway to sequence placements appropriately. Work was also underway with Housing to identify suitable accommodation for people moving on from residential placements. This would unblock things further downstream and improve patient flow in due course.

Councillor Rai asked how Healthwatch went about deciding which services they should undertake enter and view visits upon. Ms Modhvadia stated that Healthwatch’s visits and projects were based upon evidence it received from the local community; it kept a database of feedback received on health services and once it saw trends giving rise to concern, it would investigate. Any member of the community, including professionals, councillors and members of the public, could send evidence and feedback to Healthwatch and this could be done anonymously.

Members asked how Healthwatch advertised itself locally. Ms Modhvadia stated that it put out advertisements in the local press and put up posters in public spaces, for example. She was not sure whether Healthwatch advertised itself in local GP surgeries but would look into this.

In response to questions, Ms Modhvadia stated that Healthwatch did not have powers to sanction service providers if their responses to its investigations were inadequate; however, it could escalate the matter to the CQC, raise issues with this Committee or the BDCCG, who may well intervene if they were the commissioner for the service.

She stated, with regards to Five Elms GP, that Healthwatch was not entirely satisfied with the Practice’s response to its findings and therefore, it would be carrying out another visit soon.

Ms Morrow stated that the BDCCG would be happy to discuss some of Healthwatch’s findings outside of this meeting with a view to resolving areas giving rise to concerns.

The Committee thanked Ms Modhvadia for her update.

62. Care Quality Commission’s Inspections of Local Providers

The HSCIM presented a report providing information on the outcomes of CQC inspections of a number of adult social care providers in the borough, which were carried out in quarters two and three of 2015.

Members noted that the following providers had received a judgement of “requires
improvement” after their inspection:

- Lynwood (Dharshivi Ltd);
- Alexander Court (Orchard Care Homes);
- Harp House (Triangle Community Services); and
- Chosen Services (Chosen Services UK).

The HSCIM stated that clients of adult social care services were encouraged by the local authority to opt for providers who were on the home care provider framework’s list; however, people could choose providers who were not on the list if they wished. The provider, Chosen Services, was not on the list.

Members asked whether the CQC took into consideration, as part of its inspection of Lynwood care home, the fire (resulting from suspected arson), which took place there in late 2015, and whether, for example, the CQC had given the care home extra time to implement the recommendations for improvement. The DDASC stated that the local authority was supporting the provider, which was making very good progress, and therefore, did not necessarily need extra time.

In response to a question, the DDASC stated that the CQC would look at a wide range of evidence as part of its inspection of a provider. The Local Authority worked closely with providers in support, for example, the CQC may wish to look at the providers’ support plans for clients and the local authority would check to see whether these were personalised.
## Title: Referral to Treatment in Barking and Dagenham, Havering and Redbridge

### Report of the Director of Law and Governance

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| **Report Author:** Masuma Ahmed, Democratic Services, Scrutiny, Law & Governance | **Contact Details:** Tel: 020 8227 2756  
E-mail: masuma.ahmed@lbbd.gov.uk |

**Accountable Divisional Director:** Fiona Taylor, Director of Law & Governance  

**Accountable Director:** Chris Naylor, Chief Executive

### Summary:

On 26 April 2016 the Health and Wellbeing Board (HWB) received a report from the Joint Referral to Treatment Lead for the Barking and Dagenham, Havering and Redbridge Clinical Commissioning Groups (BHR CCGS) and the Barking and Dagenham, Havering and Redbridge University Trust (BHRUT) regarding the Trust's performance on waiting times for planned surgery and outpatient treatment for patients across the three boroughs. This is referred to as “referral to treatment” (RTT). The HWB expressed grave concerns at the scale of the issue, having noted that BHRUT revealed in its March 2016 Board papers that it had a large number of patients waiting more than 52 weeks on the elective RTT pathway. The Chair of the HWB, Councillor Maureen Worby, suggested that the Chair of Health and Adult Services Select Committee (HASSC) consider the issue of the RTT as part of its Work Programme for further investigation as a matter of priority.

- At Appendix 1 members will find the Trust’s March 2016 Issue Brief which provides summaries of the performance issues around RTT and the Trust’s plans to address them.
- At Appendix 2, the full report on RTT to the HWB on 26 April 2016 is provided.
- Provided at Appendix 3 are the minutes of the HWB’s discussions around the RTT report it received.
- At Appendix 4 is the presentation that will be delivered by the Trust to the HASSC on 9 June 2016.

Members are asked to also note that NHS Improvement started an investigation in July 2015 into the awarding of a contract to BHRUT to operate the North East London NHS Treatment Centre by the BHR and Waltham Forest CCGs. The Centre provides a range of health services, such as general surgery, orthopaedics and ophthalmology. The Council was notified on 26 May 2016 that the CCGs had given undertakings to NHS Improvement as part of the conclusion of the investigation to abandon the procurement and extend the contract to operate the Centre with the current provider, Care UK.

- At Appendix 5 members will find a briefing by NHS Improvement explaining its decision to accept the CCGs’ undertakings.
Recommendation(s)

The HASSC is recommended to:

(i) Receive the presentation from BHRUT which provides an update on the Trust’s RTT performance and its plans to address waiting times, and

(ii) Ask questions of Matthew Hopkins, the Trust’s Chief Executive, to help determine issues such as the extent to which Barking and Dagenham residents are affected, how this will be resolved, how the problems and plans to address them are being communicated to those affected, the predicted time-scale required to resolve the issues and, what is being put in place to ensure future performance of RTT, and monitoring of it, is robust.

Reason(s)

This report relates to the Council’s priority to enabling social responsibility and under it, the objectives to “protect the most vulnerable, keeping adults and children healthy and safe” and to “ensure everyone can access good quality healthcare when they need it”.

Financial Implications and Legal Implications

There are no financial or legal implications arising directly from this report.

Background Papers Used in the Preparation of the Report:

None.

List of appendices:

Appendix 1  BHRUT’s March 2016 Issue Brief on RTT
Appendix 2  RTT report to HWB report on 26 April 2016
Appendix 3  26 April 2016 Draft HWB minutes of discussions around RTT report
Appendix 4  BHRUT’s presentation on RTT for HASSC on 9 June 2016
Appendix 5  NHS Improvement’s briefing on decision to accept undertakings from CCGs
ACCESSIBLE CARE FOR OUR PATIENTS

Our patients have been waiting too long for planned surgery and outpatient treatment. A major project has taken place to ensure we have a clear picture of the issues, and a plan in place to ensure all of our patients receive high-quality, accessible care.

Background

We announced back in early 2014 that we had introduced a new reporting system which had identified several operational issues with our Referral to Treatment (RTT) reporting, dating back several years.

RTT is a national guidance which states that patients should receive hospital treatment within 18 weeks of having been referred by their GP.

Once the issues with our systems came to light, we carried out a thorough exercise, checking the data to make sure we were confident with our figures. This is called validation. We suspended reporting of our RTT performance while that took place.

What’s the problem?

The validation work showed that thousands of people had been waiting too long to be seen.

A long-standing mismatch of capacity and demand, coupled with the issues with reporting our performance, meant that a significant backlog had built up.

We shared this situation with our local partners and you, our stakeholders.

We have significantly reduced the number of patients who have been waiting, but still have a long way to go.
How will we fix it?

While the validation exercise was underway, we introduced thousands of extra clinics so that we could immediately begin to see and treat the people who had been waiting too long.

We initially focused on those waiting for surgery, and then moved on to those who had been referred for outpatient care.

This year we will have provided 520,000 outpatient appointments – 25,000 more than last year.

We have put in place a robust recovery and improvement plan, supported by the NHS Trust Development Authority and NHS England.

Assuming that we achieve the milestones set out in that plan, we will be compliant with the national Referral to Treatment standard by the end of 2016/17.

The key focus of our work is to treat those who have been waiting too long as quickly as possible, to assure ourselves that they have not come to any harm as a result of that wait, and to ensure that we put sustainable systems in place so this situation does not arise again.

We need to ensure that we have the capacity to meet the demand on our services.

That means providing additional appointments, carrying out more operations and employing more specialist staff.

We will also be carrying out more investigations – MRIs, CT scans, ultrasounds and endoscopies.

We will be using other measures so that our services run as smoothly as possible, and that includes reducing the number of people who don’t show up for their appointments.

Throughout this project we have been supported by our partners, and are working with our Clinical Commissioning Groups to look at how we could move care into more appropriate settings.

We are also considering how we manage GP referrals.

What happens next?

Our recovery and improvement plan - setting out the detail of the work taking place - will be shared at a public board meeting, and made available on our website.

As we now have far more confidence in the quality of our data, we aim to resume reporting of our performance as soon as possible.

We will keep you fully updated about the improvements we are making, and the reduction in our waiting lists.

Working with our patients

We are working closely with patient group Healthwatch Havering and Havering Council’s Overview and Scrutiny Committee.

Chairs Anne-Marie Dean and Cllr Nic Dodin said: “We want to ensure that patients receive the best possible care, so are carrying out a review of delays in treatment.

“The Trust is happy to work with us on this, and we welcome their openness and transparency.”

To find out more

- NHS Choices [www.nhs.uk](http://www.nhs.uk) has a [Guide to NHS waiting times](http://www.nhs.uk)

- NHS England has published [Consultant-led Referral to Treatment Waiting Times Rules and Guidance](http://www.nhs.uk)
Title: Referral To Treatment (RTT) issues in BHR

Report of Accountable Officer for BHR Clinical Commissioning Groups

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Sponsor: Conor Burke, Accountable Officer BHR Clinical Commissioning Groups

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

BHR CCGs and BHRUT were tasked to develop and deliver by NHS England (NHSE) and the NHS Trust Development Agency (NTDA), an RTT recovery plan and report regularly to NHSE/ NTDA to provide the necessary assurance.

Despite BHRUT data quality not being assured its March 2016 Board papers stated that it had 1,015 patients waiting more than 52 weeks on the elective RTT pathway. This led to considerable national publicity.

An independent auditor has now been brought in to verify the data and patient numbers. Details on the precise number of Barking and Dagenham (B&D patients waiting is to be confirmed by BHRUT shortly).

Since March the number of 52 week waiters in BHRUT has reduced to reportedly just under 800. NHSE (London), has written to the BHR CCG Chairs and Accountable Officer outlining their concerns.

BHRUT does not have sufficient spare capacity to address the current backlog or the levels of referrals currently being generated by GPs.
An RTT summit took place on Thursday 14 April with BHRUT Chief Executive, Medical Director, CCGs Accountable Officer, CCG Chairs and clinical directors from both organisations and agreed a system RTT recovery plan. These actions tackle the following areas:

- Trust capacity and delivery
- Theatre productivity
- Transfer of activity to the independent sector
- Referral management

**Recommendation(s)**

Members of the Health and Wellbeing Board are recommended to:

1. Note that the CCGs and BHRUT have developed and agreed a refreshed RTT recovery plan to more effectively tackle the issue of long patient waits and to offer necessary assurance to all stakeholders including patients and the public.

2. The recovery plan is currently being reviewed by NHS England and NHS Improvement (formerly NTDA).

**Reason(s):**

The timely treatment of patients referred to secondary care by their GPs is a right under the NHS constitution and a marker for a safe, high quality, local NHS.

### 1. **Background**

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

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

1.3 BHRUT, which runs King George and Queen’s Hospitals, suspended formal reporting of its Referral to Treatment (RTT) performance in February 2014. This was due to a lack of confidence in the ability of the Trust to reliably report both the numbers of patients waiting, and the length of wait for elective care and treatment. A number of other trusts across England have also suspended reporting due to data issues during this time.
1.4 The Trust identified issues with the accuracy of waiting times data since upgrading their Patient Administration System which led to a backlog of patients waiting longer than the 18 week referral to treatment time standard.

1.5 As a result, the BHR CCGs and the Trust were tasked, by NHSE and the NDTA, with developing a plan to deliver the constitutional target. In additional regular reporting to NHSE and the NDTA was put in place to provide the necessary assurance on progress. The CCGs have been working closely with the Trust since that time to support their recovery plan. Despite this, the RTT performance issue has remained a high level risk.

1.6 This information was shared with stakeholders in RTT briefings from the Trust, available on its website: http://www.bhrhospitals.nhs.uk/about-us/News/issue-briefs.htm

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

2. Scale of the issue

2.1 Despite BHRUT data quality not being assured, BHRUT revealed in its March 2016 Board papers that it had 1,015 patients waiting more than 52 weeks on the elective RTT pathway. The number of patients waiting over 18 weeks is circa 17,500. This is the largest number of patients in the NHS. In addition to the existing local concerns, the release of the data led to national publicity about the length of the waiting times for BHRUT patients and additional scrutiny on the local system.

2.2 The number of 52 week waiters has already reportedly come down to just over 800, but NHSE (London), has written to commissioners outlining its ongoing concerns.

2.3 An independent auditor has now been brought into BHRUT to verify the data and patient numbers. We are still waiting for confirmation of the number of B&D patients waiting for treatment having been referred by their GP.

3. Commissioner and Trust response to date

3.1 As a result, commissioners and the Trust have increased resources to address the issue and put a series of additional actions in place, forming project groups to deliver a number of urgent work streams and setting up a dedicated Project Management Office (PMO) to enable partners to effectively tackle this issue together.

3.2 Based on the current position, the cost of clearing the RTT backlog and the Trust returning to compliance with the Constitutional Standard is estimated at £9m-£14m
in 16/17. No additional funding has yet been made available to Commissioners who are asked to plan for this expenditure within existing allocations and business rules.

3.3 BHRUT does not have sufficient spare capacity to address the current backlog or the levels of referrals currently being generated by GPs so commissioners are urgently setting up a response that includes:

- Outsourcing/redirection waiting patients to alternative providers
- Demand management including use of alternative providers, (including additional community provider clinics)
- Improving patients pathways to reduce delays and duplication
- Trust looking to increase capacity by recruiting 17 additional staff
- Trust looking to increase activity through its operating theatres
- Weekly assurance meetings with NHSE as well as local RTT Programme Board
- A new PMO supporting data collection/sharing and monitoring for assurance
- A communications and engagement plan which includes patients, public and other stakeholders.

3.4 An example of an action that has been taken is that a Community Dermatology Service will be running in Barking and Dagenham from 25th April. Further details on the actions being taken and the governance/programme structure in place to oversee the plan is included in Appendix 1 (the most up to date position will be shared at the meeting)

3.5 A number of principles have been agreed regarding this work including:

- not suppressing clinical necessary referrals, for example consultants will still be able to referral patients to other consultants when this is a part of the patient pathway
- not increasing the workload on primary care, without agreement for example establishing additional shared care pathways.

4. RTT summit

4.1 An RTT ‘summit’ took place on Thursday 14 April with CCG and BHRUT clinicians, the BHRUT CE and Medical Director and CCG Accountable Officer to:

- Approve the revised plan and governance arrangements
- Agree that there be better engagement between primary and secondary care clinicians
- That each CCG take a lead for x3 specialities and alternative arrangements on behalf of all three CCGs
- Clear communications to all affected and key stakeholders.
5. **Support from the Health and Wellbeing Board**

5.1 Given the scale of the problem the members of the Health and Wellbeing Board can provide valuable support in the following ways:

- In communicating the message to members of the public
- Championing BHRUT as a good place to work, supporting staff recruitment
- Supporting members of the public to choose alternative providers.
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Minute 91:

Matthew Hopkins, Chief Executive, Barking, Havering and Redbridge University Hospitals NHS Trust, introduced the report and led the presentation, supported by Clare Burns, BHRUHT Programme Director for Demand Management. Matthew explained that the NHS Constitution gave patients the right to access services within 18 weeks following a GP Referral. It became apparent in 2014 that in BHRUT this was not being achieved and due to the lack of confidence in the reliability of the data BHRUT had suspended formal reporting of its Referral to Treatment (RTT) performance in February 2014.

The Patient Administration System (PAS) computer system had been updated in December 2013. There appeared to have been both a misunderstanding and mismanagement of the data within the Trust over a number of years, for which the Trust was now apologising.

NHS England had subsequently tasked BHRUT and Barking Havering and Redbridge CCGs to develop a recovery plan and to report regularly to the NHSE / TDA to provide the necessary assurance that changes were happening. Despite the data not being assured in March 2016, BHRUT Board Papers stated that it had 1,015 patients waiting more than 52 weeks on the elective RTT pathway, which had led to significant national publicity. Independent auditors had now been appointed to verify the data and patient numbers but the exact numbers were still being verified. The only positive resulting from this problem was that the data deficiencies had allowed an opportunity to investigate where there were gaps between patient demand and capacity of services.

Since March the number of people waiting 52 weeks had reduced to around 800. NHS London had also written to BHR CCGs outlining their concern.

Matthew explained that 95% of patients should have had their procedures / diagnoses within 18 weeks of GP referral. For an organisation the size of BHRUT it would be expected that there would be around 30,000 people on the process / waiting list at any one time. The Trust had 58,000 people on the waiting list. In the past year the Trust had delivered an additional 1,200 operations and 30,000 extra outpatient appointments but there was still a large number of people waiting over 18 weeks. Matthew added that the Junior Doctors strike action had resulted in 4,000 appointments being cancelled on 26 April alone.

The aim now was to achieve compliance with the NHS Constitution standards by March 2017. To achieve that BHRUT were now looking towards other providers across the region, however, some people have indicated that they would prefer to wait longer to stay local. BHRUT had a programme of improvement for the data accuracy and to deal with the backlog of patients waiting for appointments or treatment.

Clare Burns explained that work now needed to be undertaken to provide services locally to resolve demand at the hospitals. As patients do not seem to want to travel for treatment, this would include alternative routes to treatment, such as a community dermatologist service in LBBD. Clare added that LBBD referrals were often to orthopaedic and surgery when that was not always the answer and alternatives such as physiotherapy and living with the pain for a short while may be the answer. GPs should not stop referring patients, but should have other options in place, which may have more rapid results for patients.
Consultant auditors were checking for clinical harm, that correct governance and robust process were in place, demand and capacity issues and were also undertaking a modelling review.

The Chair said that she felt that it was not a credible statement to say that people would want to wait longer to be seen within the Trust than to travel to another provider and asked where the evidence was supporting this, for example how had people been approached and how many had been contacted, how long had they been told they might have to wait, had they been told they could go elsewhere? Matthew agreed to provide the evidence to the Board in due course.

The Board asked Matthew what was going to happen to reduce the number of people still waiting. Matthew advised that extra work had already been undertaken which had resulted in the delivery of 1,200 extra operations and they had also provided funding to resolve the computer / data issues.

The Board was concerned that the Trust had suspended reporting but had not advised the Board of the difficulties for 18 months. The Board felt that selected reporting of poor performance was unacceptable. Matthew responded that as an organisation it was felt that it was wrong to continue reporting faulty and erroneous data and that before they started reporting again the data must be correct, robust and credible. The Department of Health had provided a support team in September 2015 to review the BHRUT data and consultants, Ernst and Young, had now been engaged to undertake a full review and checks.

The Board was disbelieving of the claim that there had been no clinical harm to the individuals that had been waiting up to 52 weeks or more for treatment and that there could also be psychological harm caused by the stress of waiting and the delay in treatments. Matthew advised that a clinical harm review had been undertaken and there were only two patients with moderate to severe clinical harm from the wait. Clare Burns advised that one of those was a patient with increased problems with a shoulder.

The Chair commented that this situation had not been considered or reported to the Council’s health scrutiny committee, known as the Health and Adult Services Select Committee (HASSC), and suggested to Councillor Keller, Chair of HASSC, that the issue of the Referral to Treatment was added to its Scrutiny Work Programme for further investigation as a matter of priority.

Councillor Butt, LBBD Cabinet Member for Crime and Enforcement, was concerned that both the document and presentation referred to ‘waiters’ and asked that BHRUT not use the term ‘waiters’ in their future reports and suggested that ‘patients’ or ‘people’ was more appropriate.

Councillor Turner, LBBD Cabinet Member for Children’s Social Care, reminded the Board of the legal duty of candour and asked Matthew to whom they had reported the suspension of reporting data. Matthew advised that the Department of Health had been advised as soon as it became apparent that there was a significant issue.

Cllr Turner asked if anybody within BHRUT had been held accountable for the failures. Matthew responded that there had been a systemic lack of capacity in dealing with the
problem over many years, as well as incompetency, rather than a wilful misreporting of
data. As a result appropriate disciplinary action had been taken but he was not prepared to
share what that was with the Board as it was personal information.

Councillor Turner asked who would be the named individual responsible for ensuring the
data issues were sorted and the time people were waiting was resolved. Matthew
explained that BHRUT and BHR CCG had developed a refreshed Referral to Treatment
recovery plan to more effectively tackle the issue of long patient waits and provide the
necessary assurance to all stakeholders. The refreshed recovery plan was being reviewed
by NHS England and NHS Improvement (formerly TDA) and consultants were also
verifying the data. However, as Chief Executive and Accountable Officer he accepted that
he was responsible for ensuring the data issue was resolved and patients waiting times
were reduced.

Conor Burke, Accountable Officer, Barking and Dagenham CCG, advised that he had just
received details on the patients waiting and this would be shared with GPs so that they
could look at the individual cases and make the appropriate contact.

The Board:

(i) Noted that the Barking, Havering and Redbridge Clinical Commissioning Groups and
Barking, Havering and Redbridge University Hospitals NHS Trust had developed a
refreshed Referral to Treatment recovery plan to more effectively tackle the issue of long
patient waits that sought to offer necessary assurance to all stakeholders, including
patients and the public;

(ii) Noted the recovery plan was being reviewed by NHS England and NHS Improvement
(formerly NTDA) and external consultants had been engaged by BHRUT to independently
verify the data accuracy and assist BHRUT in the resolution of the problem;

(iii) The Board also wished to place on record its serious concern in regard to:

(a) The decision of BHRUT to 'not report' nor advise the Board of the problem over
the last 18 months;
(b) The apparent lack of urgency at BHRUT in regard to resolving the problem at
an earlier point in time;
(c) The significant number of patients who were waiting more than the 18 weeks
referral to treatment target, set out in the NHS Constitution, with some patients
still waiting for over 52 weeks;
(d) The potential deterioration in patients’ conditions and the physiological and
social harm that may be caused to patients by the delays;

(iv) Requested that the Board be provided with regular performance updates on this issue,
including:

· Details of the action being taken by BHRUT to reduce patient wait times;
· The performance achieved in the previous quarter;
· The projected trajectory rates to achieving the 18 week referral to treatment target
across all specialities;
The numbers of patients in each specialist area and how many of those patients were Barking and Dagenham residents;

Evidence to substantiate the anecdotal claim by BHRUT that patients were prepared to wait longer to be seen within BHRUT rather than being treated by other providers;

(v) Requested that BHRUT do not use the term ‘waiters’ in their future reports and suggested that ‘patients’ or ‘people’ was more appropriate; and

(vi) Recommended that the LBBD Health and Adult Services Select Committee include the issue of the Referral to Treatment in its Scrutiny Work Programme for further investigation as a matter of priority.
APPENDIX 4

18 week Referral To Treatment

Sarah Tedford
Chief Operating Officer
Executive summary

• Since the RTT issue was identified, good progress has been made to reduce the admitted backlog and we have completed a major validation of the non-admitted waiting list.

• There is a very significant challenge to return to meeting the RTT standards in a sustainable manner that will involve undertaking around 5k operations and 93k outpatient appointments over an 18 month period.

• Even with material demand management, outsourcing and additional recruitment, the size of the programme means this work will take until March 2017 to clear (based upon aggressive assumptions).
Our approach

1. Frame – strategic context
2. Diagnosis – key issues
3. Forecast – position to be achieved
4. Options review
5. Prioritisation – chosen approach
6. Delivery – leadership, resource, risk management
7. Governance – management and assurance
8. RTT Update
Frame – strategic context

• NHS Constitution
  – Patients legal right to start non-emergency NHS consultant-led treatment within a maximum of 18 weeks from referral

• CQC Quality Report 2 July 2015
  – Improve the service planning and capacity of outpatients by continuing to reduce the 18 week non-admitted backlog of patients as well as ensure no patients waiting for an appointment are coming to harm whilst they are delayed, reduce the did not attend, hospital cancellation and hospital changes rates and improve the 31 day cancer wait target.
Diagnosis – key issues

- Poor governance and oversight of RTT
- Insufficient physical capacity to deliver volume of activity
- Ineffective systems and processes
- Poor data quality and information systems
- Ongoing structural misalignment between demand and capacity
- Limited operational capability of waiting list management
- Insufficient and inexperienced operational managers
- Disempowerment of clinical body
We are proposing to deliver a sustainable performance against the RTT standard by:

- Clearing the current backlogs of admitted and non-admitted patients to sustainable levels;
- Reducing outpatient waiting times to sustainable levels, and;
- Putting in place capacity to address the structural gaps in demand and capacity to ensure the backlog does not arise again.

This section covers the additional activity that is required to achieve this and how we expect to deliver it.

The capacity to be created through additional substantive staff, temporary appointments, productivity, outsourcing and material demand management and transfer of follow up activity out of secondary care

40% of the admitted activity is expected to be outsourced. 54% of the non-admitted activity will need to come from demand management, diversion to the independent sector and modernisation of pathways to reduce follow up in secondary care

The increase in activity is very significant and although the programme will start ed in late Q3 of 15/16 it will not be completed until the end of March 2017, and this relies on all the assumptions regarding capacity being realised.

There will be imperfections in the analysis as a consequence of an only recently validated PTL, which remains significantly in excess of the expected size for a Trust size of BHRUT but it is unlikely to effect the overall magnitude of the scale of required recovery.
Summary of the additional activity required to deliver sustainable RTT performance, with the non-recurrent element taking place over 18 months.

- Backlog: 8,980
- Structural gap: 19,721
- Reduce to 6w: 7,923
- Follow up: 56,401
- Total (nonadmit): 93,025

- Backlog reduction: 762
- Structural gap: 794
- Conversion from OP Wait: 3,190
- Total: 4,746

Non admitted
Admitted
Demand
• The mix of capacity to deliver sustainable RTT performance is different for admitted and non-admitted

• For non-admitted there is a significant requirement for demand management, transferring follow up activity out of secondary care, and directing new referrals into alternative settings.
There will be a material requirement for additional diagnostic capacity resulting from the additional non-admitted activity.

<table>
<thead>
<tr>
<th>Modality</th>
<th>Current Demand per 1,000 attends</th>
<th>Likely Additional Demand</th>
</tr>
</thead>
<tbody>
<tr>
<td>CT</td>
<td>29/1,000 attends</td>
<td>2,698</td>
</tr>
<tr>
<td>MRI</td>
<td>30/1,000 attends</td>
<td>2,804</td>
</tr>
<tr>
<td>US</td>
<td>74/1,000 attends</td>
<td>6,908</td>
</tr>
<tr>
<td>Endo</td>
<td>18/1,000 attends</td>
<td>1,608</td>
</tr>
</tbody>
</table>
Demand and Capacity bridge for 2 example specialities

Ortho Admitted

ENT Admitted

Ortho Non admitted

ENT Non admitted
The additional activity requires a very large scaling up in capacity.
Prioritisation – chosen approach

Top 5 actions

1. Appoint to new posts and undertake additional activity
2. Productivity – Increase theatre and clinic utilisation; reduce DNA rate, N:FU ratios; virtual clinics
3. Outsourcing
4. Demand Management
5. ISTC
To address the challenges in the demand and capacity plan, the CCGs and Trust have:

- Established a joint Clinical Reference Group that have reviewed the capacity gap and devised a joint plan building on the existing demand management plans and look to accelerate current initiatives including:
  - Dermatology – remove 100% of non-cancer activity
  - Musculoskeletal – remove 20% of activity
  - Gastroenterology - remove 50% of activity
  - Rheumatology – remove 100% of activity
  - Cardiology – remove 10% of activity

- Plans to focus on alternative provision and referral and pathway education

Plan subject to review through RTT NHSE and NHSI assurance meetings and as part of Commissioning Intentions for 16/17
Delivery – leadership and resource

Leadership
- Chief Operating Officer executive lead
- Deputy COO – Elective Care

Resource
- External subject matter expertise
- Increase in clinical consultant body
- Enhanced operational management
• Patient choice
  - MITIGATION – agree formal process
• Capacity – people
  - MITIGATION – recruitment
• Capacity – physical resource
  - MITIGATION – Productivity, ISTC and review of pathways
  - Diagnostic support
    - MITIGATION – recruitment
• Capability
  - MITIGATION – External expertise, enhanced operational management
• Internal systems and processes
  - MITIGATION – Training programme, admin and clerical review, SOPs
• Lack of demand management
  - MITIGATION – CCGs to establish demand management centre
• Affordability
  - MITIGATION – Jointly agree funding and timescales for resolution
Governance – management and assurance

**Management**
- Weekly programme board - reporting to Trust Executive Committee
- Access board – reporting to programme board - chaired by Chief Operating Officer

**Assurance**
- Fortnightly RTT Programme Board
- Monthly review by Trust Board
- Weekly NHSE/NHSI Assurance Group – chaired by NHSE
- Monthly mtg NHSI- chaired by NHSI
- System Resilience Group – multi-stakeholder membership – chaired by CCG
**52 Week Trajectory:** The Trust has developed a trajectory for clearing the current backlog of patients >52 and all prospective 52 week waiters up to 30/09/16. The RTT Recovery Programme is well ahead of the planned trajectory

- The backlog has demonstrated a 26.03% reduction since 03/04/16. Work continues to focus on expediting treatment for this patient cohort

**Clinical Harm Review:** A key element of the RTT Recovery Plan is the Clinical Harm Programme. The programme is designed to ensure risk to patients waiting longer than NHS Constitutional standards for their treatment are appropriately and efficiently managed.

  - Phase 1 focused on patients on the Admitted pathway. A clinical review process was initiated where the Trust assessed >900 patients. No moderate or severe harm was identified.
  
  - Phase 2 of the clinical harm review process focuses on patients on the Non Admitted pathway >52 and will review >800 patients
• **Recruitment:** The Trust have a recruitment plan in place to support the increase in overall capacity in the system to support the reduction long waits
  – 19 consultant posts have been approved and are in the process of recruitment with phased start dates from April 16
  – 5 additional leadership roles have been appointed, to support the management of the RTT Recovery Programme and drive the internal changes that will support the reduction in waiting times
  – 16 additional administrative staff have been sourced to support patient pathway management

• **Productivity:** The Trust have initiated a Theatre Productivity Programme to increase the number of operations for patients on the Admitted pathway.
• **Outsourcing**: The Trust has developed relationships with independent providers who can assist in referral to treatment for suitable cohorts of patients on the Admitted and Non Admitted pathway
  
  • The focus will be on >52 weeks, >18 weeks patients (and any other clinically suitable patients)
  
  • **Validation**: Validation of the Non Admitted PTL has seen the waiting list reduce from 112,414 to approximately 58,000. Work continues on the validation of Non Admitted pathways.
  
  • **Communication**: A system wide communications strategy has been developed which sets out a joint communication and engagement approach between commissioners and service providers in relation to improving waiting times for elective care in Barking, Havering and Redbridge for local people.
Investigation into the commissioning of elective services from the North East London Treatment Centre: decision to accept undertakings

We have decided to accept undertakings under Regulation 16 of the Procurement, Patient Choice and Competition Regulations¹ instead of continuing our investigation into the commissioning of elective care services from the North East London Treatment Centre (the treatment centre). These undertakings prevent, remedy or mitigate any failures to comply with the Procurement, Patient Choice and Competition Regulations that we might have identified as a result of our investigation.

The undertakings have been offered by the commissioners in this case: NHS Barking and Dagenham Clinical Commissioning Group, NHS Havering Clinical Commissioning Group, NHS Redbridge Clinical Commissioning Group and NHS Waltham Forest Clinical Commissioning Group (collectively, the local CCGs). The main elements of the undertakings offered by the local CCGs are as follows:

- they will rescind their decision to award a contract to provide elective care services from the treatment centre to Barking, Havering and Redbridge University Hospitals NHS Trust (Barking, Havering and Redbridge Trust) and will abandon the procurement exercise we were investigating; and

- they will extend their existing contract with Care UK Clinical Services Limited (Care UK) to provide elective care services from the treatment centre until 30 June 2017 to ensure the on-going provision of those services. They will also take steps to ensure that Care UK’s lease of the treatment centre premises is extended for a period consistent with the contract extension.

The CCGs told us that since the commencement of our investigation they have arrived at a better understanding of the challenges that Barking, Havering and Redbridge Trust faces which raises issues about whether it would be appropriate to make the contract award to Barking, Havering and Redbridge Trust. This, together with our investigation, has prompted the CCGs to change their procurement plans.

We opened our investigation in July 2015 following a complaint to us by Care UK about the local CCGs’ procurement exercise to select a provider of elective care services from the treatment centre and their decision to select Barking, Havering and

¹ National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013; these Regulations confer a power on Monitor to accept an undertaking from clinical commissioning groups to take specified action in connection with arrangements for the provision of health care services.
Redbridge Trust. Care UK’s complaint raised a number of issues related to the local CCGs’ compliance with the Procurement, Patient Choice and Competition Regulations and the National Tariff rules in relation to local variations.²

We were investigating a number of issues. A key question was whether selecting Barking, Havering and Redbridge Trust to operate the treatment centre was consistent with the local CCGs’ obligations to act in the interests of patients in line with Regulations 2 and 3(3) of the Procurement, Patient Choice and Competition Regulations.³

The local CCGs have decided to rescind their decision to award the contract to provide elective care services from the treatment centre to Barking, Havering and Redbridge Trust and will abandon the procurement exercise we were investigating. The local CCGs have offered undertakings to this effect. They will also extend their existing arrangements with Care UK, which Care UK has agreed to and which ensures the on-going provision of services from the treatment centre by a provider with a track record of providing those services. The local CCGs have told us that this extension will give them time to re-procure the provision of elective care services from the treatment centre on a longer term basis. For these reasons, it is our view that accepting the offered undertakings achieves a good outcome for patients and prevents, remedies or mitigates any failures to comply with the Procurement, Patient Choice and Competition Regulations that we could have found. We have therefore closed our investigation without determining whether any such failures occurred.

We are required to maintain a register of undertakings. The undertakings and this decision will be placed on our website.

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² Section 115 of the Health and Social Care Act 2012 and the rules outlined in the 2014/15 National Tariff Payment System. As the CCGs will abandon the procurement exercise and therefore the proposed pricing arrangement we were investigating, this outcome also addresses any failings we might have identified in relation to the National Tariff rules and we have also closed our investigation into those aspects.

³ Regulation 2 requires commissioners to act with a view to securing the needs of people who use the services, improving the quality of the services and improving efficiency in the provision of the services, including through the services being provided in an integrated way. Regulation 3(3) requires commissioners to procure the services from one or more providers that are most capable of delivering the objective referred to in Regulation 2 in relation to the services and provide best value for money in doing so.
HEALTH AND ADULT SERVICES SELECT COMMITTEE

9 June 2016

Title: Joint Health Overview and Scrutiny Committee

Report of the Director of Law & Governance

Open Report

Report Author: Masuma Ahmed, Democratic Services, Scrutiny, Law & Governance

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Accountable Divisional Director: Fiona Taylor, Director of Law & Governance

Accountable Director: Chris Naylor, Chief Executive

Summary:

This report is to:

i. Inform the Health and Adults Services Select Committee (HASSC) of the local arrangements for joint health scrutiny and,

ii. Ask the Committee to appoint three HASSC members to the Joint Health Overview and Scrutiny Committee (JHOSC) for the 2016/17 municipal year.

This report and the appended Terms of Reference explain local joint health scrutiny arrangements amongst the boroughs of Barking and Dagenham, Havering, Redbridge, and Waltham Forest, which cover the Outer North East London area.

The Terms of Reference at Appendix 1 state that the JHOSC will consist of three members of each local authority represented, appointed by each borough’s health overview and scrutiny committee. In previous years the Lead and Deputy Lead members of the HASSC have usually been put forward to fill two of the three vacancies.

Recommendations

The HASSC is recommended to:

(i) Note the Terms of Reference for the JHOSC;
(ii) Note the letter from the JHOSC to the Chief Executive of the NHS, and
(iii) Agree to appoint three HASSC members to the JHOSC.

Reason

To accord with joint health scrutiny arrangements.
1. **Powers of Health Scrutiny in general**

Regulations under the National Health Service Act 2006 state that local authorities in England have the power to:

- "Review and scrutinise matters relating to the planning, provision and operation of the health service in the area. This may well include scrutinising the finances of local health services.
- Require information to be provided by certain NHS bodies about the planning, provision and operation of health services that is reasonably needed to carry out health scrutiny.
- Require employees including non-executive directors of certain NHS bodies to attend before them to answer questions.
- Make reports and recommendations to certain NHS bodies and expect a response within 28 days.
- Set up joint health scrutiny committees with other local authorities and delegate health scrutiny functions to an overview and scrutiny committee of another local authority.
- Refer NHS substantial reconfiguration proposals to the Secretary of State if a local authority considers:
  - The consultation has been inadequate in relation to the content or the amount of time allowed.
  - The NHS body has given inadequate reasons where it has not consulted for reasons of urgency relating to the safety or welfare of patients or staff.
  - A proposal would not be in the interests of the health service in its area".  

2. **Joint Health Scrutiny Arrangements**

2.1 The Department of Health Guidance ('the Guidance') issued in June 2014 describes two types of joint scrutiny committees; discretionary and mandatory. Discretionary joint committees are set up by local authorities by choice to scrutinise health matters that cross local authority boundaries. Mandatory joint committees are required by regulation to be set up when a relevant NHS body or health service provider consults more than one local authority’s health scrutiny function about substantial reconfiguration proposals.

2.2 In such circumstances, the regulations state that:

- "Only the joint committee may respond to the consultation (i.e. rather than each individual local authority responding separately).
- Only the joint committee may exercise the power to require the provision of information by the relevant NHS body or health service provider about the proposal.
- Only the joint committee may exercise the power to require members or employees of the relevant NHS body or health service provider to attend before it to answer questions in connection with the consultation."  

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1 Department of Health, Local Authority Health Scrutiny Guidance, 27 June 2014, p12
2 Department of Health, p17
2.3 Individual councils or departments would still be able to respond informally to any consultations but the responsibility to give a formal response would lie with the mandatory JHOSC.

3. **Referrals to the Secretary of State for Health**

3.1 The Guidance makes it clear that the above restrictions do not apply to referrals to the Secretary of State. "Local authorities may choose to delegate their power of referral to the mandatory joint committee but they need not do so. If a local authority had already appointed a discretionary committee, they could even delegate the power to that committee if they choose to. If the local authority has delegated this power, then they may not subsequently exercise the power of referral. If they do not delegate the power, they may make such referrals."³

3.2 The London Borough of Barking and Dagenham's Constitution delegates the power of referral to the Secretary of State to the HASSC.

4. **Outer North East London Joint Health Overview and Scrutiny Committee**

4.1 The Outer North East London JHOSC consists of three members from each of the following boroughs:

- Barking & Dagenham
- Havering
- Redbridge and
- Waltham Forest.

The Essex County Council Health Overview and Scrutiny Committee is permitted to appoint one member to the JHOSC.

4.2 **Background to the JHOSC**

The Outer North east London JHOSC was established by the health overview and scrutiny committees of the above boroughs, exercising their powers under section 7 of the Health and Social Care Act 2001 and the Local Authority (Overview and Scrutiny Committees Health Scrutiny Functions) Regulations 2002. This legislation, together with directions issued by the Secretary of State for Health in 2003, required all local authorities affected by what they considered to be 'substantial variations' in local health services to form a 'joint health overview and scrutiny committee' to consider those changes.

5. **Further information regarding the JHOSC and Appointment of Members**

5.1 The Terms of Reference at Appendix 1 describe the remit and governance of the JHOSC. These state that the JHOSC will consist of three members of each local authority represented, appointed by each borough’s health overview and scrutiny committee. In previous years the HASSC has agreed to appoint its Lead and Deputy Lead members to fill two of the three vacancies and if the HASSC agrees to do the same at its meeting on 9 June 2016, it would need to appoint one further member. If more than three nominations are received, a vote will be conducted to determine the appointments.

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³ Department of Health, p17
5.2 There are typically four JHOSC meetings a year with the four boroughs taking turns to host each meeting. The chair of the health scrutiny committee from the hosting borough chairs the JHOSC meeting. The meetings are clerked by Anthony Clements, Principle Committee Officer at the London Borough of Havering, who charges the boroughs for his support in proportion to the number of members they may appoint to the Committee.

5.3 Four JHOSC meetings have been scheduled for the 2016/17 municipal year as listed below. The latter three will be put to the first meeting for agreement.
   - 2pm, 12 July 2016 – Barking & Dagenham
   - 2pm, 18 October 2016 – Havering
   - 2pm, 17 January 2017 – Redbridge
   - 2pm, 18 April 2017 – Waltham Forest.

Update on issues discussed at the last JHOSC

5.4 The last JHOSC meeting was hosted by Waltham Forest on 19 April 2016. The following matters were discussed at this meeting:
   - Pre-exposure prophylactics;
   - Transforming Services Together;
   - Moorfields hospital move project, and
   - GP primary medical services contracts.

With regards to pre-exposure prophylactics (HIV treatment), the JHOSC agreed that it would write to Simon Stevens, the Chief Executive of the NHS, regarding its concerns over NHS England’s decision not to put forward the treatment for national funding. The letter is provided at Appendix 2, for the HASSC’s information, and the boroughs’ MPs have also been sent a copy of the letter.

5.5 The minutes of all the JHOSC meetings held during 2015/16 are available on http://democracy.havering.gov.uk/ieListMeetings.aspx?CommitteeId=273

6. Financial and Legal Implications

There are no financial or legal implications arising directly from this report.

Background Papers Used in the Preparation of the Report:

Barking and Dagenham Council Constitution
http://moderngov.barking-dagenham.gov.uk/ieListDocuments.aspx?CId=626&MId=9162&Ver=4

Local Health Scrutiny Guidance 2014, Department of Health:

List of appendices:

Appendix 1 Joint Health Overview and Scrutiny Committee’s Terms of Reference
Appendix 2 Letter from JHOSC to the Chief Executive of the NHS regarding funding of pre-exposure prophylactics
Establishment of the JHOSC

1. The Outer North East London Joint Health Overview and Scrutiny Committee (the JHOSC) is established by the Overview and Scrutiny Committees having health responsibilities of the London Borough Councils of Barking & Dagenham, Havering, Redbridge and Waltham Forest (“the borough OSCs”) in accordance with s.190-191 of the Health and Social Care Act 2012 and consequential amendments and the Local Authority (Overview and Scrutiny Committees Healthy Scrutiny Functions) Regulations 2002.

Membership

2. The JHOSC will consist of three Members appointed of each of the Borough OSCs.

3. In accordance with section 21(9) of the Local Government Act 2000, Executive Members may not be members of an Overview and Scrutiny Committee.

4. The Essex County Council Health Overview and Scrutiny Committee may nominate one full Member for the Joint Health Overview and Scrutiny Committee. Thurrock Borough Council Health Overview and Scrutiny Committee may nominate an observing Member of the Joint Health Overview and Scrutiny Committee. The Councils of the Borough of Brentwood and District of Epping Forest may also each nominate an observing Member.

5. Appointments made to the JHOSC by each participating London borough OSC will reflect the political balance of the borough Council, unless a participating borough OSC agrees to waive the requirement and this is approved by the JHOSC.

Attendance of Substitute Members

6. If a Member is unable to attend a particular meeting, he or she may arrange for another Member of the borough OSC to attend as substitute, provided that a Member having executive responsibilities may not act as a substitute. Notice of substitution shall be given to the clerk before the commencement of the meeting.

Role and Function of the JHOSC

7. The JHOSC shall have the remit to review and scrutinise any matter, including substantial variations, relating to the planning, provision and operation of health services that affect two or more boroughs in Outer North East London. The
JHOSC will have the right to respond in its own right to all consultations on such matters, both formal and informal.

8. In fulfilling its defined role, as well as reviewing documentation, the JHOSC will have the right to do any or all of the following:

   a. Request information or to hold direct discussions with appropriate officers from each of the following organisations or their successor bodies:

      Barking and Dagenham Clinical Commissioning Group (CCG)
      Havering CCG
      Redbridge CCG
      Waltham Forest CCG
      NHS England
      North East London Commissioning Support Unit
      Barking, Havering and Redbridge University Hospitals NHS Trust
      Barts Health NHS Trust
      North East London NHS Foundation Trust
      North East London Community Services
      London Ambulance Service NHS Trust

      as well as any other NHS Trust or other body whose actions impact on the residents of two or more Outer North East London Boroughs;

   b. Co-operate with any other Joint Health Overview and Scrutiny Committee or Committees established by two or more other local authorities, whether within or without the Greater London area;

   c. Make reports or recommendations to any of the NHS bodies listed above and expect full, written responses to these;

   d. Require an NHS or relevant officer to attend before it, under regulation 6 of the Regulations, to answer such questions as appear to it to be necessary for the discharge of its functions in connection with a consultation;

   e. Such other functions, ancillary to those listed in a to d above, as the JHOSC considers necessary and appropriate in order to fully perform its role.

Although efforts will be made to avoid duplication, any work undertaken by the JHOSC does not preclude any individual constituent borough Overview and Scrutiny Committee from undertaking work on the same or similar subjects.

**Co-optees**

9. The JHOSC shall be entitled to co-opt any non-voting person as it thinks fit or appropriate to assist in its debate on any relevant topic. Each borough Healthwatch organisation for Barking & Dagenham, Havering, Redbridge and
Waltham Forest shall be entitled to nominate one co-opted (non-voting) member of the JHOSC. The power to co-opt shall also be available to any Working Groups formed by the JHOSC.

Formation of Working Groups

10. The JHOSC may form such Working Groups of its membership as it may think fit to consider any aspect or aspects of its work. The role of such Groups will be to consider the matters referred to it in detail with a view to formulating recommendations on them for consideration by the JHOSC. The precise terms of reference and procedural rules of operation of any such Groups (including number of members, chairmanship, frequency of meetings, quorum etc) will be considered by the JHOSC at the time of the establishment of each such Group; these may differ in each case if the JHOSC considers it appropriate. The meetings of such Groups should be held in public except to the extent that the Group is considering any item of business from which the press and public could legitimately be excluded under the Access to Information legislation.

Meetings of the JHOSC

11. The JHOSC shall meet formally at such times, at such places and on such dates as may be mutually agreed, provided that five clear days’ notice is given of the meeting. The Committee may also meet informally as and when necessary for purposes including, but not limited to, visiting appropriate sites within the boroughs or elsewhere.

12. Meeting venues will normally rotate between the four Outer North East London boroughs.

13. Meetings shall be open to the public and press in accordance with the Access to Information requirements. No tape or video recorders, transmitters, microphones, cameras or any other video recording equipment shall be brought into or operated by any person at a meeting of the JHOSC unless the Chair of the meeting gives permission before the meeting (this exclusion will not apply to the taping of the proceedings by officers responsible for producing the minutes). When permission is given, a copy of any tape made must be supplied to the London Borough of Havering, in its role as Administrator.

Attendance at Meetings

14. Where any NHS officer is required to attend the JHOSC, the officer shall be given reasonable notice in advance of the meeting at which he/she is required to attend. The notice will state the nature of the item on which he/she is required to attend to give account and whether any papers are required to be produced for the JHOSC. Where the account to be given to the JHOSC will
require the production of a report, then the officer concerned will be given reasonable notice to allow for preparation of that documentation.

15. Where, in exceptional circumstances, the officer is unable to attend on the required date, and is unable to provide a substitute acceptable to the JHOSC, the JHOSC shall in consultation with the officer arrange an alternative date for attendance.

16. The JHOSC and any Working Group formed by the JHOSC may invite other people (including expert witnesses) to address it, to discuss issues of local concern and/or to answer questions. It may for example wish to hear from residents, stakeholders and members and officers in other parts of the public sector and shall invite such people to attend.

17. The JHOSC shall permit a representative of any other authority or organisation to attend meetings as an observer.

Quorum

18. The quorum for the JHOSC shall be four, provided there is present at least one Member from at least three of the London borough OSCs. For meetings involving the writing or agreeing of a final report of the Committee, the quorum shall comprise at least one representative from each of the four London borough OSCs.

Chair and Vice Chair

19. Each meeting will be chaired by a Member from the host borough on that occasion.

Agenda items

20. Any member of the JHOSC shall be entitled to give notice to the Clerk of the Joint Committee that he/she wishes an item relevant to the functions of the JHOSC to be included on the agenda for the next available meeting. On receipt of such a request (which shall be made not less than five clear working days before the date for despatch of the agenda) the relevant officer will ensure that it is included on the next available agenda.

Notice and Summons to Meetings

21. The Clerk of the Joint Committee will give notice of meetings to all members. At least five clear working days before a meeting the relevant officer will send an agenda to every member specifying the date, time and place of each meeting and the business to be transacted, and this will be accompanied by such reports as are available.

22. Any such notice may be given validity by e-mail.

23. The proper officer of each Council shall ensure that public notice of the meeting is displayed in accordance with the customary arrangements of that Council for giving notice of Committee etc. meetings.
Reports from the JHOSC

24. Once it has formed recommendations the JHOSC will prepare a formal report and submit it to the relevant bodies. In accordance with the Department of Health Guidance on the Overview and Scrutiny of Health dated July 2003, the JHOSC should aim to produce a report representing a consensus of the views of its members. If consensus is not reached within the JHOSC, minority views will be included in the report.

25. In undertaking its role the JHOSC should do this from the perspective of all those affected or potentially affected by any particular proposal, plan, decision or other action under consideration.

Formal Consultations and Referrals to Secretary of State

26. Under guidance on Local Authority Health Scrutiny issued by the Department of Health in June 2014, only the JHOSC may respond to a formal consultation on substantial variation proposals covering health services in more than one constituent Council area. This power also extends to the provision of information or the requirement of relevant NHS officers to attend before the JHOSC in connection with the consultation.

27. The JHOSC may only refer matters directly to the Secretary of State on behalf of Councils who have formally agreed to delegate this power to it.

Procedure at JHOSC meetings

28. The JHOSC shall consider the following items of business:

   (a) minutes of the last meeting;
   (b) matters arising;
   (c) declarations of interest;
   (d) any urgent item of business which is not included on an agenda but the Chair, after consultation with the relevant officer, agrees should be raised;
   (e) the business otherwise set out on the agenda for the meeting.

Conduct of Meetings

29. The conduct of JHOSC meetings shall be regulated by the Chair (or other person chairing the meeting) in accordance with the general principles and conventions which apply to the conduct of local authority committee meetings.
30. In particular, however, where any person other than a full or co-opted member of the JHOSC has been allowed or invited to address the meeting the Chair (or other person chairing the meeting) may specify a time limit for their contribution, in advance of its commencement which shall not be less than five minutes. If someone making such a contribution exceeds the time limit given the Chair (or other person chairing the meeting) may stop him or her.

31. The Chair (or other person chairing the meeting) may also structure a discussion and limit the time allowed for questioning by members of the JHOSC.

Officer Administration of the JHOSC

32. The London Borough of Havering will be the Lead Authority for clerking and administering the JHOSC. The Clerk of the Committee will be the Principal Committee Officer, London Borough of Havering. Costs of supporting the JHOSC will be shared, in proportion to their representation on the Committee, by the London Boroughs of Barking and Dagenham, Havering, Redbridge, Waltham Forest and by Essex County Council, in cash or in kind.

Voting

33. Members may request a formal vote on any agenda item by informing the Clerk of the Joint Committee at least five working days before a meeting. If it is not possible to give this notice, Members have the right to request a vote at a meeting itself, provided they explain to the meeting why it has not been possible to give the standard notice of this request. The decision on whether to allow a vote, if the standard notice has not been given, will rest with the Chairman of that meeting.

34. Any matter will be decided by a simple majority of those members voting and present in the room at the time the motion was put. This will be by a show of hands or if no dissent, by the affirmation of the meeting. If there are equal votes for and against, the Chair or other person chairing the meeting will have a second or casting vote. There will be no restriction on how the Chair chooses to exercise a casting vote. Co-opted members will not have a vote.

Public and Press

35. All meetings of the JHOSC shall be open to the public and press unless an appropriate resolution is passed in accordance with the provisions of Schedule 17 of the National Health Service Act 2006.

36. All agendas and papers considered by the JHOSC shall be made available for inspection at all the constituent authority offices, libraries and web sites.

Code of Conduct
37. Members of the JHOSC must comply with the Code of Conduct or equivalent applicable to Councillors of each constituent Local Authority.

**General**

38. These terms of reference incorporate and supersede all previous terms of reference pertaining to the JHOSC.
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TO:

Simon Stevens
Chief Executive
NHS England
PO Box 16738
Redditch
B97 9PT

Your Reference: AC

Date: 13 May 2016

Dear Mr Stevens

Refusal by NHS England of funding for Pre-Exposure Prophylactics (PReP)

As a member of the Outer North East London Joint Health Overview and Scrutiny Committee I wish to write to you, on behalf of the current Chairman, regarding concerns the Committee has recorded over the recent decision by NHS England not to put forward the PReP HIV treatment for national funding. The Committee supports the view that it should be the responsibility of NHS England to fund treatment of this kind and that it should not be left to Local Authorities to find any funding for this.

The Committee feels that the PReP treatment has demonstrated very successful results in areas, such as the USA, Israel and Kenya, where it has already been licensed and that funding should be allocated (by NHS England) to make the treatment available in Outer North East London, as well as nationally. Whilst of course mindful of the current challenging financial situation, the Committee also understands that the cost of the treatment is likely to drop significantly from mid-2017 when it is due to come off patent.

In conclusion, the Committee is concerned that NHS England is not currently prepared to fund provision of this treatment and wishes to formally request that NHS England reconsider this decision. If you could address any response to the Clerk to the Committee, contact details shown above, I have asked that your comments in reply be forwarded to the members of the Committee as soon as possible.

The Joint Health Overview and Scrutiny Committee is exercising its powers as conferred under the NHS Act 2006, section 245 (as amended by the Health and Social Care Act 2012). This is distinct from and separate to those powers exercised by the Executive of the constituent Councils.
I look forward to hearing from you.

Yours sincerely

Councillor Nic Dodin
Havering Member, Outer North East London Joint Health Overview and Scrutiny Committee

CC:

All Members and Supporting Officers, Outer North East London Joint Health Overview and Scrutiny Committee
All Members of Parliament, Outer North East London