PAPER H

WEST LEICESTERSHIRE CLINICAL COMMISSIONING GROUP

BOARD MEETING

08 September 2015

Title of the report:	Board Assurance Framework
Section:	Governance – How we manage our business
Report by:	Amy Stevens – Corporate Affairs Officer
Presented by:	Ket Chudasama – Assistant Director Corporate Affairs

Report supports the following West Leicestershire CCG's goal(s) 2012 – 2015:			
Improve health outcomes	✓	Improve the quality of health-care services	✓
Use our resources wisely	✓		

Equality Act 2010 – positive general duties:
1. The CCG is committed to fulfil its obligations under the Equality Act 2010, and to ensure services commissioned by the CCG are non-discriminatory on the grounds of any protected characteristics. 2. The CCG will work with providers, service users and communities of interest to ensure if any issues relating to equality of service within this report are identified and addressed.

Additional Paper details:	
Please state relevant Constitution provision	Section 6.6.1(a) - ensuring that the Group has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the Group's principles of good governance
Please state relevant Scheme of Reservation and Delegation provision (SORD)	N/A
Please state relevant Financial Scheme of Delegation provision	N/A

Please state reason why this paper is being presented to the WLCCG Board	To update the Board on the CCG's key strategic and operational risks as at 31 August 2015
Discussed by	CCG sub-groups in August 2015
Alignment with other strategies	2014-15 and 2015-16 Operational Plan
Environmental Implications	None Identified
Has this paper been discussed with members of the public and other stakeholders, if so please provide details	No

EXECUTIVE SUMMARY:

1. The Board Assurance Framework (BAF) has been reviewed and updated to show the latest position as at 31 August 2015. The BAF contains risks to the achievement of strategic objectives for the year, plus other risks 'escalated' from the constituent risk registers where there is an inherent risk rating of 12 or more. As at 31 August 2015 the red rated risks are:

    - Failure to assure local health economy financial viability over the next five years
    - The quality of care provided by UHL does not match commissioner's expectations with respect to quality and safety
    - Patient safety risk due to capacity of EMAS
    - Clinical risk associated with poor performance of CNCS OOH service
    - Safe staffing concerns across Community Health Services and at the Mental Health Services Divisions
    - Failure to improve A&E performance
    - Failure to improve 18 week RTT performance

RECOMMENDATIONS:

The West Leicestershire Clinical Commissioning Group is requested to:

APPROVE the latest iteration of the 2015/16 Board Assurance Framework

DISCUSS the presentation of the risks on the concentric diagram

DISCUSS if any further actions are required to address the risks

WEST LEICESTERSHIRE CLINICAL COMMISSIONING GROUP

BOARD MEETING

8 September 2015

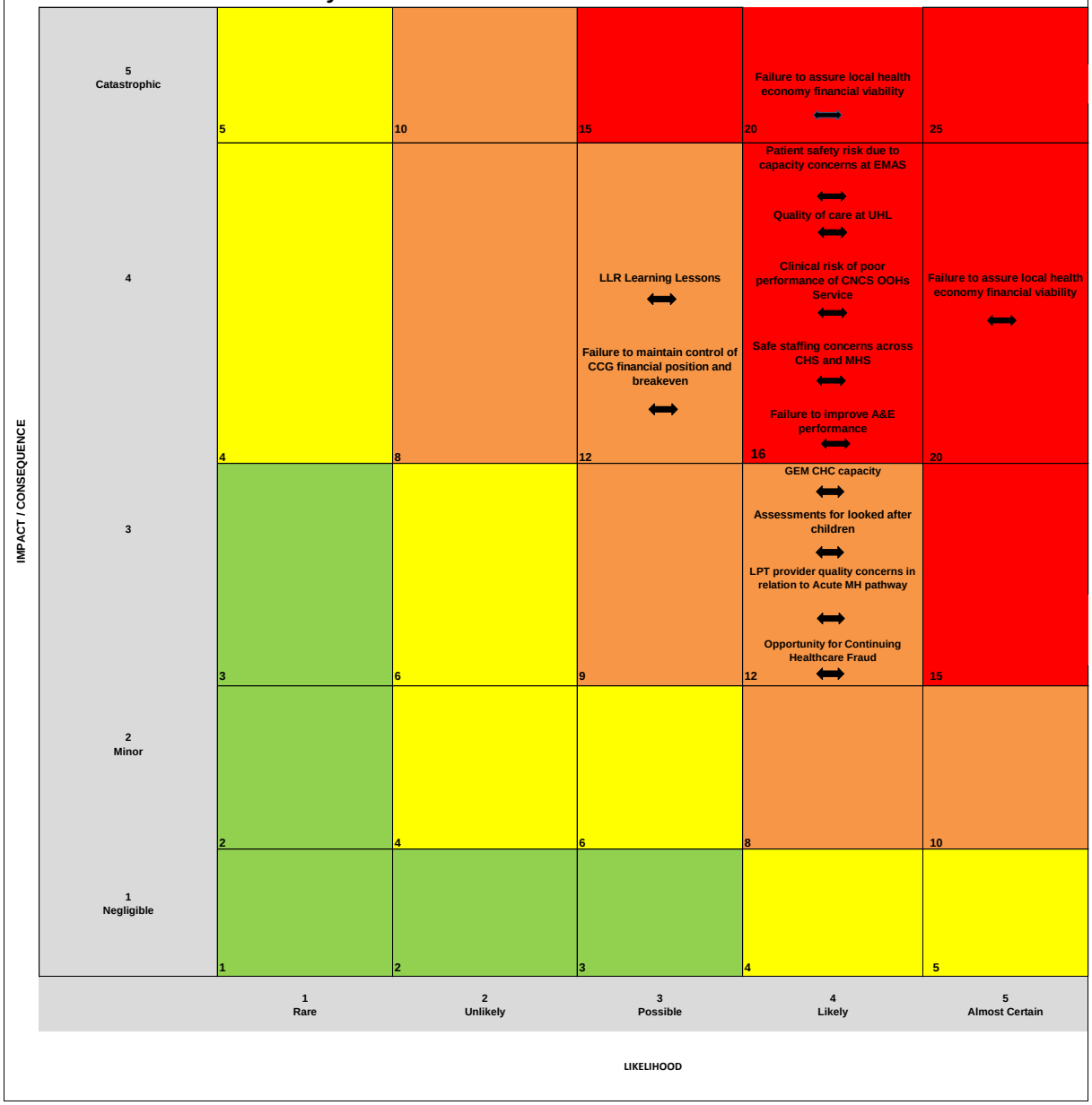
BOARD ASSURANCE FRAMEWORK

INTRODUCTION

1. The Board Assurance Framework (BAF) has been reviewed and updated and shows the latest position as at 31 August 2015. The updated BAF contains risks to the achievement of strategic objectives for the year, plus other risks 'escalated' from the constituent risk registers where there is an inherent risk rating of 12 or more.

2. The following matrix shows the position as at 31 August 2015:

Summary of "live" Risks on 5 x 5 Risk Assessment Matrix



3. Board members are asked to note that there are five key urgent care risks which are reported to the Urgent Care Board. These risks and their mitigating actions are included in the consolidated RTT risk (1.7) and EMAS capacity risk (1.3) on our CCG BAF, however, members are asked to note these specific urgent care risks which are a sub-set of our BAF urgent care risks. The risk position below is as at August 2015.

Risk Description	Key Controls	Net Risk Score
Patients could receive sub-optimal care, including increasing risk of harm as a direct result of increasing pressures in urgent care pathway due to: 1. Lack of EMAS capacity resulting from volume/handover issues leading to patients waiting 'unsighted' in the community for a first response following initial telephone triage	Additional resources on overtime or VAS/PAS to provide cover at projected peaks. Emergency Conveyance reduction - Pathfinder Training ongoing Q4 2014/15. Emergency Conveyance reduction - Falls Training ongoing Q4 2014/15. EMAS wide REAP level 4 actions.	**3 x 3 = 9** ⟷
2. Overcrowding in ED/CDU leading to risk of high need patients being incorrectly prioritised and/or not being assessed and treated in line with their relative priority	Weekly audit of ED metrics. Staffing flexed to ensure nursing and medical staffing ratios appropriate for managing patients cohort. Triage at ED front door. Process for reviewing long wait patients by "safety doctor". "Safety doctor" available to support ED. Real-time monitoring of ED activity. Implementation of ED action plan in response to I Sturgess report (endorsed by NTDA). Gold Command Meetings (led by UHL Director 7 days a week). Increased Consultant presence at weekends on our key medical wards at the LRI.	**4 x 4 =16** ⟷
3. Handover delays for EMAS crews at LRI leading to risk of patients condition deteriorating while waiting	Dynamic HALO deployed to assist with Pre-Handover delays. Regional Operations Manager role introduced in EOC. LLR/UHL Task & Finish Group established to review progress and implement improvements. Daily system performance conference calls - EMAS, UHL, UCC and TDA.	**3 x 3 = 9** ⟷

4. Short notice cancellation of elective procedures as a result of bed availability resulting in patients (including cancer patients) deteriorating while waiting for treatment to be rescheduled	Daily Bed Meetings. UHL Cancelled Escalation Policy which identifies which patients should be cancelled first and wherever possible the consultant is always involved re prioritisation. Use of independent sector for additional capacity. Additional capacity wards. LIA project.	**4 x 4 =16** 
5. Overstretched nursing and medical ward staff cover in UHL acute and LPT community hospital beds leading to harm from delays in care, treatment compliance and patient deconditioning	**UHL** UHL and LPT - hard truths staffing data monitored routinely. Use of bank staff and locum staff where available including agency staff off NHS payment framework. Staffing flexed across sites to manage greater risk areas. UHL - ward metrics in place to monitor and oversee ward performance. **LPT** Shift by shift review of staffing on community hospital wards and movement as required. Use of bank staff and locum staff where available. Enhanced medical inpatient model utilising ANP's and geriatricians for community hospitals is in place. Full week acuity review underway for one month in community hospitals and MHSOP, week commencing 5th January to establish more accurate staffing levels. Increased monitoring through locality governance, risk register review and incidents, complaints and SI review. MHSOP Staff levels increased above budgeted establishment through agency and bank deployment in line with patient dependency and severity until new recruits are in post and inducted.	**4 x 4 =16**  **3 x 3 = 9**

	AMH Shift by shift management of staffing requirements and use of bank and agency to maintain safe staffing levels. Staffing contingency plans in operation and ongoing recruitment. Increased monitoring through weekly operational meetings, safer staffing activity, divisional risk register review, incidents and SIs Monitoring of e-rostering to ensure efficient usage of staff Staffing workshop held on 29/04/15 **FYPC** Staffing levels for in-patients monitored on individual shift basis. On-call staffing is monitored daily and discussed with operational managers and reported on at weekly ops. Any breaches that occur to due to lack of capacity are reported, escalated and investigated.	**3 x 3 = 9** **3 x 3 = 9**

4. As at 31 August 2015 the highest scoring risks along with their mitigating actions and next steps are as follows:

Risk Description	Impact	Liklihood	Risk Score	Next Steps
Failure to assure local health economy financial viability over the next 5 years.	**4**	**5**	**20 (R)** ⟷	Implentation of year 1 project actions Updating organisational financial models - WLCCG medium term draft plan due for submission 11th September 2015 Source of transitional funding to be secured to enable change to take place in future years Implementation/Contractual Agreement of Bed Reconfiguration phase 1 Drafting Pre-consultation Business Case prior to November Consultation, including impact of consultation options and refresh of 5 year financial outlook
The quality of care provided by UHL does not match commissioner's expectation with respect to quality and safety, due to a deterioration in performance across a number of areas: - poor performance across the urgent care pathway - deterioration in RTT performance - 62 day cancer waits at speciality level - disparity of SHMI across sites (high SHMI at LRI site) - inconsistency in FFT across wards	**4**	**4**	**16 (R)** ⟷	Despite LLR CCGs oversight and scrutiny performance at across the range of services continues to give significant cause for concern and has not yet reduced the risk (reviewed monthly). Performance against national 4 hr ED is not achieving acceptable levels despite focussed efforts within UHL (reviewed monthly). Monitoring via CQRG, RTT Board, CPM and technical meetings, Cancer Board, Cancer action group. This is reviewed at PPAG. UHL to ensure plans in place to meet the targets set on trajectories. Problem areas that need extra scrutiny are upper and lower GI and lung. Currently backlog is 125 at the end of April. Trajectory states it should be 60, UHL to provide action plan to bring back target.

Risk Description	Impact	Liklihood	Risk Score	Next Steps
Patient safety risk due to capacity of EMAS to deliver Red 1 and A19 requirements and the issuing of an improvement notice from CQC (2013), which highlights certain patient risks. CQC revisit (2014) continues highlight concerns	**4**	**4**	**16 (R)**	•Better Patient Care report has been provided to Commissioners providing assurance on progress against the EMAS Quality Improvement Plan •Poor progress on the CQC Action Plan escalated to the Partnership Board, Collaborative Commissioning Meeting and EMAS Quality Governance Committee. •Patient Safety issues in light of the change of practice for transfer of Critical Care Patients have been addressed by escalation of the concerns and an immediate reinstatement of these transfers •EMAS has acknowledge misinterpretation of the contract in relation to the Critical Care Transfers and have reinstated this service with immediate effect •Local issues are being addressed through the Locality meeting •Close liaison with UHL to address Handover and Turnaround •Handover and Turnaround working group set up and initial actions agreed, to be reviewed in terms of impact after one month •Falls Pathway under review •Address any concerns identified through monitoring of SI's, incidents and complaints •Monitoring issues escalated by primary medical care
Clinical risk associated with poor performance of the CNCS OOH service.	**4**	**4**	**16 [R]**	Contract and Quality leads to asses performance against trajectory Monitoring of complaints and incidents Weekly monitoring of staffing and rotas Unannounced visits to service to assess risks
Safe Staffing (nursing) concerns across Community Health Services and at the Mental Health Services Divisions (Bradgate Mental Health Unit) may impact on the quality and continuity of care for patients. This is due to gaps in the substantive nursing workforce and significant reliance on temporary staff to fill gaps in availability.	**4**	**4**	**16 [R]**	LPT to provide monthly up-to-date/real time staffing and recruitment summary (all divisions) along with monthly staffing and recruitment reports required via the quality schedule (May CQRG). Commissioners to review the response and actions taken to mitigate the risks.
Failure to improve A&E performance leading to removal of the CCG's responsibility to commission urgent care services	**4**	**4**	**16 [R]**	Ongoing Monthly contractual performance review. Weekly Urgent Care Meetings take place under the LLR Resilience Governance Plan. External clinical consultant in post working with UHL to identify pathway changes over a period of 6 months. Daily remedial actions undertaken daily by Emergency Care Director. New urgent care plan and recovery tragectory built in to 2015/16 plans. A&E performance at the end of February had deteriorated and is at 86.63% compared to January, however this has recovered again in march with a current monthyl average of 87.6% showing . Activity has not changed significantly although the number of admissions has increased and is currently 12% above last years position. The A&E metrics are agreed but are only being met in part. Performance is monitored through PPAg on a monthly basis. Daily remedeial actions undertaken by Emergency Care Director.
Failure to improve 18 week RTT performance leading to removal of the CCG's responsibility to commission elective services	**5**	**3**	**15 (R)**	Ongoing monthly contractual performance review. Embedding of robust monitoring arrangements via RTT Board. Ensure RTT Board provides appropriate focus on sustainability. As a result of concerns re diagnostics there will now be a focussed piece of work on direct access to MRI. RTT Board agreed to monitor the following on a weekly basis. Clock stops actual against plan Backlog actual against plan Performance actual against plan On a monthly basis to monitor clearance times on a quarterly basis to monitor referrals demand and impact of emergency admissions. Rollout of MSK Triage in West Leicestershire CCG in July 2015. Review and monitoring of Out of County performance and issues through Planned Care Delivery Group (reports by exception into Planning and Delivery Sub Group). UHL expected to acheive performance standards with the exception of T+O. T+O on escalated monitoring internally in order to improve performance.

5. Following feedback at the August Board meeting on the new BAF concentric diagram, work on this is still in progress and an updated version of this diagram will be presented to Board members in October.

6. Individual risk registers are maintained by the three sub-groups and by CMT, and are reviewed on a monthly basis. In addition, the Audit Committee provides further scrutiny and challenge on the risk registers and BAF at each meeting. The detailed registers are available to Members for review at any time.

RECOMMENDATIONS:

The West Leicestershire Clinical Commissioning Group is requested to:

APPROVE the latest iteration of the 2015/16 Board Assurance Framework

DISCUSS the presentation of the risks on the concentric diagram

DISCUSS if any further actions are required to address the risks

Board Assurance Framework 2014/15 - August 2015

Risk Reference	Strategic Objective	Risk Owner	Risk Description	Risk Score: Impact	Ongoing Actions	Monitoring	Risk scores: Likelihood	Risk scores: Rating	Actions in the next period	Last reviewed
1.1	3a, 3b, 3c & 3d	Spencer Gay (CFO)	**Failure to assure local health economy financial viability over the next 5 years.**	4	BCT programme established Permanent promgrame director appointed SOC agreed and submitted to TDA / NHS England	BCT board meetings CFO / DF meetings monthly	5	20 (R) ⟷	Implentation of year 1 project actions Updating organisational financial models - WLCCG medium term draft plan due for submission 11th September 2015 Source of transitional funding to be secured to enable change to take place in future years Implementation/Contractual Agreement of Bed Reconfiguration phase 1 Drafting Pre-consultation Business Case prior to November Consultation, including impact of consultation options and refresh of 5 year financial outlook	Sep-15
1.2	1a, 2a & 2b	Caroline Trevithick (CNQL)	**The quality of care provided by UHL does not match commissioner's expectation with respect to quality and safety, due to a deterioration in performance across a number of areas:** - poor performance across the urgent care pathway - deterioration in RTT performance - 62 day cancer waits at speciality level - disparity of SHMI across sites (high SHMI at LRI site) - inconsistency in FFT across wards	4	Collaborative commissioning arrangements in place (Commissioning Collaborative Board and Provider Performance Assurance Group). Memorandum of agreement between LLR CCGs in place governing collaborative arrangements. Monthly contract meetings. Review and robust challenges to data by LC CCG Hosted Team. Actions pursued via contractual arrangements.	Monthly Integrated quality & performance reports reviewed by Performance Collaborative and individual organisation subcommittees/ Governing Body Triangulation of data to inform unannounced quality visits Oversight and scrutiny and sign off of Serious Incidents GP concerns reporting mechanism	4	16 (R) ⟷	Despite LLR CCGs oversight and scrutiny performance at across the range of services continues to give significant cause for concern and has not yet reduced the risk (reviewed monthly). Performance against national 4 hr ED is not achieving acceptable levels despite focussed efforts within UHL (reviewed monthly). Monitoring via CQRG, RTT Board, CPM and technical meetings, Cancer Board, Cancer action group. This is reviewed at PPAG. UHL to ensure plans in place to meet the targets set on trajectories. Problem areas that need extra scrutiny are upper and lower GI and lung. Currently backlog is 125 at the end of April. Trajectory states it should be 60, UHL to provide action plan to bring back target.	Sep-15
1.3	1a, 1b, 2a, 2c, 3b & 3c	Caroline Trevithick (CNQL)	**Patient safety risk due to capacity of EMAS** to deliver Red 1 and A19 requirements and the issuing of an improvement notice from CQC (2013), which highlights certain patient risks. CQC revisit (2014) continues highlight concerns	4	Financial sanctions Local quality monitoring with EMAS Increased dialogue with Erewash CCG who facilitate the contract on behalf of the CCG. Providers CQC Action Plan received from Erewash CCG 9lead commissioners). Local performance meetings with EMAS Discussion with GEM regarding reporting timelines has taken place Recovery Action Plan in place which has had oversight by the Trust Development Agency (TDA), the Care Quality Commission (CQC) and regional commissioners - monthly meetings to review progress commenced in January 2014. GEM Comms team to pick up any local media issues.	Locality Meetings Quality Assurance Group Meetings (QAG) Recovery Action plan in place - Better Patient Care Programme Dashboard (QIP) Monitoring serious incident reports, incident data and complaints Monthly meetings between NHS Erewash and EMAS to act on hot topics Risk summit (QIP) EMASs CQC Action Plan Task and Finish Group Report to Q&P sub-group. TDA oversight group in place	4	16 (R) ⟷	•Better Patient Care report has been provided to Commissioners providing assurance on progress against the EMAS Quality Improvement Plan •Poor progress on the CQC Action Plan escalated to the Partnership Board, Collaborative Commissioning Meeting and EMAS Quality Governance Committee. •Patient Safety issues in light of the change of practice for transfer of Critical Care Patients have been addressed by escalation of the concerns and an immediate reinstatement of these transfers •EMAS has acknowledge misinterpretation of the contract in relation to the Critical Care Transfers and have reinstated this service with immediate effect •Local issues are being addressed through the Locality meeting •Close liaison with UHL to address Handover and Turnaround •Handover and Turnaround working group set up and initial actions agreed, to be reviewed in terms of impact after one month •Falls Pathway under review •Address any concerns identified through monitoring of SI's, incidents and complaints •Monitoring issues escalated by primary medical care •Escalate concerns to monthly NTDA Oversight Group. Review of the new CQC process and the impact on providers.	Sep-15
1.4	1a, 1b, 2a, 2c, 3b & 3c	Caroline Trevithick (CNQL)	**Clinical risk associated with poor performance of the CNCS OOH service.**	4	Monthly CQRG Monthly Contract meetings Remedial action plan with trajectory in place Ad hoc clinical quality meetings with provider	CQRG Contract Performance meeting Oversight meetings	4	16 (R) ⟷	Contract and Quality leads to asses performance against trajectory Monitoring of complaints and incidents Weekly monitoring of staffing and rotas Unannounced visits to service to assess risks	Sep-15

1.5	**1a, 2a & 2b**	**Jim Bosworth**	**Safe Staffing (nursing) concerns across Community Health Services and at the Mental Health Services Divisions** (Bradgate Mental Health Unit) may impact on the quality and continuity of care for patients. This is due to gaps in the substantive nursing workforce and significant reliance on temporary staff to fill gaps in availability.	**4**	The Trust is required via the Contract Quality Schedule to demonstrate; a) Safe staffing levels (in line with staffing levels NHSE), b) A safe and effective workforce provision c) Sustainable improvements in MH Services d) Quality metrics for Bradgate Mental Health Unit (monthly) Additionally the following has been requested of the Trust: - Undertake a deep dive into the staffing levels at the Bradgate Unit, identifying gaps and how they are being addressed. - Provide commissioners with further detail on the 'rolling recruitment process' that the Trust has said is currently in place for the Bradgate Unit. - Undertake a risk assessment of all of the wrads relating to safe staffing levels following the closure of St Luke's ward. - Provide detail to enable commissioners to gain an understanding of the Trust recruitment strategy.	Monthly detailed reporting to CQRG of staffing levels at ward level and recruitment/vacancy levels by division. To include actions relating to addressing staffing shortages and mitigating risks to patients. Regular 1 to 1 meetings between the Director of Nursing and Quality (LCCCG) and Cheif NUrse (LPT). The Trusts formal response to the specific information requests to the CQRG. Safer staffing reports to LPT Trust Board (monthly and 6 monthly). • Undertake a deep dive into the staffing levels at the Bradgate Unit, identifying gaps and how they are being addressed. • Provide commissioners with further detail on the 'rolling recruitment process' that the Trust has said is currently in place for the Bradgate Unit. • Undertake a risk assessment of all of the wards relating to safe staffing levels following the closure of St Luke's ward.Provide detail to enable commissioners to gain an understanding of the Trust recruitment strategy.	**4**	**16 [R]**	LPT to provide monthly up-to-date/real time staffing and recruitment summary (all divisions) along with monthly staffing and recruitment reports required via the quality schedule (May CQRG). Commissioners to review the response and actions taken to mitigate the risks.	Sep-15
1.6	**1a, 1b, 2a, 2b, 2d, 3b & 3d**	**Caron Williams (AD:SP)**	**Failure to improve A&E performance** leading to removal of the CCG's responsibility to commission urgent care services	**4**	Performance has stabalised at current performance level. The Urgent Care Board have developed a new plan to take the perfomance to 95%. The meetings have been moved to fortnightly, to allow the elements to work through the UCWG sub-groups. 4 action areas have been identified each with a series of actions which can generate rapid solutions or interventions. Weekly progress against the short-term RAP is monitored by the Hub at the weekly delivery group and then reported into the Urgent Care Board. This is being underpinned by KPI's (key performance indicators) for each of the work streams to support the monitoring of performance and delivery against intended outcomes. UHL Contract Management Team hosted by City CCG. Monthly contract technical, performance and CQRG meetings will escalate issues via Provider Performance Assurance Group to CCG Boards for action. UHL dashboards produced weekly and closely monitored at the UCB. Recovery plan in place to support system flow and monitored through the reporting arrangements at UCB. Rollover of RAP into 14-15 contract now agreed, but to include revised action plan (as per TDA submission June 2014) and revised trajectories with revised consequences of breach from Q3 as applicable. Agreement in principle to rebate penalties from Q3 subject to the attainment for 3 or 4 key outcome measures.	CCG formal Collaborative Commissioning arrangements agreed. Monthly Technical and CPM minutes for major contracts. Governing Body contract performance reports, minutes and papers. Urgent care working group reports and minutes Terms of Reference for Provider Performance Assurance Group, agreed by GB, including reports/papers and minutes of meetings. Weekly Urgent Care Board meeting agendas, reports and minutes. National standards checklist in place informing the recovery plan. High impact interventions in place that are monitored weekly. Interim report from Ian Sturgess available to CCGs with key focus on clinical leadership.	**4**	**16 [R]**	Ongoing Monthly contractual performance review. Weekly Urgent Care Meetings take place under the LLR Resilience Governance Plan. External clinical consultant in post working with UHL to identify pathway changes over a period of 6 months. Daily remedial actions undertaken daily by Emergency Care Director. New urgent care plan and recovery tragectory built in to 2015/16 plans. A&E performance at the end of February had deteriorated and is at 86.63% compared to January, however this has recovered again in march with a current monthyl average of 87.6% showing . Activity has not changed significantly although the number of admissions has increased and is currently 12% above last years position. The A&E metrics are agreed but are only being met in part. Performance is monitored through PPAg on a monthly basis. Daily remedeial actions undertaken by Emergency Care Director.	Sep-15
1.7	**1a, 1b, 2a, 2b, 2c, 2d, 3a, 3b, 3c & 3d**	**Spencer Gay (CFO)**	**Failure to improve 18 week RTT performance** leading to removal of the CCG's responsibility to commission elective services	**5**	UHL Contract Management Team hosted by City CCG. Monthly contract technical, and CPM meetings escalate issues via Provider Performance Assurance Group to CCG Boards for action. UHL dashboards produced monthly and closely monitored. Non recurrent and recurrent additional funding identified through transformational funding and contract envelope for 2015/16. RTT Board established 23.04.14 to hold UHL to account. Individual CCGs developing RTT plans to ensure delivery against NHS Constitution requirements. National RTT recovery exercise (part of resilience planning) has required revised plans for additional activity, outsourcing, promotion of patient choice and data validation. Progress monitored fortnightly through RTT Board with weekly/twice-weekly telecons to monitor operational implementation. National exercise for the transfer for elective patients to the IS sector with national additional funding. Now confirmed as benefiting long waiting patients. New director of performance and information in post from January 15 has introduced new modelling tool to give greater assurance.	Minutes of Technical and CPM minutes including progress reports and exception reports. Governing Body contract performance reports, minutes and papers. Terms of Reference for Provider Performance Assurance Group, agreed by GB, including reports/papers and minutes of meetings. Contract management correspondence with UHL:1. RTT RAPS RTT Board minutes, agendas and papers. MDs minutes, agendas and papers. Assurance that non admitted and incompletes performance already meeting.	**3**	**15 (R)**	Ongoing monthly contractual performance review. Embedding of robust monitoring arrangements via RTT Board. Ensure RTT Board provides appropriate focus on sustainability. As a result of concerns re diagnostics there will now be a focussed piece of work on direct access to MRI. RTT Board agreed to monitor the following on a weekly basis. Clock stops actual against plan Backlog actual against plan Performance actual against plan On a monthly basis to monitor clearance times on a quarterly basis to monitor referrals demand and impact of emergency admissions. Rollout of MSK Triage in West Leicestershire CCG in July 2015. Review and monitoring of Out of County performance and issues through Planned Care Delivery Group (reports by exception into Planning and Delivery Sub Group). UHL expected to acheive performance standards with the exception of T+O. T+O on escalated monitoring internally in order to improve performance.	Sep-15
1.8	**1a, 1b, 2a & 2b**	**Caroline Trevithick (CNQL)**	**LLR Learning Lessons** to Improve Care published July 2014, potential risk of loss of confidence in local NHS providers regarding ability to implement actions required	**4**	5 point action plan updated Clinical Task Force in place with engagement with all agencies Clinical and Public Engagement Events - Information generated now being analysed Audit will be repeated to enable robust monitoring and to ensure that the 5 point action plan is delivering required results	Programme timeline agreed and included in March board report LLR Learning Lessons to Improve Care Clinical Taskforce in place to monitor operational management of Action Plan 5 point action plan to be incorporated into the Better Care Together plan. Link to Better Care Together Programme formalised Clinical and managerial oversight of actions Quarterly reporting to CCG. Next one March 2015 Respond to concerns raised by LMC and Healthwatch regarding actions and progress	**3**	**12 (A)**	Monitor and respond to media/public/stakeholder interest Establish governance arrangements for ongoing monitoring of action plan i.e. present update on action plans to CCG Board in 3 months - update to be received in March 15 Respond to concerns raised by LMC and Healthwatch regarding actions and progress Interim Project Manager in place to finalise and collate progress to date and granular action plan that supports implementation of the overarching joint action plan Update to be presented at CCG Board in March.	Sep-15
1.9	**1a, 1b, 2a, 2b & 3a**	**Jim Bosworth**	**Due to concerns relating to the Mental Health Acute Pathway,** in particular quality and patient safety as identified by the CQC inspection, capacity, timely crisis response and poor quality performance data.	**3**	Plan agree with LPT to address the CQC findings. Crisis House opened February 2015. Contractual agreement for LPT to manage risk has improved patient flow and reduced overspill. Clinical Forum has agreed a new crisis pathway which is being implemented.	Joint arrangements with the TDA to monitor implementation of CQC plan. Monthly reports to Contracting Structure & Mental Health Clinical Forum. Informal patient feedback.	**4**	**12 (A)**	Continued monitoring of pathway through contractual meetings and Clinical Forum.	Sep-15
2.0	**2a & 2b**	**Caroline Trevithick (CNQL)**	**A lack of capacity in the GEM CHC team** has created a risk to the welfare of CHC funded patients, due to a large number of case reviews being overdue	**3**	Process in place for CHC to undertake reviews in order of priority i.e. those which have no mainstream health involvement, safeguarding issue, longest time since last review etc. Strategic Plan developed regarding capacity issues - Report / Paper to CHC Board in April 2013 and Joint Managing Director meetings requesting 5 additional members of staff - CHC Board attended represented by each CCG - MI, Chief Finance Officer. Internal Audit undertook a CHC review, report issued in January 2013 with 'Limited Assurance' and 20 audit recommendations - tabled at LC CCG's Audit Committee in January 2013 - Progress monitored by CHC Management Board and Corporate Affairs Team. Monthly meetings with senior managers CCG/GEM Additional support identified from wider GEM team.	CHC Management Board to monitor backlog monthly (established in March 2013) Internal monitoring process for CHC. CHC Board reports / papers and minutes of meetings, including details of attendance. CHC CPM meetings monitoring trajectory monthly.	**4**	**12 (A)**	GEM CHC have undertaken a recruitment process to ensure that all posts are filled. This is an ongoing process to fill new vacancies. The CHC team are now sharing this information with the contract team on a regular basis. The GEM CHC contract performance team receives monthly information regarding overdue reviews to ensure that a backlog doesn't build up. GEM CHC to develop a mitigation plan with controls and assurance. This is now monitored on a monthly basis on East CCG PPAG register. Service improvement plan in place.	Sep-15
2.1	**3a, 3b, 3c and 3d**	**Spencer Gay (CFO)**	**Failure to maintain control of CCG financial position and deliver statutory duty to breakeven over the coming 5 year planning period.**	**4**	5 year plan developed March 2014. First draft uodated 15/16, 16/17 plan submitted to NHS E Nov 14. balanced financial plan in place for 2015/16.	Finance committee for review of plan and monitoring of performance Board for review of plan and monitoring of performance	**3**	**12 (A)**	Investigate oppurtunities to reduce risk through fixed contract values Review QIPP schemes for feasibility & monitor achievement Ensure consistancy of QIPP with BCF and BCT programmes Produce a refreshed 5 Year plan during Q2 of 2015/16.	Sep-15

2.2	**2c, 2d, 3a, 3b, 3c and 3d**	**Spencer Gay (CFO)**	**Poor financial control and opportunity for fraud on Continuing Healthcare.**	**3**	High cost placements are scrutinised by a panel CCG signatories have been identfied Internal Audit - recommendations to be implemented	Annual review of each patient Monthly CCG level reporting of spend Scrutiny of invoicing of deceased patients	**4**	**12 (A)** ⟷	Ensure all annual reviews are up to date and appropriately conducted - This is now on track Consider annual audit - requested it is covered by GEM Service Auditor report in 15/16 - Not undertaken in 14/15. Monitoring of GEM performance through KPIs and Milestones over the forthcoming three months. Expansion of CHC team agreed with specific milesytones and insentives to review packages and clear backlogs	Sep-15
2.3	**2a, 2b, 2c**	**Caroline Trevithick (CNQL)**	**Initial health assessments for looked after children are not being completed within the statutory time frame.**	**3**	Initial health assessments for looked after children are not being completed within the statutory time frame. (Statutory Guidance on Promoting the Health and Well-being of Looked After Children 2009) of 28 days. Therefore a health care plan is not available for the child/young person's first review of their foster care placement 28 days after entering care. To resolve this issue the following is required: • Timely notification from local authority social care departments to health • Adequate number of IHA Clinics provided by LPT Ensuring improved timescale for completion of IHA is a key priority for the Leicestershire and Rutland Local Safeguarding Children Board and has been highlighted by a recommendation from a current Child Serious Case Review. The issue has been highlighted by a Leicester City LSCB Ofsted Inspection. The importance of timely IHAs has also been acknowledged by the East Leicestershire and Rutland CCG and West Leicestershire CCG Performance and Quality Meetings. The 2014-2015 Key Performance Indicator target of 85% of Initial Health Assessments (IHA) to be completed by LPT paediatricians within 28 days of booking, was transferred from the LAC Service Level Agreement (SLA) to the Paediatric Medical Services Contract. This target has not been met for Quarter 3.	In February 2015 the CCG raised a Contract Query in relation to the underperformance of LPT to meet the required standards. The LPT has responded by increasing IHA Clinic availability from 1st March 2015 to include up to 70 IHA Clinic appointments a month. This increase in clinic availability will manage the backlog of IHA and enable timely assessments for all new appointments.	**4**	**12 (A)** ⟷	CT and JH will provide data that reflects the child's journey. This will support the Executive Nurses discussion with the Directors of Social Care about the issue of late notification of IHAs by the local authorities. Awaiting results of LPT Q4 performance monitoring by the CCG Contracts team.	Sep-15