AGENDA
A meeting of the Governing Body Part I

Date: 13 July 2017
Time: 10.00 am - 12.30 pm
Venue: Cantilever House, Eltham Road, London SE12 8RN
Chair: Dr Marc Rowland

Enquiries to: Lesley Aitken
Telephone: 020 7206 3360
Email: lesley.aitken@nhs.net

Voting Members
Dr Marc Rowland (Chair) Chair
Dr David Abraham Senior Clinical Director
Alison Browne Registered Nurse
Dr Charles Gostling Clinical Director
Anne Hooper Lay Member
Dr Sebastian Kalwij Clinical Director
Shelagh Kirkland Lay Member
Dr Faruk Majid Senior Clinical Director
Dr Jacqueline McLeod Clinical Director
Dr Angelika Razzaque Clinical Director
Tony Read Chief Financial Officer
Ray Warburton OBE (Vice-Chair) Lay Member
Martin Wilkinson Chief Officer

Non-Voting Members
Aileen Buckton Executive Director, Community Services, Lewisham Council
Dr Danny Ruta Public Health Director, Lewisham Council
Dr Simon Parton Local Medical Committee Chair
Dr Magna Aidoo Healthwatch Lewisham Representative

Quorum
The Governing Body will be deemed quorate when a minimum of 7 members, 4 of which must be Clinical Directors, one must be either the Chief Officer or Chief Financial Officer and two must be independent members (Lay Members, Secondary Care Doctor or Registered Nurse).

A member who is present at Governing Body meeting and is conflicted by a particular agenda item will not contribute to the quoracy of the meeting for the duration of that agenda item.

Chair: Dr Marc Rowland
Chief Officer Martin Wilkinson
Order of Business

Members of the public are requested to give any questions to the Governing Body in relation to matters not on the agenda before the meeting in writing to the Board Secretary. These will be responded to, at the discretion of the Chair, at the designated time shown on the agenda.

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<td>1. 10:00</td>
<td>Welcome and Introductions</td>
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<td>Chair</td>
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<td>2.</td>
<td>Apologies for absence</td>
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<td>3.</td>
<td>Declarations of Interest</td>
<td>1 - 2</td>
<td>Chair</td>
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<tr>
<td>4. 10:05</td>
<td>To agree the minutes of the last meeting</td>
<td>3 - 14</td>
<td>Chair</td>
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<td>5. 10:10</td>
<td>Matters Arising</td>
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<td>6. 10:15</td>
<td>Chair's Report</td>
<td>15 - 16</td>
<td>Dr Marc Rowland</td>
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<td>7. 10:20</td>
<td>Chief Officer's Report</td>
<td>17 - 22</td>
<td>Martin Wilkinson</td>
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<td>8. 10:25</td>
<td>Audit Committee Chair's Report</td>
<td>23 - 24</td>
<td>Ray Warburton</td>
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<td>9. 10:30</td>
<td>2016/17 Annual Accounts and Financial Performance</td>
<td>25 - 38</td>
<td>Tony Read</td>
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<td>10. 10:40</td>
<td>Finance and Investment Committee Chair's Report</td>
<td>39 - 40</td>
<td>Shelagh Kirkland</td>
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<tr>
<td>11. 10:45</td>
<td>Primary Care Commissioning Committee Chair's Report</td>
<td>41 - 44</td>
<td>Shelagh Kirkland</td>
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<td>12.</td>
<td>10:50</td>
<td><strong>Public Engagement and Equalities Chair's Report</strong>&lt;br&gt;To receive and note for information from the meeting held on 7 June 2017</td>
<td>45 - 46</td>
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<tr>
<td>13.</td>
<td>10:55</td>
<td><strong>Questions in relation to agenda items from members of the public</strong></td>
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<td><strong>INTEGRATED GOVERNANCE</strong></td>
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<tr>
<td>14.</td>
<td>11:00</td>
<td><strong>Integrated Governance Committee Chair's Report</strong>&lt;br&gt;To receive and note for information from the meetings held on 18 May and 22 June 2017</td>
<td>47 - 50</td>
</tr>
<tr>
<td>15.</td>
<td>11:15</td>
<td><strong>Board Assurance Framework (BAF)</strong>&lt;br&gt;To agree the current risk scores and the target risk scores for the risks contained in the BAF, to agree that there are adequate controls in place to mitigate the risks to the Corporate Objectives and where existing controls have not reduced the current risk score to the target risk score there are credible action plans.</td>
<td>51 - 78</td>
</tr>
<tr>
<td>16.</td>
<td>11:30</td>
<td><strong>Proposals for Over the Counter (OTC) Self Care and Cessation of Supply of Antimalarials on Prescription</strong>&lt;br&gt;To agree the proposed changes to prescribing OTC medicines and those of limited clinical value in Lewisham and proceed to consultation and proposed changes to existing guidance and proceed to consultation.</td>
<td>79 - 90</td>
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<tr>
<td></td>
<td></td>
<td><strong>STRATEGY AND PLANNING</strong></td>
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<tr>
<td>17.</td>
<td>11:45</td>
<td><strong>Strategy and Development Workshop Chair's Report</strong>&lt;br&gt;To receive and note for information from the meeting held on 1 June 2017</td>
<td>91 - 92</td>
</tr>
<tr>
<td>18.</td>
<td>11:50</td>
<td><strong>Urgent Care Review - New Cross Walk in Centre</strong>&lt;br&gt;To approve the recommendation to commence</td>
<td>93 - 96</td>
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<td>Time</td>
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<td>Details</td>
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<tr>
<td>12:05</td>
<td>Strengthening Lewisham's Governance and Partnership Arrangements for the Delivery of Community Based Care</td>
<td>To endorse the intended direction of travel, to note further work being undertaken to formalise governance and partnership arrangement and to note interim steps to adopt stronger and more collaborative working within existing arrangements.</td>
<td></td>
</tr>
<tr>
<td>12:20</td>
<td>Potential Audit and Risk Management Issues</td>
<td>To identify any issues which the Governing Body consider would benefit further scrutiny by the Audit Committee.</td>
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<tr>
<td>12:25</td>
<td>Any Other Business</td>
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<tr>
<td>12:25</td>
<td>Questions from members of the public</td>
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**FOR INFORMATION ONLY**

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<thead>
<tr>
<th>Time</th>
<th>Item</th>
<th>Details</th>
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<tbody>
<tr>
<td>24.</td>
<td>Approved Committee minutes for information only:</td>
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<tr>
<td></td>
<td>Audit Committee (April 2017)</td>
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<tr>
<td></td>
<td>Integrated Governance Committee (April 2017)</td>
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<td></td>
<td>Strategy and Development Workshop (April 2017)</td>
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<tr>
<td></td>
<td>Committee in Common (March 2017)</td>
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**Date of next meeting:** Thursday, 14 September 2017, 10.00 am

The Committee to agree that, if required, the public should be excluded from the meeting while the remaining business is under consideration, as publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted.
Managing Conflicts of Interest: Governing Body, committees, sub-committees and working groups

1. The chair of the Governing Body and chairs of committees, subcommittees and working groups will ensure that the relevant register of interest is reviewed at the beginning of every meeting, and updated as necessary.

2. The chair of the meeting has responsibility for deciding whether there is a conflict of interest and the appropriate course of corresponding action. In making such decisions, the chair may wish to consult the member of the governing body who has responsibility for issues relating to governance.

3. All decisions, and details of how any conflict of interest issue has been managed, should be recorded in the minutes of the meeting and published in the registers.

4. Where certain members of a decision-making body (be it the governing body, its committees or sub-committees, or a committee or sub-committee of the CCG) have a material interest, they should either be excluded from relevant parts of meetings, or join in the discussion but not participate in the decision-making itself (i.e., not have a vote).

5. In any meeting where an individual is aware of an interest, previously declared or otherwise, in relation to the scheduled or likely business of the meeting, the individual concerned will bring this to the attention of the chair, together with details of arrangements which have been confirmed by the governing body for the management of the conflict of interests or potential conflict of interests. Where no arrangements have been confirmed, the chair may require the individual to withdraw from the meeting or part of it. The new declaration should be made at the beginning of the meeting when the Register of Interests is reviewed and again at the beginning of the agenda item.

6. Where the chair of any meeting of the CCG, including committees, sub-committees, or the governing body, has a personal interest, previously declared or otherwise, in relation to the scheduled or likely business of the meeting, they must make a declaration and the deputy chair will act as chair for the relevant part of the meeting. Where arrangements have been confirmed with the governing body for the management of the conflict of interests or potential conflicts of interests in relation to the chair, the meeting must ensure these are followed. Where no arrangements have been confirmed, the deputy chair may require the chair to withdraw from the meeting or part of it. Where there is no deputy chair, the members of the meeting will select one.

7. Where significant numbers of members of the governing body, committees, sub committees and working groups are required to withdraw from a meeting or part of it, owing to the arrangements agreed by the Governing Body for the management of conflicts of interest or potential conflicts of interest, the remaining chair will determine whether or not the discussion can proceed.

8. In making this decision the chair will consider whether the meeting is quorate, in accordance with the number and balance of membership set out in the CCG’s standing orders or the relevant terms of reference. Where the meeting is not quorate, owing to the absence of certain members, the discussion will be deferred until such time as a quorum can be convened. Where a quorum cannot be convened from the membership of the governing body, committees, sub committees and working groups owing to the arrangements for managing conflicts of interest or potential conflicts of interest, the chair may invite on a temporary basis one or more of the following to make up the quorum so that the CCG can progress the item of business:

   a) an individual GP or a non-GP partner from a member practice who is not conflicted
   b) a member of the Lewisham Health and Wellbeing Board;
   c) If quorum cannot be achieved by a) or b) (above) a member of a governing body of another clinical commissioning group.

9. These arrangements will be recorded in the minutes.
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<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Start Date</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marc Rowland</td>
<td>Chair of the Governing Body</td>
<td>19/06/15</td>
<td>Partner of Jenner Practice, a GP practice in Deptford, London. Member of the London Clinical Commissioning Council. Small sum for GP research costs received by the practice annually. Variable, less than £5,000 over the past 5 years.</td>
</tr>
<tr>
<td>Aileen Buckton</td>
<td>Director of Adult Social Care</td>
<td>26/06/15</td>
<td>None</td>
</tr>
<tr>
<td>Danny Ruta</td>
<td>Director of Public Health, London Borough of Lewisham</td>
<td>18/06/15</td>
<td>Non-Exec Director Basketball Foundation. Member of the Institute of Medical Education at the London Southbank University. Has relative working for KPMG medical division.</td>
</tr>
<tr>
<td>David Abraham</td>
<td>Senior Clinical Director</td>
<td>18/06/15</td>
<td>GP Principal PMS Practice, Morden Hill Medical Practice. Wife is a practice nurse in Elm House Surgery, Beckenham. Member of IFR panel and is remunerated for one session a month.</td>
</tr>
<tr>
<td>Ray Warburton</td>
<td>Vice Chair</td>
<td>18/06/15</td>
<td>None</td>
</tr>
<tr>
<td>Faruk Majid</td>
<td>Senior Clinical Director</td>
<td>18/06/15</td>
<td>Partner Hilly Fields Practice. Director of Ray Warburton’s Perspectives Limited. Member of the NHS Equality and Diversity Council.</td>
</tr>
<tr>
<td>Jacqueline McLeod</td>
<td>Clinical Director</td>
<td>16/06/15</td>
<td>Salaried GP, The Vale Medical Centre, Forest Hill, SE23. GP Appraiser, NHS SE London, GP Triager Referral Support Scheme, BexleyHealth LTD.</td>
</tr>
<tr>
<td>Angelika Razzaque</td>
<td>Clinical Director</td>
<td>18/06/15</td>
<td>GP Partner, Queens Road Partnership. Director of husbands company - Adaptarose. Vice Chair of Executive Committee of Primary Care Dermatology Society.</td>
</tr>
<tr>
<td>Martin Wilkinson</td>
<td>Chief Officer</td>
<td>18/06/15</td>
<td>None</td>
</tr>
<tr>
<td>Tony Read</td>
<td>Chief Financial Officer</td>
<td>18/06/15</td>
<td>None</td>
</tr>
<tr>
<td>Simon Parton</td>
<td>Board Member LMC Rep</td>
<td>02/07/14</td>
<td>GP Partner and member of SELDOC - practices in Neighbourhood 3 were registered as limited company. Director, MMP Oncology LTD. LTD company set up to support partners private oncology work in SW London; Dr Marina Parton (Partner) Co-Director of MMP Oncology Ltd.</td>
</tr>
<tr>
<td>Alanson Browne</td>
<td>Registered Nurse</td>
<td>04/05/17</td>
<td>None</td>
</tr>
<tr>
<td>Shelagh Kirkland</td>
<td>Lay Member</td>
<td>04/05/17</td>
<td>Pure Leapfrog, Pure Leapfrog Bridge Finance Limited. Non Executive Director, Phoenix Futures, Non Executive Director, the Mulberry Centre.</td>
</tr>
<tr>
<td>Sebastian Kalwij</td>
<td>Clinical Director</td>
<td>05/08/15</td>
<td>GP, Amersham Vale Practice. Director, Dr iSeb Ltd.</td>
</tr>
<tr>
<td>Mark Hamilton</td>
<td>Secondary Care Doctor</td>
<td>02/04/16</td>
<td>None</td>
</tr>
<tr>
<td>Magna Aidoo</td>
<td>Healthwatch Representative</td>
<td>03/11/16</td>
<td>Trustee/Director Trustee of Healthwatch Bromley and Lewisham, Healthwatch. Member of DAFNE plus research collaborative. Have given educational presentations on behalf of pharmaceutical industry - Novo Nordisk, Lilly, MSD, Sanofi-Aventis, Takeda.</td>
</tr>
<tr>
<td>Hooper Anne</td>
<td>Lay Member</td>
<td>01/06/17</td>
<td>None</td>
</tr>
<tr>
<td>Charles Gostling</td>
<td>Clinical Director</td>
<td>08/10/15</td>
<td>GP Partner - Morden Hill Surgery. Member of DAFNE plus research collaborative. Member of the London Southbank University.</td>
</tr>
<tr>
<td>Mark Hamilton</td>
<td>Secondary Care Doctor</td>
<td>02/04/16</td>
<td>None</td>
</tr>
<tr>
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<td>02/04/16</td>
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<td>02/04/16</td>
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<td>Clinical Director</td>
<td>18/06/15</td>
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<tr>
<td>Mark Hamilton</td>
<td>Secondary Care Doctor</td>
<td>02/04/16</td>
<td>None</td>
</tr>
<tr>
<td>Magnus Aidoo</td>
<td>Healthwatch Representative</td>
<td>03/11/16</td>
<td>Trustee/Director Trustee of Healthwatch Bromley and Lewisham, Healthwatch.</td>
</tr>
<tr>
<td>Mark Hamilton</td>
<td>Secondary Care Doctor</td>
<td>02/04/16</td>
<td>None</td>
</tr>
<tr>
<td>Mark Hamilton</td>
<td>Secondary Care Doctor</td>
<td>02/04/16</td>
<td>None</td>
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Governing Body meeting

Minutes of the meeting of the Lewisham Clinical Commissioning Group (LCCG) Governing Body held on Thursday, 11 May 2017 at Cantilever House, London SE12 8RN

Dr Marc Rowland Chair, LCCG (Chair)
Dr David Abraham Senior Clinical Director, LCCG
Dr Magna Aidoo Representative, Healthwatch Lewisham
Ms Alison Browne Registered Nurse, LCCG
Ms Aileen Buckton Executive Director Community Services, LB Lewisham
Dr Charles Gostling Clinical Director, LCCG
Ms Anne Hooper Lay Member, LCCG
Dr Sebastian Kalwij Clinical Director, LCCG
Ms Shelagh Kirkland Lay Member, LCCG
Dr Jacqueline McLeod Clinical Director, LCCG
Dr Angelika Razzaque Clinical Director, LCCG
Mr Tony Read Chief Financial Officer, LCCG
Ms Gwenda Scott Public Health Strategist (Dietician) for Public Health, LBL
Mr Ray Warburton OBE Lay Deputy Chair, LCCG
Mr Martin Wilkinson Chief Officer, LCCG

In Attendance

From Lewisham CCG;

Ms Lesley Aitken Board Secretary (notes), LCCG
Mr Russell Cartwright Head of Communications and Engagement, LCCG
Ms Alice Frenken PA to Corporate, Nursing and Quality and Commissioning and Primary Care Directors
Mr Graham Hewett Associate Director of Quality, LCCG
Ms Deborah Iles PA to Chair, Chief Officer and Chief Financial Officer, LCCG
Mr Charles Malcolm-Smith Associate Director, Strategy and Organisational Development, LCCG
Ms Susanna Masters Corporate Director, LCCG
Ms Victoria Medhurst Associate Director, Integrated Governance, LCCG
Ms Hannah Reeves Corporate Services Administration Manager, LCCG
Ms Hannah Whitehead Administrative Assistant, LCCG

There were 5 members of the public present for the meeting.

Apologies

Dr Faruk Majid Senior Clinical Director, LCCG
Dr Simon Parton LMC Chair
Dr Danny Ruta Public Health Director, LB Lewisham
LEW 17/50  Welcome and Announcements

Dr Rowland welcomed all to the Governing Body meeting in particular the newly appointed Governing Body members, Lay Members Ms Shelagh Kirkland and Ms Anne Hooper and Registered Nurse member Ms Alison Browne. Ms Kirkland introduced herself and explained that she was originally started with the CCG as a member of the Audit Committee from early 2016; she is a qualified accountant and is employed by Investec. Ms Hooper is a Lewisham resident, has been a Non-Executive Director with a voluntary organisation, and was Chair of the Healthwatch Croydon and Chief Executive of Trinity Hospice. She has extensive knowledge of Patient and Public Engagement. Ms Browne is also the CCG’s Director of Nursing and Quality and has been a nurse for 42 years.

Dr Rowland wished to record the Governing Body’s appreciation to Dr Mark Hamilton for his contribution to the work of the CCG and that he would be writing to Dr Hamilton to convey the CCG’s thanks. Dr Hamilton had stood down as the CCG’s Secondary Care Doctor due to a new role as a Medical Director.

LEW 17/51  Declarations of Interest

There were no new declarations of interest given at this point of the meeting.

LEW 17/52  Previous Minutes

The minutes of the Governing Body meeting held on 8 March 2017 were taken as a true record subject to the following:

Dr Rowland stated that at the last meeting of the Governing Body there was an oversight as the meeting was not quorate, which should have been noted and then suggested a way of dealing with it.

While it was useful to have the written comments of Dr Mark Hamilton, we remained inquorate without his actual presence. Despite the oversight, at the meeting, there was a good discussion among Governing Body members, in public, on a range of issues, to which Dr Hamilton’s written comments contributed. Today it was not intended to revisit those discussions, and related decisions, as overall there was unanimity and momentum needed to be retained.

Going forward, lessons could be learned from what happened. First and foremost, quoracy should be affirmed at the start of each meeting, and open and transparent decisions made on how to proceed if throughout we are, or during, a meeting we become, inquorate. Second, in the rare likelihood of a vote being required at any point in our meetings, then that vote can only be valid if we are quorate or we have made suitable arrangements to deal with a lack of quoracy.

The Governing Body members were asked if they agreed to what has been proposed with regard to both the last meeting and to future meetings of the Governing Body. The Governing Body agreed with these proposals.

There was now a full complement of Lay Members, and progress was being made in our recruitment of Dr Hamilton’s successor, it was anticipated that quoracy would not be challenged for the foreseeable future.
The following amendment was made to the minutes:

17/30 Dr McLeod asked what was the link between the Better Care Fund (BCF) and Primary Care; Mr Wilkinson said that the BCF was supporting Primary Care issues.

LEW 17/53 Action Log and Matters Arising

It was explained that the actions shown as amber are those which officers have proposed from their point of view were addressed and therefore closed. The proposed status of the action can be challenged by Governing Body members at the meeting.

Updates were given on the open actions and the log was reviewed and revised.

17/36: regarding the Continuing Care review process into accessing care, Mr Wilkinson responded that work was progressing across South East London on checking processes. The due date on the action would be updated. This action would remain open.

Regarding the matter of public attendance at the Annual General Meeting (AGM), Mr Warburton reminded the Governing Body members that they had been requested to send any ideas on promoting and improving attendance at the AGM, the Primary Care Commissioning Committee and Governing Body meetings, which were all held in public, to Mr Russell Cartwright, Head of Communications and Engagement.

LEW 17/54 Chair’s Report

Dr Rowland highlighted that Chair’s action taken to approve the Terms of Reference for the Primary Care Commissioning Committee (PCCC).

Dr Rowland highlighted that the Board to Board with Lewisham and Greenwich Trust (LGT) was a productive meeting with discussions on aligning objectives and on working closer together.

Mr Warburton asked whether the changing of the current arrangements of 2 year terms to Governing Body GP members to 3 year terms should have been referred to the Remuneration Committee. Mr Malcolm-Smith responded that this was not a final decision; the proposal had been taken to the neighbourhood meetings of the CCG and would be subject to a further Membership Forum discussion and a Constitution change. The matter would be considered by the Remuneration Committee in June with a comparison across London. Mr Malcolm-Smith confirmed that the three year terms proposal was to be a permanent change.

The Governing Body NOTED the report and NOTED the Chair’s action taken on approving the Primary Care Commissioning Committee (PCCC) Terms of Reference

LEW 17/55 Chief Officer’s Report

Mr Wilkinson gave the report and highlighted the following:

- The engagement event for Lewisham residents to hear more about the local Sustainability and Transformation Plan (STP) direct from NHS leaders would be held on the evening of 29 June 2017. A ‘save the date’ message would be sent to stakeholders.
• A&E services over Easter and the bank holiday weekends locally had coped well with the additional demand, though it was acknowledged that there were still challenges in the urgent care system.
• Annual Stakeholder Survey, overall the outcomes of the survey had showed that the CCG had a positive relationship with the membership and those in local practice.

The Governing Body NOTED the report

LEW 17/56 Audit Committee Chair Report

Mr Warburton summarised the highlights from the report from the Audit Committee meetings held on 28 March and 25 April 2017.

• The Committee had given comments on the draft Annual Report before, during and after the meeting and on behalf of the Governing Body approved the draft Annual Report prior to submission to NHSE and the External Auditor, Grant Thornton. All the strict deadlines had been met.
• The Committee gave comments on the draft unaudited Annual Accounts before and during the meeting and on behalf of the Governing Body approved them for submission to NHSE and the External Auditor.
• The Committee approved the Accounting Policies for the 2016/17 Annual Report and Accounts.
• Three out of the four final reviews conducted by the CCG’s Internal Auditor, KPMG achieved a rating of ‘significant assurance with minor improvements’; the fourth on Information Governance achieved a ‘significant assurance’. There had been no major recommendations made.
• A draft Head of Internal Audit Opinion report had been given an ‘overall significant assurance with minor improvement opportunities’, which was a good achievement.
• The draft plans of the CCG’s assurance providers, Local Counter Fraud Service, Local Security Management Specialist and Internal Audit (RSM) were received.

Mr Wilkinson thanked, on behalf of the Governing Body, Mr Warburton and Audit Committee members for all their work on the Annual Report and Accounts.

The Governing Body NOTED the report

LEW 17/57 Primary Care Commissioning Committee (PCCC) Chair’s Report

Ms Kirkland, as Chair of the PCCC gave the report from the first meeting of the Committee which had been held on 25 April 2017. She reiterated that the Terms of Reference had been agreed by Chair’s action. The PMS contract reviews negotiations had been concluded with the Local Medical Committee and the CCG was now in the position to complete the assurance template. Lewisham were the first CCG to reach this position. An extra meeting would be held this month to approve the NHSE PMS review assurance template.

Mr Warburton highlighted that the PCCC was a meeting held in public but that no members of the public had attended. He reiterated that these meetings needed to be promoted through engagement processes. Dr McLeod responded that the AGM was now part of the Membership Engagement in Clinical Commissioning Local Improvement Scheme brief, so we should also expect greater GP practice member attendance this year.
The Governing Body NOTED the report

LEW 17/59  **Questions for Members of the Public**

Questions were taken from members of the public at this stage of the meeting on items heard to this point in the agenda.

Q: Was not aware of the dates of the PCCC meeting, could a forward planning list of these meetings be produced.

A. Ms Kirkland said that the dates for the PCCC meetings were now on the website. Mr Wilkinson added that the dates would be advertised in public notices in the local press.

LEW 17/60  **Integrated Governance Committee (IGC)**

Mr Read reported that two meetings of the IGC had been held on 23 March and 27 April. He highlighted the following:

**Quality**
- The CQC reviews and quality assurance letters relating to aspects of care at LGT had been noted. A report back from CQRG by June had been requested.

**Performance**
- The A&E 4 hour standard and Cancer Waiting Times, relating to GP Referral to Treatment within 62 days had not met their NHS Performance Indicator; the IGC had not been assured on performance, work was ongoing with partners across the system on improvement plans. The IGC meeting had been brought forward in May to hold a deep dive to address the concerns.
- On a positive note, the Cancer two week waits target and the Early Intervention in Psychosis and Improving Access to Psychological Therapies (IAPT) standard, including the completion target had been met.

**Finance**
- The draft unaudited accounts had been submitted to NHSE and were now undergoing the statutory audit.
- Subject to audit; there was a targeted cumulative surplus of £7.6m at year end with an actual of £10.03m, the difference was the release of the 1% System Risk Reserve. All financial targets had been met.

**Information Governance**
- The Information Toolkit scoring for 2016/17 was presented and the IGC were assured that the evidence underpinning the Toolkit justified the preliminary score of 87% which was an improvement from 2015/16 of 82%.

**QIPP**
- There was scrutiny on the QIPP plans which had increased from an efficiency saving of last year of £7m to £14m this year. There was a plan for 2017/18 with a risk of £2m. There were plans being developed for 2018/19. IGC were looking at this detail each month.
Dr Aidoo asked if there was data for March regarding IAPT for patients completing treatment. Mr Read responded that the data was not yet available; however there were no concerns that the target would not be achieved as there was an upward trend of performance to hit the target.

Mr Warburton was pleased to see that the concerns and challenges over achieving the Constitutional Standards were acknowledged. In response to Mr Warburton’s comments on the finances in year and the risk discussion at the March Governing Body where the budget had been agreed, subject to risk mitigation, Mr Read responded that the budget had been agreed with work to reduce the financial risk. Deloitte had looked in detail at the 2017/18 QIPP including the confidence level in the deliverability of schemes and areas which the CCG could go faster on. Their final report had now been received. There had been discussions held with the Clinical Directors to bring forward plans. The SEL CCGs would look at de-risking the financial plans. All further QIPP details would be considered at IGC.

Mr Read added that the level of risk in the financial plan had not yet been de-risked; the level of reserves was lower than last year and higher than the financial risk.

Mr Warburton said that the £14m QIPP efficiencies was ambitious with too many schemes, was this manageable? Mr Read responded that for the 2017/18 QIPP process it would have been good to have fewer schemes, delivering larger benefits but that there was not time this year to replace the planned QIPP. This would be looked at for 2018/19. Mr Warburton added that Ms Braithwaite, Commissioning and Primary Care Director and her team, would be required to spend a disproportionate amount of time managing all the schemes.

Dr Gostling explained that for 2018/19 there was an opportunity that RightCare could be used to design and streamline QIPP to deliver objectives.

Mr Read added that the Governing Body needed to be clear on what was agreed at the March meeting for the budget including the QIPP plan. The 2017/18 QIPP plan has started to deliver and was embedded within provider contracts.

Mr Wilkinson stated that the A&E and Cancer challenges were in the Corporate Objectives and that the Clinical Directors and Management Team were now meeting more regularly to look at the QIPP plans. The intense work would be streamlined with a review of resources required and ways of working to deliver the QIPP, this would be taken to IGC.

Dr McLeod, referring to the hospital discharges before 1pm to enable patient flow, said that the Queen Elizabeth Hospital (QEH) percentage had not moved much in a year. Mr Wilkinson agreed and said that the learning would be shared between hospitals; this would be reflected in the performance plans.

Ms Buckton added that the six Local Authority Directors across the STP area were looking at details for the 1pm discharge, checking on processes. There was good practice to be shared. Ms Aidoo informed that Healthwatch were undergoing work on discharge processes as well.

The Governing Body NOTED the report

LEW 17/61 Corporate Objectives and Board Assurance Framework (BAF)
Mr Wilkinson presented a report which set out the further work undertaken to confirm the Corporate Objectives immediate priorities to be delivered in the first six months of 2017/18 and to develop the Board Assurance Framework (BAF) for 2017/18. These were:

1. Whole System Accident and Emergency (A&E) delivery at LGT – there was greater scrutiny on the plans to achieve a reduction in attendances and admissions, supporting discharge and simplifying community services offer.
2. Contract Management – to have a tighter grip on contracts.
3. Delivering the 2017/18 QIPP programme – to reduce the risk of achieving the £14m efficiencies, working with SEL colleagues.
4. Planning QIPP Programme for 2018/19 – preparation work to be undertaken.

Mr Warburton, referring to the priorities asked what was being done differently, in relation to contract grip, to address issues. Also that Health and Social Care workforce issues did not readily surface; assurance was needed that these areas would be worked upon during 2017/18.

Mr Wilkinson responded that work was being undertaken on how all contracts were resourced to ensure contract grip. The following was highlighted:

- For acute services, neighbouring CCGs were working together on strengthening approaches.
- For Community Health Services further conversations were being held including the requesting regular monitoring reports on the community dashboard.
- For mental health there was a review across boroughs on how to lever greater change with SLaM.
- Also there had been an improvement in ways of working both clinically and managerially. An example was the Board to Board with LGT.
- For integration work; the Health and Care Partners were laying the foundation for a different system, the Accountable Care System, being worked through as a whole system where the contractual relationship between strategic commissioners and providers would be different.

Dr Rowland stated that the BAF included Workforce and he added that he was chairing the London Clinical Cabinet, which was discussing Practice Nursing where Lewisham had been highlighted as doing good work. This would be developed on a Pan London basis.

Ms Browne explained that Lewisham had the highest number of student nurses in London; she recognised that the student nurses should be encouraged to undertake their community service placements in Lewisham. The grip had been lost on how to commission training placements.

Ms Buckton added there was a review of the development and sustainability of markets across London. The streamlining of workforces required coordination and to sit within the training framework, including apprenticeship levies.

Dr Abraham described the work of Clinical Cabinets for Greenwich, Bexley, Lewisham and LGT. The Terms of Reference needed redefining with their objectives being aligned with those of the CCG.

Mr Wilkinson acknowledged that Governing Body seminar time was needed to discuss contract grip and how it was being improved in 2017/18.

Dr McLeod stated that IT was a key enabler, but where was the assurance that this would be delivered. Dr Gostling added that Connect Care had been delayed and deferred, but that there was
proactive work on the digital pathway. It was recognised that the development of IT was not an immediate priority unless it was instrumental in delivering the priority workstreams.

Mr Wilkinson agreed that further work was needed to simplify the language used on the BAF and particularly on the risk appetite matrix.

Item 2.3 Board Assurance table provided a summary of the ‘High and ‘Very High’ risks to achieving the Corporate Objectives which included workforce. Dr Gostling said that workforce shortfalls were across SEL and asked if therefore the risk level and target score were too low. Mr Wilkinson responded that there were two aspects of the risk, workforce capacity and capability both immediate and going forward. He agreed that the scores would be reconsidered.

Mr Warburton added that a grip was needed on workforce issues. The approach on table 2 was good, but he believed that the target scores were too ambitious. The QIPP needed linkage and conductivity across SEL, with the Governing Body having confidence of better outcomes of LGT moving from acute to community care provision through contracts. Engagement with the population was required to discuss about what services were required. Ms Browne said that the grip on contracts for workforce was missing, acknowledging that the CCG does not employ the staff. The shift to community services was not explicit in contracts.

Mr Read agreed with the comments that target scores but did not understand the description of actions and the context of the impact changes. Referring to the Corporate Objectives for 2017/18 Quarters 1-2, Mr Read asked if there was there was sufficient sight on actions and work to date; this would link with the risks assessments. Mr Wilkinson said that the target scores would be looked at again at IGC along with reassessing the original score for workforce. There was acknowledgement that there was more work to do on actions and gaps on the actions, these would be reviewed.

Mr Warburton added that the Governing Body needed to demonstrate more confidence and resolve in what the CCG was doing was in the best interests of Lewisham residents.

The Governing Body NOTED the immediate Corporate Objectives priority areas which are required to be delivered by the CCG during April-September 2017, AGREED its risk appetite for each of the Corporate Objective areas for April-September 2017, AGREED that the Board Assurance Framework included the appropriate high/very high level risks to achieving the Corporate Objectives and; DID NOT AGREE the assessment of the Original risk and Target risk scores for each of the risks for the beginning of 2017/18 with the Governing Body asking for the original risk and target risks to be reviewed, particularly for Workforce, to ensure that the identified actions would achieve the target risk score.

ACTION: Martin Wilkinson

LEW 17/62 Delegated Financial Authority for Level III Primary Care Commissioning

Mr Read gave the report explaining that under delegated commissioning for primary care the CCG commenced payments for GP contracts in April 2017. This required authorisations to be in place for March 2017. These payments were made at short notice by the Chief Financial Officer in order to ensure that all Lewisham practices received contract payments in April 2017. The limits were reported to the Audit Committee at its meeting in March 2017. These limits can be changed by the CCG. There were two amendments to be made; The Director of Quality and Chief Nurse should be Director of Nursing and Quality and; the title of Director of Integrated Commissioning should be Director of Commissioning and Primary Care.
It was explained that the £15m limit for the Chief Officer was not likely to be reached; the overall budget was £40m and that payments were made on a monthly basis.

The Governing Body NOTED the proposed amendments and APPROVED the approval limits set for authorisation of GP payments from April 2017.

LEW 17/63  Strategy and Development Workshop Chair’s Report

Dr Abraham provided the report from the Strategy and Development Workshop held on 6 April 2017. The aim of the workshop had been to review the key strategic change areas for priorities for 2017/18 which included reflections on the Board to Board with LGT. Outcome from the Board to Board was a commitment to develop stronger clinical dialogue and that the reality of delivering community based care needed to be better articulated.

The Governing Body NOTED the report

LEW 17/64  Potential Audit and Risk Management Issues

There were no particular issues, though it was acknowledged that deep dives into BAF areas would be held.

LEW 17/65  Any Other Business

There was no any other business at this stage of the meeting.

LEW 17/66  Questions from Members of the Public

Q: There had been no direct reference to Simon Steven’s reports on the performance of local providers not meeting standards and the impact on risks.

A: Dr Rowland agreed that there was no particular reference made. Mr Wilkinson added that there have been discussions at the March Governing Body held around the Operating Plan on Referral to Treatment concerns, particularly at King’s. The Improvement Plan’s purpose was to monitor our position and scrutinise these areas where the CCG was not meeting the NHS Constitutional Standards.

Q: Referring to the improvement in premises discussed at the March Governing Body meeting, was there any funds available to improve existing premises, including lifts, as this would be an advantage to older residents to be able to stay in their own practices. Were there any grants available?

A: Dr Rowland said that bids had gone to the Estates and Technology Transformation Fund (ETTF), however many practices were in converted house which were not fit for modern practices. Mr Read added that there were areas of funding available; IT connectivity and delivering high quality support in buildings. Improvement grants were held by NHSE which GP practices could bid against to improve their premises; but that this was of low value.

Q: Regarding the £40m for GP contracts, is this more than previous years?
A: The overall funding for GP contracts had been increased for inflation compared to last year also there was more funding for GP services to extend access to primary care such as the 8am – 8pm service which would be located at the hospital site. It was noted that the budget from NHSE was not yet fully finalised.

Q: Regarding the Elective Orthopaedic presentation from OHSEL, is there an update?

A: Dr Abraham responded that there was more work to do incorporating comments on modelling and the option of three sites against two as had been agreed at the last Committee in Common meeting. Mr Wilkinson confirmed that work was continuing; a date for the next Committee in Common was to be set. The Orthopaedic group would continue after purdah.

LEW 17/67 Reports Taken for Information

67.1 Changes to NHS Bexley, NHS Greenwich and NHS Lewisham CCGs Clinical Quality Review Group with Lewisham and Greenwich NHS Trust

67.2 The approved minutes from the following meetings were taken for information:
- Integrated Governance Committee (February and March 2017)
- Strategy and Development Committee (February 2017)
- Public Engagement and Equalities Committee (February 2017)
- Committee in Common (March 2017)
- Health and Wellbeing Board (December 2016)

LEW 17/68 Date of Next Meeting

The next meeting of the Governing Body would be held on Thursday 13 July 2017 at Cantilever House, Eltham Road, London SE12 8RN.
<table>
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<tr>
<th>Minute Ref</th>
<th>Action</th>
<th>Owner</th>
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<th>Due Date</th>
<th>Status</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>17/36</td>
<td>Once available, the Continuing Care review process into accessing care would be brought back to the Governing Body</td>
<td>Aileen Buckton/Dee Carlin</td>
<td>March updated May 2017</td>
<td>September 2017</td>
<td>Open</td>
<td>Work progressing across SE London on checking processes. The action date has been updated.</td>
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**ACTIONS CLOSED AT MAY 2017 MEETING**

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<tr>
<th>Minute Ref</th>
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<tbody>
<tr>
<td>17/40</td>
<td>Paper to the Health and Wellbeing Board on Community Connections would be circulated to the Governing Body members</td>
<td>Martin Wilkinson</td>
<td>March 2017</td>
<td></td>
<td>Closed</td>
<td>Action closed – report circulated on 27 April 2017</td>
</tr>
<tr>
<td>17/44</td>
<td>Delegated Commissioning – the detailed delegated framework would be circulated outside of the meeting to Governing Body members</td>
<td>Martin Wilkinson/Tony Read</td>
<td>March 2017</td>
<td></td>
<td>Closed</td>
<td>Covered by Item 6 on the Governing Body agenda – Chair's action for the approval of the Terms of Reference for the Primary Care Commissioning Committee.</td>
</tr>
</tbody>
</table>
Lewisham is a very refreshing place to be. We have a good balance between optimism and pragmatism that is not common. These are not easy times and we have to ensure that money for Lewisham residents is spent as effectively as possible, but we also have great opportunities to work across organisations in health and with social care to give more joined up services that we know our residents want.

There are changes happening in some ways that we work commissioning across SEL as those of you, just over 100, will have heard at the public meeting at the Civic Centre last week. The feedback from the meeting was very helpful and I appreciate the energy and passion and robustness that everybody puts into it!

You may be aware that the Chief Executive of Lewisham and Greenwich Trust, Tim Higginson, is leaving next March after 10 years dedicated work for Lewisham Hospital and then helping join with Greenwich to make the Lewisham and Greenwich Trust. He has given his all for Lewisham and will be difficult to replace. They are also looking to appoint a new Chair, who should be announced in the near future.

We are developing even closer clinical working relationships with the hospital and the newly formed GP Federation – One Health Lewisham, South London and Maudsley. This will help improve the way we work for our population. In order to learn about how effective what we do is, we are also starting to work with innovative IT solutions to support clinical practice transformation and work on for the best population health we can overall, rather than have independent pockets of excellence. This system will take data from all the systems we have now and present it in a way that we can easily work with to identify conditions, how and when they occur, where the go to with them and allow us to improve effective treatments and see inequalities more easily and quickly. It is working in other parts of the country and beginning to deliver change there although, as with all IT systems, it will take some time to show real benefits.

We have set up Lewisham Primary Care Academy and some other work streams to help practices look at how they work and develop way of working that have improved clinical care, increased patient satisfaction on feedback and improved job satisfaction. It is just starting but there is a lot of enthusiasm and I look forward to seeing this reflected in feedback from everybody.

On 28th June we held a very useful board to board meeting with our Governing Body counterparts in Greenwich CCG as we are jointly the main commissioners of LGT. We took this opportunity to share our approaches to developing community based care and local care networks, and looked specifically at Greenwich’s experience of redesigning the pathway for frail, elderly people. We found many areas in common with opportunities for closer working to pursue our shared strategic priorities, and we agreed that possible changes to the arrangements for acute commissioning would be an opportunity to strengthen clinical dialogue and to work more closely with our main acute provider and other CCGs.

**Marc Rowland**

**July 2017**
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Chief Officer’s Report  
Governing Body July 2017

1. South East London Commissioning Review

The first phase of the review into the collaborative working arrangements amongst the six south east London CCGs completed in early June. This looked at 55 functions of the CCGs, with 29 included for an in depth review through workshops with representatives to identify the optimum levels of responsibility and deployment. A workshop with members of the CCGs’ governing bodies looked at the definitions of the levels of commissioning and the evaluation criteria that would be applied to any proposals. The outcomes of this phase include the identification of the highest priority functions for most immediate review: CCG leadership, strategic finance and financial management leadership, acute commissioning and contracting, and the Sustainability & Transformation Plan (STP) programme management office and leadership. These further reviews are due to be completed by September 2017, with the review of other areas to be finalised by November.

2. Sustainability and Transformation Plan (STP update)

Delivery Plans
The Sustainability and Transformation Plan (STP) is submitting delivery plans for 10 national programmes:
- Urgent and emergency care
- Cancer
- Primary care
- Mental health
- Transforming care
- Diabetes
- Maternity
- Elective care
- Prevention
- Finance

Financial Strategy

Work is also being undertaken to review and improve financial modelling that will ensure alignment with local authority positions, better risk assessment, and revised delivery plans.

Review of Specialist Services

This review is being carried out with NHS England and with south west London to look at acute specialised services across south London, the majority of which are
provided by three providers (the Guy’s and St Thomas’s, King's College Hospital, and St George’s University Hospital NHS Foundation Trusts). The review plan includes paediatric, neurosciences, cancer, and cardiac and renal specialised services.

**Elective Orthopaedic Services**

Work is also being undertaken by COs and CCG chairs to consider the next steps for the provision for elective orthopaedic inpatient care in south east London.

Providers are being supported to develop a proposal for a three site model and to further understand the financial and other impacts of going forward with either the three- or the two-site model. This work is still underway. At the same time, there is a continued focus on developing a network approach across south east London in line with recommendations by Professor Tim Briggs, Getting it right first time, to improve clinical quality and efficiency for orthopaedic patients.

There are a number of issues that need to be addressed to make sure that everyone in south east London has access to the best services, and in a way that is sustainable for the NHS in the future:

- We have some excellent services but the standard of care isn't the same for every patient
- Surgery is cancelled too often and some patients wait too long for their procedure, which affects their experience
- Demand is increasing so we need to find a way to care for a lot more people in the future than we do today
- The money available to the NHS is limited so we must find a cost effective way of providing these services

**Public Engagement**

As part of a wider programme of engagement on the Sustainability and Transformation Plan (STP), a public event was held in the Lewisham Civic Suite on Thursday 29. With market stalls and a Q&A session, the event raised awareness about the STP, demystifies some of the common perceptions about it and explains its history and journey to date and provided an opportunity to seek feedback on key areas under development.

3. **Capped Expenditure Process (CEP)**

South East London is part of NHS England’s capped expenditure process. The purpose of the capped expenditure process is to ensure NHS organisations meet the financial targets set by their regulators (control totals) in 2017/18. Whilst individual organisations remain responsible for their finances, and decisions on this are for CCG governing bodies and trust boards, there is a requirement that all NHS organisations in South east London collectively live within their financial means. The CCG is working with partner NHS organisations in South east London to explore ways in which additional financial efficiencies and savings can be delivered in 2017/18, over and above the CCG’s plans submitted in March 2017. Inevitably this
will include consideration of difficult choices. We are following a three stage CEP process:

1. Ensuring all organisations are making of their individual financial positions;
2. Ensuring contracts are aligned between providers and commissioners;
3. Ensuring south east London collaborative efforts to increase productivity are taken.

Our CEP submission to NHS England reflects our three-stage approach and builds on the work we have been doing to improve clinical pathways and improve productivity through working together. There are no proposals to close clinical departments in whole or part, or to reduce much-needed patient services. As proposals develop they will be taken through our usual patient engagement and design processes as required.

The major STP projects that we are working on include:

**Clinical improvement**: These projects are about changing how care is provided. This includes reducing A&E attendances, reducing the length of time people need to stay in hospital, diagnosing illness at an earlier stage, providing more care in community settings and focusing on preventing poor health.

**Hospital efficiency**: This is about sharing more ‘back office functions’. This includes things like collaborating on procurement to make the most of the collective buying power of the NHS, sharing administrative and clinical support services, and reducing the use of agency workers.

In addition the CEP will explore further areas to improve clinical effectiveness and financial efficiency using benchmarking indicators from Rightcare, on medicines management and prescribing, and long term care arrangements.

4. **Better Care Fund**

During 2016/17, the BCF supported the development of Prevention and Early Intervention tools, the delivery of Community Based Care including the development of Neighbourhood Community Teams and the Neighbourhood Care Networks and the redesign of services to deliver Enhanced Care and Support. A full report on the 2016/17 Better Care Fund went to the **July Health and Wellbeing Board**.

NHS England, the Department of Health and Department for Communities and Local Government published the **Integration and BCF planning requirements for 2017-19** on 4 July. Key changes since 2016-17 include:

- A requirement for plans to be developed for the two-year period 2017-2019, rather than a single year; and
- The number of national conditions which local areas will need to meet through the planning process in order to access the funding has been reduced from eight to four.

The four national conditions require:
i. That a BCF Plan, including at least the minimum contribution to the pooled fund specified in the BCF allocations, must be signed off by the HWB, and by the constituent LAs and CCGs;

ii. A demonstration of how the area will maintain in real terms the level of spending on social care services from the CCG minimum contribution to the fund in line with inflation;

iii. That a specific proportion of the area’s allocation is invested in NHS-commissioned out-of-hospital services, or retained pending release as part of a local risk sharing agreement; and

iv. All areas to implement the High Impact Change Model for Managing Transfer of Care to support system-wide improvements in transfers of care.

In addition, local authorities now benefit from the additional funding for social care announced in the Spring Budget 2017. This money is included in the Improved Better Care Fund grant to local authorities and will be included in local BCF pooled funding and plans. This funding was provided for the purposes of:

- Meeting adult social care needs;
- Reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready; and
- Ensuring that the local social care provider market is supported.

The national metrics for measuring progress of integration through the BCF will continue as they were set out for 2016-17, these are:

a) Non-elective admissions (General and Acute);
b) Admissions to residential and care homes;
c) Effectiveness of reablement; and
d) Delayed transfers of care;

The timetable for assurance and approval of BCF plans requires the plan to be submitted by 11 September 2017. As in 2016/17 the BCF Plan is being developed by Lewisham Council and Lewisham CCG. The BCF Plan 2017-19 will be an evolution of the 2016/17 Plan and will include a description of how the national conditions will be met, the alignment of the plan with Lewisham’s approach to integration of health and social care, a scheme level spending plan and national metric plans.

5. Market Position Statement Update

NHS Lewisham and London Borough of Lewisham (Adult Social Care) have jointly produced our first market position statement (MPS) as noted in the actions of Risk 12 with the 2016/17 BAF (January 2017).

The MPS is a ‘dynamic’ document, containing demand and supply information in the context of Lewisham’s changing demographics and current population needs. Aiming to stimulate a responsive and resilient mixed market of voluntary sector, public and private sector support and care, the MPS offers insights to providers & citizens about the opportunities to deliver innovative, sustainable and community-based services, for different population groups in Lewisham.
The MPS

- Gives clear messages to provider organisations, service users and their communities about how commissioning will be done, with emphasis on principles of personalised and co-produced services that are outcome-focused & delivered collaboratively where necessary;

- Makes clear statements about what the priorities will be for care, and why this matters;

- Gives information about available resources (i.e. financial and non-financial assets available across the health & care system)

The MPS content was developed through survey and focus group & telephone interview engagement with multi-sector providers, officers, councillors and members of the public (November 2016 to January 2017). The final version of the MPS was approved through CCG and Council senior management groups (May/June 2017) and is posted on partner websites. Please see Lewisham MPS (CCG site).

Martin Wilkinson
7 July 2017
Governing Body meeting on 13 July 2017

Report from the Chair of the Audit Committee

Date of Meeting reported: 25 May 2017

Author: Ray Warburton, Chair of the Audit Committee

Main issues discussed

- Service Auditor Reports for the Commissioning Support Unit and the NHS ESR System
- The Head of Internal Audit Opinion for 2016/17
- The audited Annual Report for 2016/17
- The audited Annual Accounts for 2016/17
- External Audit’s Audit Finding Report for 2016/17 and Management’s Letter of Representation
- Internal Audit’s Progress Report for work carried out from 1 April 2017
- Recent IT cyber attacks

Key achievements

The Committee received the Service Auditor Reports. It was noted that an issue for Lewisham CCG had been dealt with effectively. KPMG (the CCG’s Internal Auditors for 2016/17) confirmed that their Head of Internal Audit Opinion would not change as a result.

KPMG confirmed that their Head of Internal Audit Opinion for 2016/17, based on their own reviews and the Service Auditor Reports, remained one of ‘significant with minor improvements’ assurance. This opinion refers to the overall adequacy and effectiveness of the CCG’s framework of governance, risk management and control.

The Committee noted that its previous comments on the draft Annual Report and Annual Accounts, including comments made very recently, had been, by and large, taken into account.

Grant Thornton the CCG’s External Auditors (for 2016/17) gave an unqualified opinion in respect of the both the Accounts and the Value for Money (VfM) Conclusion, as well as an unqualified Regularity Opinion. As a result of their work a minimal number of amendments had been made to the draft unaudited Accounts. Grant Thornton reported that a control issue regarding the filing of contracts was being dealt with appropriately.

On behalf of the Governing Body, and based on the reports of KPMG and Grant Thornton, the Audit Committee approved the Annual Report, the Annual Governance Statement and Annual Accounts for submission to NHS England, in good time, by 31 May 2017.

The Audit Committee agreed that the chair of the Audit Committee and the Chief Financial Officer should, on behalf of the Governing Body, sign and deliver the Letter
of Representation to Grant Thornton as required. The letter confirmed that the accounts are fair and true, and prepared in accordance with appropriate accounting policies.

The Audit Committee heard a progress report from RSM (the CCG’s Internal Auditors for 2017/18 and beyond) and was pleased to hear that the handover from KPMG had been smooth.

**Key challenges addressed**

As ever, the challenges faced by the staff of the CCG in preparing the draft Annual Report and draft Annual Accounts against very tight deadlines were met. All CCG staff members involved in both documents were thanked for their hard and successful work.

There was a smooth transition from our outgoing Internal Auditors, KPMG, to our incoming Internal Auditors, RSM. The Committee thanked KPMG for their good service to the CCG.

Equally, Grant Thornton who are handing over their role as the CCG’s External Auditor for 2017/18 to KPMG, were thanked for their good service to the CCG.

**Key risks (include assurances received positive and negative)**

The Committee heard from the Chief Financial Officer that the CCG’s IT did not suffer and problems through the recent ‘Ransomware’ attack. There were also no incidents reported by GPIT and LGT.

RSM were asked to give insights, based on their work with other London CCGs, into ways of encouraging the public and others to attend the CCG’s AGM or other public meetings.

The importance of case studies to illuminate the Annual Report was emphasised by the Committee. CCG managers were asked to bring a range of case studies to the Audit Committee meeting in January 2018 so that some could be selected early on for the Annual Report for 2017/18.

**How did the meeting help address inequalities and fairness?**

The Audit Committee was pleased that the Annual Report made appropriate reference to the diversity of the borough of Lewisham. The Committee asked about the diversity of the Readers Panel which plays an important part in making sure that the Annual Report reads as well as it can to our population.
### Annual Accounts and Financial Review 2016/17

<table>
<thead>
<tr>
<th>RESPONSIBLE LEAD:</th>
<th>Tony Read, Chief Financial Officer</th>
</tr>
</thead>
<tbody>
<tr>
<td>AUTHOR:</td>
<td>Tony Read, Chief Financial Officer</td>
</tr>
<tr>
<td>RECOMMENDATIONS:</td>
<td>The Governing Body is asked to note that the report</td>
</tr>
</tbody>
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**SUMMARY:**
- The annual accounts for 2016/17 have been audited and submitted to NHS England with the required deadlines. There are no external audit qualifications.
- The Audit Committee approved draft accounts and audited accounts on behalf of the Governing Body.
- The CCG delivered all of its statutory financial duties in 2016/17.
- The CCG complied with NHS England’s requirements of the 1% system risk reserve.
- The CCG’s audited Annual report and Accounts 2016/17 can be found on the CCG’s website and are available via the weblink contained in this meeting’s agenda.

**CONSULTATION HISTORY:**
- Audit Committee
- Integrated Governance Committee

**PUBLIC ENGAGEMENT**
To be presented at the CCG Annual General Meeting.

**HEALTH INEQUALITY DUTY:**
Not specifically impacted by this report

**PUBLIC SECTOR EQUALITY DUTY:**
Not specifically impacted by this report

**STAKEHOLDER INVOLVEMENT:**
To be communicated to the GP Membership.

**RESPONSIBLE LEAD CONTACT:**
- Name: Tony Read
- E-Mail: tonyread@nhs.net
- Telephone: 0203 049 3833
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2016/17 Year End Results - Summary

Allocation £427,168k
Other income £4,119k
Gross expenditure £(421,257k)
Surplus £10,030k

Planned surplus at April 2016 £7,643k
Release of system risk reserve £4,050k
Less TSA related payment £(1,750k)
Required surplus at March 2017 £9,943k
Surplus achieved greater than requirement £87k
Annual Accounts 2016/17 Overview

- Our annual accounts for 2016/17 have been prepared on a going concern basis.
- Sound financial management and robust management of financial risks have ensured that we have delivered all of our statutory financial duties in 2016/17.
- We are required to deliver a cumulative surplus of at least 1% of available resources. CCGs must contain net expenditure within resource allocation limits set by NHS England for the year. There are separate resource allocation limits for capital and revenue expenditure, with revenue expenditure limits further split between programme spend and running costs.
## Financial performance targets - Statutory

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target £000</th>
<th>Outcome £000</th>
<th>Duty achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expenditure not to exceed income</td>
<td>431,287</td>
<td>421,257</td>
<td>Yes</td>
</tr>
<tr>
<td>Capital resource use does not exceed the amount specified in Directions</td>
<td>0</td>
<td>0</td>
<td>Yes</td>
</tr>
<tr>
<td>Revenue resource use does not exceed the amount specified in Directions</td>
<td>427,168</td>
<td>417,138</td>
<td>Yes</td>
</tr>
<tr>
<td>Revenue administration resource use does not exceed the amount specified in Directions (RCA)</td>
<td>6,608</td>
<td>6,539</td>
<td>Yes</td>
</tr>
<tr>
<td>Measure</td>
<td>Target £000</td>
<td>Outcome £000</td>
<td>Target achieved?</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>-------------</td>
<td>--------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Deliver targeted cumulative surplus</td>
<td>9,943</td>
<td>10,030</td>
<td>Yes</td>
</tr>
<tr>
<td>Cash spending not to exceed maximum cash drawdown limit</td>
<td>413,055</td>
<td>412,774</td>
<td>Yes</td>
</tr>
<tr>
<td>Cash balance at year end &lt; 1.25% of March cash drawdown</td>
<td>570</td>
<td>397</td>
<td>Yes</td>
</tr>
<tr>
<td>Make prompt payments within expectations of the Better Practice payments Code (within 30 days of receipt of valid invoice)</td>
<td>95%</td>
<td>97%</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Independent auditors opinion

The annual accounts have been audited by Grant Thornton LLP (External Auditors)

<table>
<thead>
<tr>
<th>Audit Opinion</th>
<th>Opinion Issued</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial statements present a true and fair view</td>
<td>Unqualified opinion issued</td>
</tr>
<tr>
<td>Regularity of the financial statements</td>
<td>Unqualified opinion issued</td>
</tr>
</tbody>
</table>
A planned cumulative surplus of £7,643k was agreed with NHS England for the year. The planned surplus for 2016/17 comprised the cumulative brought forward surplus of £7,643k with a planned nil in-year movement.

As set out in the 2016/17 NHS Planning Guidance, CCGs were required to hold a 1% reserve uncommitted from the start of the year, created by setting aside the monies that CCGs were otherwise required to spend non-recurrently. This was intended to be released for investment in Five Year Forward View transformation priorities to the extent that evidence emerged of risks not arising or being effectively mitigated through other means.

In the event, the national position across the provider sector has been such that NHS England has been unable to allow CCGs’ 1% non-recurrent monies to be spent in 2016/17. (Continued on next page)
Explanation of Financial Position 2 of 2

- To comply with this requirement, NHS Lewisham CCG released its 1% reserve to the bottom line, resulting in an additional surplus above plan for the year of £4.05m. This additional surplus has been partially offset against other non-recurrent cost pressures totalling £1.75m from the current financial year. The remainder has been carried forward and for drawdown in future years.

- 2016/17 expenditure on hospital services above (services from other NHS Trusts in Note 5 to the Annual Accounts) includes non-recurrent expenditure of £1.75m that was paid by the CCG to Lewisham and Greenwich Trust as part of a pre-existing NHS system-wide contractual commitment, totalling £10.5m. This contractual commitment applies to 2016/17 and 2017/18.
Expenditure by Category

Commissioning Expenditure 2016-17 (£m)

- Hospital Services, £226.69m, 54.34%
- Mental Health Services, £71.84m, 17.22%
- Community Services, £29.71m, 7.12%
- Continuing Care Services, £16.52m, 3.96%
- Better Care Fund, £20.17m, 4.83%
- Primary Care Prescribing and Other Services, £39.09m, 9.37%
- Others Services, £13.12m, 3.15%
# Expenditure on Local Acute Services

<table>
<thead>
<tr>
<th>Provider</th>
<th>Lewisham and Greenwich NHS Trust</th>
<th>Guys and St. Thomas' NHSFT</th>
<th>Kings College Hospitals NHSFT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service Type</strong></td>
<td>£m</td>
<td>£m</td>
<td>£m</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>11.22</td>
<td>1.10</td>
<td>1.90</td>
</tr>
<tr>
<td>Emergency/Non Elective</td>
<td>47.04</td>
<td>7.19</td>
<td>8.63</td>
</tr>
<tr>
<td>Outpatients</td>
<td>20.87</td>
<td>9.81</td>
<td>8.64</td>
</tr>
<tr>
<td>Inpatients</td>
<td>14.69</td>
<td>10.07</td>
<td>6.50</td>
</tr>
<tr>
<td>Maternity</td>
<td>8.14</td>
<td>3.33</td>
<td>3.28</td>
</tr>
<tr>
<td>Others</td>
<td>26.60</td>
<td>6.82</td>
<td>3.80</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>128.56</strong></td>
<td><strong>38.32</strong></td>
<td><strong>32.75</strong></td>
</tr>
</tbody>
</table>
Summary

- The CCG achieved all of its statutory financial duties for the year.
- The audited accounts were completed and submitted on time.
- There are no external audit qualifications.
- The CCG complied with NHS England’s requirements of the 1% system risk reserve.
Report of the Chair of the Finance and Investment (FIC) Committee

FIC met on 23 May 2017. The meeting was chaired by Shelagh Kirkland. The meeting was not quorate. Subsequently The Audit Chair, Chief Officer and Corporate Director have met to review the quoracy rules, in particular concerning the “independent registered nurse member”. It is proposed to bring these more into line with other Committees, whilst preserving the professional nurse input and also maximum input from lay and other independent Governing Body members

**Minor Eye Condition Scheme (MECS)**

The Committee noted that the Minor Eye Conditions Scheme (MECS) contracts would be extended from 1 April 2017 to 30 March 2018 with the existing four Any Qualified Providers (AQP) and that there would be no changes to the service of costs.
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As part of the new governance arrangements to support fully delegated GP commissioning, which came into effect on the 1\textsuperscript{st} April 2017, this was the second public meeting of the Lewisham Primary Care Commissioning Committee which was held on the 20\textsuperscript{th} June 2017.

1. Matters arising

In relation to the recommendations that were approved at the April 2017 PCCC meeting in regard to the consideration of Contractual Action following inspection by the CQC where an overall rating of ‘Requires improvement’ was received, all practices had since been re-inspected and all were now rated as good overall.

As such, it was agreed that these cases could now be closed except for Torridon Road Medical Centre where an action plan is currently being reviewed in regard to the one outstanding requires improvement domain of ‘Caring’. Once suitable assurance has been received in this respect, it was agreed to close this case also.

2. PMS contract review

The approval of the PMS Commissioning Intentions Assurance Submissions through an extraordinary Part 2 PCCC meeting held on 25th May 2017 was noted. Full documentation was included in the meeting papers.

It is still intended for the revised PMS contract to be implemented from 1\textsuperscript{st} October 2017.

3. Business cases

The following business cases were approved:

- New Cross Health Centre: Relocation business case
- Winlaton Surgery and South Lewisham Group Practice: Merger
4. Performance & Quality Report

A South East London Performance & Quality Report was shared which showed Lewisham’s relative performance against other CCGs in South East London against a range of metrics.

Key points to note include the positive performance in relation to CQC ratings:

- The SE London benchmark is 76.9% for practices rated by CQC as Good or Outstanding, compared to 76.6% for London as a whole. Lewisham CCG outperforms both benchmarks, with 85.3% of practices rated as Good or Outstanding including 1 outstanding and 0 Inadequate.

5. Finance Report

Twelve months results to 31st March 2017 are showing an underspend of £184k (0.4%) due to underspends on core services, premises cost and enhanced services offset by QIPP under achievement.

Refunds in relation to prior year business rates are expected to contribute towards the QIPP savings target.

Lewisham’s weighted population has increased by 2.5% year on year from April 2015 to April 2016 compared with a South East London average of 1.7%.

There has been a year to date growth of 1% (3,162 weighted population) for the four quarters to 1st January 2017 for Lewisham.

6. GP Forward View (GPFV): Update

A verbal update on local progress with the implementation of the GP Forward View was given. This included feedback on a General Practice Development event held on the 10th May 2017 which was attended by over 30 Lewisham practices. Following on from this, 12 practices have confirmed their interest in the Productive General Practice programme and a further 9 practices have confirmed their interest in the local Primary Care Quality Academy, supported by Southbank University.

7. Areas to note

The terms of reference for the South East London Primary Care Executive Group, which is the principle coordinating forum for general practice commissioning and contracting matters across South East London, were shared for information.

The approval letter confirming changes to the CCG Constitution, largely to support the move to level 3 primary care delegation, were also shared for information.
8. **Further information**

Full meeting papers for the Primary Care Commissioning Committee held on the 20th June 2017 are available at: [http://www.lewishamccg.nhs.uk/about-us/how-we-work/Meeting%20papers/Primary%20Care%20Commissioning%20Committee%2020%20June%202017.pdf](http://www.lewishamccg.nhs.uk/about-us/how-we-work/Meeting%20papers/Primary%20Care%20Commissioning%20Committee%2020%20June%202017.pdf)

9. **Date of next meeting**

The next scheduled meeting of the Primary Care Commissioning Committee in public is the 15th August 2017.
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Governing Body Meeting 13th July 2017

Report from the Chair of the Public Engagement & Equalities Forum
Date of Meeting(s) reported: 7th June 2017
Author: Susanna Master, Corporate Director

Main Issues discussed

The meeting was extended to all members of the CCG Governing Body and management team as the main purpose was to review the public engagement strategic framework, achievements during 2016-17 and priorities for 2017-18.

- Governance & Statutory Duties

The Forum reviewed the responsibilities of the CCG for patient and public involvement and for equalities and how they are supported by the PEEF. The group also looked at the links with and role of the public reference group (PRG), involvement of the wider CCG such as through the integrated governance committee, and connecting externally through Healthwatch and south east London networks.

- Strategic Framework for Communications & Engagement

The CCG’s communication and engagement is being reviewed. The group looked at and supported the CCG vision for public engagement, public engagement charter, and the ‘ladder of engagement’ that is forming the framework for how public engagement can be planned and developed, recognising that much of the activity to date had been focused on the lower levels of the ladder such as ‘informing’ and less on areas such as ‘collaborating’ or devolving.

- Review of Public Engagement 2016/17

The Forum looked at key engagement activities carried out during 2016/17 using the ladder of engagement. The discussion highlighted the need for early consideration of public engagement in CCG planning and the importance of clear information, as well as the wide variety of events in which the public engagement team and other teams in the CCG had been involved. The CCG’s annual general meeting (AGM) was emphasised as an opportunity for engaging Lewisham’s population in the work of the CCG. Themes that had come out of the engagement activities were reviewed, and were also compared to the learning that had come from Healthwatch in Lewisham during the same period.

- Public Engagement Priorities 2017/18

For 2017/18, the meeting received the priority areas identified so far. These are informed by the CCG corporate objectives, and by the underpinning strategic framework. Other development will focus on establishing clearer outcomes, ensuring systematic, joined up activity and reaching all communities.
Challenges

A number of challenges and further development areas for public engagement in the CCG were discussed in the meeting, including the need to build engagement early into plans and changes, establishing and maintaining diverse forums representative of our local population, and making sure that the outcomes of engagement are clear.

Quality & Safety

The Forum identified the contribution of Healthwatch in providing feedback on patient experience, and that this could be carried out more systematically through reporting to the Integrated Governance Committee.

Inequality & Fairness

The need to be sure that the variety of groups and communities in Lewisham are engaged was emphasised to ensure that their different needs and views are met.
Deep dives into the A&E 4 hour standard and improvement plan and cancer treatment waits were undertaken at the June meeting.

**A&E 4 Hour standard and the Improvement plan**

The Emergency Care Improvement Plan was submitted to NHS England on 8 May 2017. This was a jointly produced submission between the CCG and LGT.

The underlying causes for underperformance include Ambulatory Care Pathways not working at maximum capacity and the limitations of Urgent Care Centre (UCC) space on both sites.

Improvements against the 4 hour standard have been made (see below). Additional capital funding of £1.6m has been allocated for both sites, and this will include 4 additional cubicles for the ED at UHL.

It was reiterated that the system needed to be at 92% by September across both sites, and that this would require both pathway and cultural change. Steps to achieve this include utilising 111, GP streaming, a simplified front door, working with care homes and a simplified alternative care pathway for LAS across the Bexley, Greenwich and Lewisham.

The mental health suite at SLaM and pathways for people with mental health crises was discussed with the expansion of the liaison teams having received funding.

It was considered a good time to look at the ACU clinical leadership and potential to expand ACU working and Clinical Directors are to arrange clinical audits of ED and ACU.

**Cancer**

The Committee discussed the 62 Wait Constitutional standard related to Cancer, with particular challenges facing lung and lower GI. It was noted that delays in access to diagnostics result in slowing down the patient pathway. A deep dive at LGT has evidenced that the internal pathway is at or above of the standard. The pathway stalls at the interface with GSTT.
LGT are addressing the gap on capacity and are working with GSTT to minimise repeat testing, with KPIs for consultants. Additional pressure on GSTT comes from other areas referring (outside of SEL) at 60 to 70 days.

A Board has been established, chaired by Calley Palmer (from The Royal Marsden), with the executive team having face to face time with DGHs.

The GSTT plan has been agreed. Issues have been identified in workforce with regards to getting the paperwork and diagnostics to the right place in time. The Committee requested assurance on the completion of the five key planned actions that are to be taken to stop shared breaches (July meeting).

Quality

Neonatal Hip Scans

An update and detailed action plan, produced by Lewisham and Greenwich NHS Trust (LGT), to improve the pathway for Neonatal Hip Scans was received by and considered by the Integrated Governance Committee.

Audit has identified 66 babies across both sites that should have had hip scans but did not (a referral was not made in 60 cases and in 6 cases one was made but an appointment was not offered). These babies are being offered an urgent paediatric review. The action plan includes the implementation of a monitoring process aimed at providing a failsafe to ensure no more babies that require scans are missed.

The audit was carried out on a sample of babies born in 2016 and therefore it is possible that there are further cases that have not been identified. The advice from NHS England and from Public Health England is that there should be a look back exercise of all births in the preceding two years. This will be labour intensive and requires manually reviewing approximately 20,000 maternity records. Senior clinicians are discussing how this may be managed in a way that does not take essential clinical resources from current activities.

The South London & Maudsley Quality Report

The South London & Maudsley exception report was received with data up to March 2017.

The level of restraints and prone restraints has not reduced from previous levels.

In terms of staffing, there continue to be a higher level of breaches of safer staffing (by more than 20%) and there are issues in staff sickness and mandatory training completion.

The Staff Survey has been published with minor movements, but there are issues in the Workforce Race Equality Standard where BME staff indicate worse scores than Other staff.

More positively the recently published January 2017 CQC review of the Acute and PICU pathway has resulted in “Requires Improvement” overall and there were noted improvements from the previous review. The Trust is “Good” overall. On the 12th June the CQC rated the wards for older people with mental health problems as
“Good” overall and “Requires Improvement” for being safe following the March 2017 inspection. This shows improvement since the inspection in September 2015.

The NHS Improvement Single Oversight Framework has moved from 2 (some support needs identified) to 1(providers with maximum autonomy).

**NHS Constitutional Standards**

The key performance exceptions are:

- **Cancer Waiting Times relating to GP Referral to Treatment within 62 days.** The CCG was significantly below the standard in April 2017 at 71.7%, Inter Provider Transfers between Lewisham and Greenwich Trust and the tertiary centre by day 38 stood at 78.4% which is lower than the 85% standard. The effect of this on Lewisham patients will be dependent on the total number of referrals to Guys and St Thomas’, which delivers over half of all Lewisham patient treatments, and the performance of the Trust for these externally referred patients. There is a risk that sustainable improvement will not be met in 2017-18 as GSTT’s performance is not planned to deliver the standard in 2017-18. The exception report analyses breach reasons and the numbers of breaches identified as patient choice. There are 5 administrative delays breaches for April 2017.

- In April 2017 less than 92% (87.0%) of Lewisham patients were on an 18 weeks Incomplete Referral to Treatment path. Kings College Hospitals is the principal source of these breaches. It has a plan for further validation of its incomplete pathways, which will take until December 2017. Further planning on capacity and demand planning including offering patients choice of other providers is under way. However, the plan does not assume that there is any major improvement from Kings College Hospitals during 2017-18.

- While A&E performance did not achieve the standard in April 2017, it has achieved 90.2% within 4 hours and this is 1.1% higher than trajectory. Within London acute performance this performance is in the middle of the performance table. London Ambulance Service delivered the Category A Red 1 target within 8 minutes for April 2017.

- **Diagnostic waiting times –** The percentage of diagnostics within 6 weeks has fallen below the 99% standard at 98.5%. There has been a recent decrease in Kings College Hospitals performance. There are consistent delays in scopes, but there have been more delays in MRI, Audiology and CT.

**Positive Achievements**

A positive achievement for the last two months is that Cancer Waiting Time two week waits for first assessment is now being met as is the same for breast symptoms.

Early Intervention in Psychosis within 2 weeks has met the 50% standard for 2016-17 and this has continued into April 2017 at 100% and it has been met for 2016-17. There is a focus on a change to reporting in the middle of 2017-18 to use the Mental Health Minimum Data Set rather than the interim measurement set up. South
London and Maudsley is developing a plan to ensure consistent measurement and performance reporting in time for this switch over.

All Improving Access to Psychological Therapies standards have been met for Q4 2016-17 including meeting the standard of over 50% of people completing treatment reaching a Recovery level.

**Finance**

At Month 2 the CCG is reporting on plan and also forecasting to deliver a cumulative surplus of £9.29m for the year. This is in line with the Operational Plan submitted on 30th March and includes pre approved drawdown of £650k of the CCG’s historic cumulative surplus. The CCG headline financial position is provided in the table below. It should be noted that at month 2 there is limited reliable activity data on which to base acute contract performance. The net risk position for the year is negative; financial risks exceed mitigation. The requirements of the Capped Expenditure Process are not included in the month 2 finance report and this will add significantly to the CCG’s financial risk in 2016/17 and requires further QIPP stretch in the region of £2.5m.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Plan / Target</th>
<th>Forecast Outturn</th>
<th>Forecast Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Cumulative Surplus</td>
<td>£9.29m</td>
<td>£9.29m</td>
<td>Nil</td>
</tr>
<tr>
<td>Planned In-year Surplus</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
</tr>
<tr>
<td>Acute Expenditure</td>
<td>£234.28m</td>
<td>£234.28m</td>
<td>Nil</td>
</tr>
<tr>
<td>Total Expenditure</td>
<td>£461.59m</td>
<td>£461.59m</td>
<td>Nil</td>
</tr>
<tr>
<td>QIPP Delivery</td>
<td>£14.1m</td>
<td>£14.1m</td>
<td>Nil</td>
</tr>
<tr>
<td>Risk Adjusted Surplus</td>
<td>£9.29m</td>
<td>£9.29m</td>
<td>Nil</td>
</tr>
<tr>
<td>Underlying Position (2%)</td>
<td>£7.06m</td>
<td>£7.06m</td>
<td>Nil</td>
</tr>
<tr>
<td>Better Practice Payments Code</td>
<td>95.0%</td>
<td>96.2%</td>
<td>1.2%</td>
</tr>
<tr>
<td>Cash Drawdown</td>
<td>£469.75m</td>
<td>£469.75m</td>
<td>Nil</td>
</tr>
</tbody>
</table>

**Quality Innovation Productivity and Prevention (QIPP)**

Since the last report the planning risk within the QIPP plan has been mitigated from £2m risk to £0.5m risk
The Governing Body is asked to agree:

- the current risk scores and the target risk scores for the risks contained within the Board Assurance Framework
- that there are adequate controls in place to mitigate the risks to the Corporate Objectives and where existing controls have not reduced the current risk score to the target risk score there are credible action plans.

1. Background

At the Governing Body meeting on the 11th May 2017, the Corporate Objectives for the immediate priorities for the 6 months up to the end of September 2017 were noted and the Board Assurance Framework, which described those risks to achieving this which are either high or very high was agreed. However, the Governing Body did ask for the original risk and target risk scores to be reviewed, to ensure that the identified actions would plan to achieve the target risk score.

These risks, as part of the full Corporate Risk Register have been reviewed by the Senior Management Team (SMT) at the Corporate Objectives and Risk Management Group on 6th June, to ensure that the correct risks have been identified, with the appropriate associated current and target scores as well as the Integrated Governance Committee on 22 June 2017. The SMT additionally reviewed the Corporate Risk Register to assess if any risks should be escalated to the BAF, or define any new risks to the achievement of these.

During the SMT review of these risks, two themes of causality were identified. It was agreed that these themes would be contained as part of the potential cause within a number of risks. These themes are:

a) ‘the capacity and capability of the provider workforce’; and

b) ‘the alignment of CCG and provider priorities’.

The below table shows the distribution of the all risks identified through the Corporate Risk Register.
Following the assessments at these meetings, there are currently 8 risks on the CCG Risk Register that meet the criteria for inclusion on the BAF (Current Risk Score of 12 or over) which are summarised in the table below.

A further risk is also being developed with the Lewisham Health Care Partners (LHCP) Executive Board with regards to agreeing the form of and establishment of an Accountable Care System in Lewisham which will be included in the Corporate Risk Register and BAF if appropriate.
## Summary of Corporate Risk Register July 2017

<table>
<thead>
<tr>
<th>GR Corporate Objectives</th>
<th>Risk Title</th>
<th>Risk Owner</th>
<th>Original Rating</th>
<th>Impact</th>
<th>Likelihood</th>
<th>Current Rating</th>
<th>Impact</th>
<th>Likelihood</th>
<th>Target Rating</th>
<th>Impact</th>
<th>Likelihood</th>
<th>Movement</th>
</tr>
</thead>
<tbody>
<tr>
<td>60 Contract Management</td>
<td>Cancer waiting times; Cancer63 days</td>
<td>Hawthorne, Brian</td>
<td>16 Very High Risk</td>
<td>4</td>
<td>4</td>
<td>16 Very High Risk</td>
<td>4</td>
<td>4</td>
<td>12 High Risk</td>
<td>4</td>
<td>3</td>
<td>None</td>
</tr>
<tr>
<td>61 Urgent and Emergency Care</td>
<td>A&amp;E System wide delivery</td>
<td>Wilkinson, Martin</td>
<td>16 Very High Risk</td>
<td>4</td>
<td>4</td>
<td>16 Very High Risk</td>
<td>4</td>
<td>4</td>
<td>12 High Risk</td>
<td>4</td>
<td>3</td>
<td>None</td>
</tr>
<tr>
<td>62 Urgent and Emergency Care</td>
<td>Transformation of Urgent and Emergency Care Services</td>
<td>Hawthorne, Brian</td>
<td>16 Very High Risk</td>
<td>4</td>
<td>4</td>
<td>16 Very High Risk</td>
<td>4</td>
<td>4</td>
<td>9 High Risk</td>
<td>3</td>
<td>3</td>
<td>None</td>
</tr>
<tr>
<td>63 Urgent and Emergency Care</td>
<td>Supported Discharge initiatives</td>
<td>Hawthorne, Brian</td>
<td>16 Very High Risk</td>
<td>4</td>
<td>4</td>
<td>16 Very High Risk</td>
<td>4</td>
<td>4</td>
<td>9 High Risk</td>
<td>3</td>
<td>3</td>
<td>None</td>
</tr>
<tr>
<td>64 Planning/QPP Programme for 2018/19</td>
<td>QIPP - Planning for 2018/19 and 2019/20</td>
<td>Hawthorne, Brian</td>
<td>16 Very High Risk</td>
<td>4</td>
<td>4</td>
<td>16 Very High Risk</td>
<td>4</td>
<td>4</td>
<td>8 High Risk</td>
<td>4</td>
<td>2</td>
<td>None</td>
</tr>
<tr>
<td>65 Deliver the 2017/18 QIPP programme</td>
<td>QIPP: Securing in-year delivery</td>
<td>Hawthorne, Brian</td>
<td>16 Very High Risk</td>
<td>4</td>
<td>4</td>
<td>16 High Risk</td>
<td>3</td>
<td>4</td>
<td>8 High Risk</td>
<td>4</td>
<td>2</td>
<td>None</td>
</tr>
<tr>
<td>66 Contract Management</td>
<td>Route Providers – Delivering Quality; Referral to Treatment (HTT) standard</td>
<td>Hawthorne, Brian</td>
<td>12 High Risk</td>
<td>4</td>
<td>3</td>
<td>12 High Risk</td>
<td>4</td>
<td>3</td>
<td>8 High Risk</td>
<td>4</td>
<td>2</td>
<td>None</td>
</tr>
<tr>
<td>67 All Corporate Objectives</td>
<td>Financial Targets 2017/18</td>
<td>Read, Tony</td>
<td>12 High Risk</td>
<td>4</td>
<td>3</td>
<td>12 High Risk</td>
<td>4</td>
<td>3</td>
<td>8 High Risk</td>
<td>4</td>
<td>2</td>
<td>None</td>
</tr>
<tr>
<td>68 All Corporate Objectives</td>
<td>Ways of Working</td>
<td>Masters, Susan</td>
<td>9 High Risk</td>
<td>3</td>
<td>3</td>
<td>6 Moderate Risk</td>
<td>3</td>
<td>3</td>
<td>6 Moderate Risk</td>
<td>3</td>
<td>3</td>
<td>None</td>
</tr>
<tr>
<td>69 All Corporate Objectives</td>
<td>Public Engagement</td>
<td>Malcolm-Smith, Charles</td>
<td>9 High Risk</td>
<td>3</td>
<td>3</td>
<td>6 Moderate Risk</td>
<td>3</td>
<td>3</td>
<td>6 Moderate Risk</td>
<td>3</td>
<td>3</td>
<td>None</td>
</tr>
<tr>
<td>70 Contract Management</td>
<td>Pressure on mental health delivery</td>
<td>Carlin, Dean</td>
<td>9 High Risk</td>
<td>3</td>
<td>3</td>
<td>6 Moderate Risk</td>
<td>3</td>
<td>3</td>
<td>6 Moderate Risk</td>
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<td>3</td>
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<tr>
<td>71 All Corporate Objectives</td>
<td>Emergency Preparedness Resilience and Response (EPR)</td>
<td>Masters, Susan</td>
<td>9 High Risk</td>
<td>3</td>
<td>3</td>
<td>6 Moderate Risk</td>
<td>3</td>
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<td>6 Moderate Risk</td>
<td>3</td>
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<tr>
<td>72 All Corporate Objectives</td>
<td>Employee Engagement</td>
<td>Malcolm-Smith, Charles</td>
<td>9 High Risk</td>
<td>3</td>
<td>3</td>
<td>6 Moderate Risk</td>
<td>3</td>
<td>3</td>
<td>6 Moderate Risk</td>
<td>3</td>
<td>3</td>
<td>None</td>
</tr>
<tr>
<td>73 Contract Management</td>
<td>Learning Disabilities/transformation care</td>
<td>Carlin, Dean</td>
<td>9 High Risk</td>
<td>3</td>
<td>3</td>
<td>6 Moderate Risk</td>
<td>2</td>
<td>3</td>
<td>6 Moderate Risk</td>
<td>2</td>
<td>3</td>
<td>None</td>
</tr>
<tr>
<td>74 Governance - Planning and Control</td>
<td>Decision Making</td>
<td>Masters, Susan</td>
<td>6 Moderate Risk</td>
<td>3</td>
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<td>6 Moderate Risk</td>
<td>3</td>
<td>2</td>
<td>3 Low Risk</td>
<td>3</td>
<td>3</td>
<td>None</td>
</tr>
<tr>
<td>75 Governance - Planning and Control</td>
<td>Member engagement</td>
<td>Malcolm-Smith, Charles</td>
<td>6 Moderate Risk</td>
<td>3</td>
<td>2</td>
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<td>3</td>
<td>2</td>
<td>3 Low Risk</td>
<td>3</td>
<td>3</td>
<td>None</td>
</tr>
<tr>
<td>76 All Corporate Objectives</td>
<td>Equalities</td>
<td>Malcolm-Smith, Charles</td>
<td>6 Moderate Risk</td>
<td>3</td>
<td>2</td>
<td>6 Moderate Risk</td>
<td>3</td>
<td>2</td>
<td>3 Low Risk</td>
<td>3</td>
<td>3</td>
<td>None</td>
</tr>
<tr>
<td>77 Contract Management</td>
<td>Safeguarding</td>
<td>Hawthorne, Brian</td>
<td>6 Moderate Risk</td>
<td>3</td>
<td>2</td>
<td>6 Moderate Risk</td>
<td>3</td>
<td>2</td>
<td>3 Low Risk</td>
<td>3</td>
<td>3</td>
<td>None</td>
</tr>
<tr>
<td>78 Contract Management</td>
<td>Quality/Treatment standards not met (community)</td>
<td>Hawthorne, Brian</td>
<td>6 Moderate Risk</td>
<td>3</td>
<td>2</td>
<td>6 Moderate Risk</td>
<td>3</td>
<td>2</td>
<td>3 Low Risk</td>
<td>3</td>
<td>3</td>
<td>None</td>
</tr>
<tr>
<td>79 All Corporate Objectives</td>
<td>CCG Office Relocation</td>
<td>Masters, Susan</td>
<td>6 Moderate Risk</td>
<td>3</td>
<td>2</td>
<td>6 Moderate Risk</td>
<td>3</td>
<td>2</td>
<td>8 High Risk</td>
<td>3</td>
<td>3</td>
<td>None</td>
</tr>
<tr>
<td>80 All Corporate Objectives</td>
<td>Information Governance</td>
<td>Read, Tony</td>
<td>6 Moderate Risk</td>
<td>3</td>
<td>2</td>
<td>6 Moderate Risk</td>
<td>3</td>
<td>2</td>
<td>2 Low Risk</td>
<td>3</td>
<td>3</td>
<td>None</td>
</tr>
<tr>
<td>81 All Corporate Objectives</td>
<td>Conflicts of Interest</td>
<td>Middlehurst, Victoria</td>
<td>6 Moderate Risk</td>
<td>3</td>
<td>2</td>
<td>6 Moderate Risk</td>
<td>3</td>
<td>2</td>
<td>2 Low Risk</td>
<td>3</td>
<td>3</td>
<td>None</td>
</tr>
</tbody>
</table>

The Summary Risk Table shows for each risk rated 12 or above (ie “High” or “Very High”) the Original Risk score at the beginning of 2017/18, the Current risk score at June 2017 and the Target risk score.

More information is provided for the risks associated with the cancer waiting times (Risk ID 8), A&E System Wide Delivery (Risk ID 78) and Referral to Treatment Time (Risk ID 77) within the report from the Chair of the Integrated Governance Committee.

The Governing Body are asked to agree:

- the current risk scores and the target risk scores for the risks contained within the Board Assurance Framework
- that there are adequate controls in place to mitigate the risks to the Corporate
Objectives and where existing controls have not reduced the current risk score to the target risk score there are credible action plans.

Appendices
Appendix A - BAF – June 2017
Appendix B – Risk Appetite Matrix
Appendix C – Glossary of Terms

CORPORATE AND STRATEGIC OBJECTIVES

CONSULTATION HISTORY:
Integrated Governance Committee (22 June 2017) – reviewed the BAF and agreed the high level risks.
Corporate Objectives and Risk Management Group (06 June 2017) – Reviewed the Corporate Risk Register, and discussed the high level risks to the achievement of the Corporate Objectives.
Corporate Objectives and Risk Management Group (09 May 2017) – Defined the high level risks to the achievement of the Corporate Objectives.
Governing Body (11 May 2017) - discussed Corporate Objectives and BAF.
Corporate Objectives and Risk Management Group (06 June 2017) – discussed the Corporate Risk Register and the Board Assurance Framework, in line with the achievement of the Corporate Objectives.

PUBLIC ENGAGEMENT
The Public Engagement Risk has defined the risks to Public Engagement.

HEALTH INEQUALITY DUTY
How does this report take into account the duty to:
- Reduce inequalities between patients with respect to their ability to access health services.
- Reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services.

PUBLIC SECTOR EQUALITY DUTY
How does this report take into account the duty to:
- Eliminate discrimination, harassment and victimisation and any other conduct that is prohibited under the Equality Act 2010
- Advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it
- Foster good relations between people who share a relevant protected characteristic and those who do not share it
There is a specific risk with regards to Equalities considerations being effectively included in the CCG plans and activities (Risk Identifier 38). These are monitored through the Corporate Objectives and through the management Equality and Diversity Group.

<table>
<thead>
<tr>
<th>RESPONSIBLE MANAGERIAL LEAD CONTACT:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name: Susanna Masters</td>
</tr>
<tr>
<td>E-Mail: <a href="mailto:susanna.masters@nhs.net">susanna.masters@nhs.net</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>AUTHOR CONTACT:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name: Victoria Medhurst</td>
</tr>
<tr>
<td>E-Mail: <a href="mailto:Victoria.medhurst@nhs.net">Victoria.medhurst@nhs.net</a></td>
</tr>
</tbody>
</table>
### Appendix A - BAF – July 2017

<table>
<thead>
<tr>
<th>Corporate Objective:</th>
<th>Contract Management</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risk</strong></td>
<td>Cancer waiting times; Cancer 62 days (Risk ID 8)</td>
</tr>
</tbody>
</table>
| **Risk Description: (What is the risk?)** | Local providers do not deliver health services that meet the NHS Constitutional commitments on waiting times for patients with cancer or suspected cancers.  

It is caused by:  
- Poor performance of commissioned services  
- Provider failure to meet contracted quality and performance standards  
- Poor contract management  
- The capacity and capability of the provider workforce  
- The alignment of CCG and provider priorities  

It could lead to:  
- Delays to appropriate treatment and potential harm to patients  
- Failure to meet NHS Constitutional Commitments in Lewisham  
- Loss of reputation |
| **Risk Owner:**      | Braithwaite, Diana | **Risk Manager:** | Rahman, Michelle |
| **Directorate:**     | Commissioning & Primary Care Directorate |
| **Risk Appetite:**   | Low | **Risk Response:** | Mitigate |
| **Original Score:**  | Very High Risk | **Current Score:** | Very High Risk | **Target Score:** | High Risk | **Risk Movement:** | None |
| Impact 4 x Likelihood 4 | Impact 4 x Likelihood 4 | Impact 4 x Likelihood 3 |

| **Controls: (What are we doing to mitigate the risk?)** |  
- The CCG has an agreed contract with all providers  
- The CCG has included appropriate penalty clauses in its major contracts  
- The CCG has agreed a cancer recovery plan, which monitored by the Performance Group with quality issues Clinical Quality Review Group (CQRG)  
- The CCG has employed an expert multi-disciplinary team from the CSU and the CCG is developing an internal contract management multi-disciplinary team to support  
- Bexley, Lewisham & Greenwich Cancer Locality Group  
- Delivery of the SEL Cancer Improvement Plan agreed by all providers.  
- The CCG undertakes root cause analysis of cancer |
breaches including long waiters, with the Trust to support pathway development, improvements and review clinical risk and harm as part of the CCGs quality assurance framework.

<table>
<thead>
<tr>
<th>Assurance Sources:</th>
<th>Contracts with LGT, GSTT and Kings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>LGT Contract Management Board and Performance meetings minutes</td>
</tr>
<tr>
<td></td>
<td>CQRG Minutes</td>
</tr>
<tr>
<td></td>
<td>Cancer Pathway Clinical Review Group Minutes</td>
</tr>
<tr>
<td></td>
<td>Integrated Performance Report to the Integrated Governance Committee</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk Assurances: (What evidence do we have that the controls are working?)</th>
<th>Signed contracts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Performance Reports to Integrated Governance Committee</td>
</tr>
<tr>
<td></td>
<td>LGT has provided a trajectory and plan showing compliance with the Standards throughout financial year 2017/18</td>
</tr>
<tr>
<td></td>
<td>NHS England Stocktakes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Assurance Type:</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assurance level:</td>
<td>Limited</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gaps in Risk Controls:</th>
<th>Recovery plan with milestones and quantified/impact on delivering the trajectory for GSTT.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Actions:</th>
<th>The CCG is actively managing LGT cancer recovery plan as part of the CMB process</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Trusts are working together through the Area Cancer Networks to support delivery of performance through:</td>
</tr>
<tr>
<td></td>
<td>Shared pathway analysis work across the SE London Sector moves organisations on from separate action plans covering a broad range of activities that affect all/some tumour groups to a focussed view of the shared pathways between Trusts</td>
</tr>
<tr>
<td></td>
<td>Bids have been submitted through the ACN for short term, non-reoccurring funding available through NHSE to support diagnostic issues and the clearance of backlog.</td>
</tr>
<tr>
<td></td>
<td>The sector to address staffing requirements is currently recruiting both clinical and administrative staff, with clinical locum staff starting at LGT in June 2017.</td>
</tr>
<tr>
<td></td>
<td>Cancer long-waiters are being escalated to CQRG for review of clinical harm</td>
</tr>
<tr>
<td></td>
<td>Change of chair of the performance CMB to Director level</td>
</tr>
<tr>
<td></td>
<td>ICDT expansion into SEL to replicate the ways of working in LBS with the CSU</td>
</tr>
<tr>
<td></td>
<td>Recovery plans across the three SEL Providers (GSTT, KCH and LGT) are being managed by the 62 day leadership group which the CCG has a presence on</td>
</tr>
</tbody>
</table>

| Last updated: | Diana Braithwaite 29/06/2017 |
**Corporate Objective:** Deliver the 2017/18 QIPP programme

**Risk**

<table>
<thead>
<tr>
<th>Risk Description: (What is the risk?)</th>
<th>QIPP: Securing in-year delivery (Risk ID 53)</th>
</tr>
</thead>
<tbody>
<tr>
<td>If the CCG does not deliver QIPP savings, this will jeopardise delivery of the financial control total, which would impact on the opportunity to improve quality and innovation.</td>
<td></td>
</tr>
<tr>
<td>It is caused by:</td>
<td></td>
</tr>
<tr>
<td>• Insufficient QIPP programmes to deliver the £14m target</td>
<td></td>
</tr>
<tr>
<td>• Identified QIPP programmes are not robust</td>
<td></td>
</tr>
<tr>
<td>• Failure to develop pipeline schemes that deliver in year savings</td>
<td></td>
</tr>
<tr>
<td>• Lack of appropriate internal focus on QIPP</td>
<td></td>
</tr>
<tr>
<td>• The alignment of CCG and provider priorities</td>
<td></td>
</tr>
<tr>
<td>It could lead to:</td>
<td></td>
</tr>
<tr>
<td>• Failing to meet planning expectations of IAF for 2017/18</td>
<td></td>
</tr>
<tr>
<td>• Contract mediation and/or arbitration</td>
<td></td>
</tr>
<tr>
<td>• Inability to deliver balanced budget on a planning basis</td>
<td></td>
</tr>
<tr>
<td>• Inability to commit to new investments</td>
<td></td>
</tr>
<tr>
<td>• Loss of reputation</td>
<td></td>
</tr>
</tbody>
</table>

**Risk Owner:** Braithwaite, Diana  
**Risk Manager:** Braithwaite, Diana  
**Directorate:** Commissioning & Primary Care Directorate  
**Risk Appetite:** Low  
**Risk Response:** Mitigate  
**Original Score:** Very High Risk  
**Current Score:** High Risk  
**Target Score:** High Risk  
**Risk Movement:** None  
<table>
<thead>
<tr>
<th>Controls: (What are we doing to mitigate the risk?)</th>
<th>Commissioning QIPP Clinics.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>QIPP Reporting Schedule to the Integrated Governance Committee: (i) QIPP 2017/18 Programme Overview (23rd February 2017); (ii) Lessons Learnt 2016/17 (23rd March 2017); Monthly exception reporting from June; and (iii) Quarterly full programme report.</td>
</tr>
<tr>
<td></td>
<td>QIPP 2017/18 Programme Monthly reporting to the Integrated Governance Committee from June onwards.</td>
</tr>
<tr>
<td></td>
<td>Implementation of the Lessons Learnt from 2016/17 QIPP recommendations to the Integrated Governance Committee.</td>
</tr>
<tr>
<td>Assurance</td>
<td>QIPP Clinic Documentation: Action Tracker, Highlight</td>
</tr>
</tbody>
</table>
| Sources: | Reports and Project Initiation Documents (PIDS)  
• QIPP Monthly Programme Report to the Clinical Directors and Senior Management meeting and to the Integrated Governance Committee  
• Deloitte Review reported to the Integrated Governance Committee (27.04.2017)  
• Deloitte De-risk Programme reported to the Clinical Directors and Senior Management Team (15.06.2017)  
• Non-elective and elective activity trackers through the contract.  
• BGL commissioners and LGT CIP/QIPP Board |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk Assurances: (What evidence do we have that the controls are working?)</td>
<td>Activity data for 2017/18 M1 – M2 is not year available and therefore the impact of the various interventions which relate to acute activity (e.g. Elective and Non-elective activity)</td>
</tr>
<tr>
<td>Assurance Type:</td>
<td>Management</td>
</tr>
<tr>
<td>Assurance level:</td>
<td>Limited</td>
</tr>
</tbody>
</table>
| Actions: | Commission support to develop 2 year QIPP programme recognising the interfaces with the SEL Control Expenditure Programme – CEP (Diana Braithwaite; July 2017);  
• Resource QIPP and Right Care PMO on a sustained basis (SMT; July 2017) |
| Last updated: | Diana Braithwaite 15/06/2017 |
**Corporate Objective:** Contract Management

**Risk**

Acute Providers – Delivering Quality: Referral to Treatment (RTT) standard (Risk ID 77)

**Risk Description: (What is the risk?)**

The acute providers do not deliver against contract requirements including performance and/or quality standard for RTT

It is caused by:
- The contract requirements and specification are not appropriately defined and agree with providers.
- The CCG does no utilise all available resources and processes to manage contract variations against performance and quality standards.
- Poor provider performance.
- The capacity and capability of the provider workforce
- The alignment of CCG and provider priorities

It could lead to:
- NHS Constitutional Standards are not met or agreed local trajectory is not delivered
- Elective Activity is not in line with plan impacts on Trust ability to deliver against the constitutional standards
- A serious safeguarding incident
- Harm to patients
- Poor patient experience
- Inequalities are not reduced
- Failure to deliver and/or overshoot agreed activity levels
- Failure to deliver and/or deliver in excess of financial limits Assurance to NHSE/ Services operating at risk

**Risk Owner:** Braithwaite, Diana  
**Risk Manager:** Rahman, Michelle

**Directorate:** Commissioning & Primary Care Directorate

**Risk Appetite:** Moderate  
**Risk Response:** Mitigate

**Original Score:**  
**Current Score:**  
**Target Score:**  
**Risk Movement:** None

<table>
<thead>
<tr>
<th>Impact</th>
<th>Likelihood</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>3</td>
</tr>
</tbody>
</table>

**Controls: (What are we doing to mitigate the risk?)**
- LGT RTT recovery Trajectory has been agreed and submitted to NHSE
- Challenged specialties at LGT are required to provide an appropriate recovery plan and trajectory
The CCG is working with the expert multi-disciplinary team at the CSU to work across the system to understand challenges at other SEL Trusts (KCH and GSTT) in relation to RTT delivery.

**Assurance Sources:**
- Integrated Performance Reports to the Integrated Governance Committee
- Contract Management Board (CMB) minutes and reports.
- CQRG minutes and reports
- CSU service Auditors Reports (SARs)
- CCG and SLCSU MDT
- NHS and stocktakes

**Risk Assurances: (What evidence do we have that the controls are working?)**
- Signed contracts and register
- Integrated Performance Reports to the Integrated Governance Committee
- Bi-monthly performance reports to the Governing Body
- Quality indicator reports to CQRGs
- Lewisham & Greenwich Trust Contract Management Board and Performance Reports
- Revised RTT Trajectory Plan has been agreed with LGT
- NHS England Stocktakes
- Bi-weekly teleconference calls with the Trust to review the Patient Tracking List (PLT) and monitor progress towards clearing the backlog (CSU & CCG)

**Assurance Type:** Management

**Assurance level:** Adequate

**Gaps in Risk Controls:**
- KCH Validation of 18 weeks waiting list and therefore assurance of delivery of the trajectory is dependent on this second tranche

**Actions:**
- The host commissioner via CSU to provide the CCG with a validated position or milestones for achievement.
- KCH are working with the ICDT to assess the costs of insourcing, with the Concordia and 18 Week Support as the companies being considered as the independent providers
- NHSI have stated that KCH is required to have a fully integrated recovery plan for RTT by the end of June 2017
- LGT have a remedial action plan in place for backlog reduction in order to return the Trust to compliance in aggregate by the end of Q1 2017-18 which is being monitored via performance CMB and bi-weekly commissioner and Trust teleconference calls
- LGT recognise that to deliver the recovery plan theatre productivity is key to the admitted pathways and are undertaking a theatre transformation programme of work with Ernst Young (EY).
- Change of chair of the performance CMB to Director level
- ICDT expansion into SEL to replicate the ways of
working in LBS with the CSU
• LGT are also securing additional capacity from a number of external providers to support backlog clearance
• LGT are working with commissioners on a number of demand management schemes aimed at pathway improvement such as the headache pathway to support neurology

<p>| Last updated: | Diana Braithwaite 29/06/2017 |</p>
<table>
<thead>
<tr>
<th>Corporate Objective:</th>
<th>Urgent and Emergency Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risk</strong></td>
<td>A&amp;E: System wide delivery (Risk ID 78)</td>
</tr>
</tbody>
</table>
| **Risk Description: (What is the risk?)** | The improvement programme across Lewisham, Greenwich and Bexley local system does not deliver the anticipated outcomes for our patients and local populations at the pace required. 

It is caused by:
Incorrect diagnosis of the issues leading to the wrong plan and therefore under performance
Poor cross-organisational collaboration, leadership and ownership of the issues and/or plan and/or delivery of the actions agreed
Capacity and capability within the EDs, hospitals and wider system to adopt improvements to pathways and processes at the pace identified in the plan
Poor execution of plan
Clinical leadership necessary to drive and lead the change is not in place
Workforce constraints - both numbers and mindset
Lack of holding partners to account for their aspect of delivery whether through contracts or partnership arrangements
Misaligned focus or priorities such as between BGL, sites, LA areas, or competing agendas
Pace and scale of change not recognised or delivered
Delivery is not adequately tracked through data caused by poor systems, capacity or ineffective PMO

It could lead to:
Improvement trajectory agreed through Operating plan for this key NHS Constitution Standards is not met.
Potential harm or safeguarding incidents occur for patients
Poor patient experience of care
Inappropriate activity is undertaken in the wrong care setting, including admissions and re-admission
Adverse financial impact to CCG and providers/failure to achieve financial recovery
Improvement of urgent and emergency care services does not occur or is short lived
Adverse impact on staff morale and retention
Worsening inequalities caused by poor access
Organisations being put into ‘special measures’ |

<table>
<thead>
<tr>
<th>Risk Owner:</th>
<th>Wilkinson, Martin</th>
<th>Risk Manager:</th>
<th>Braithwaite, Diana</th>
</tr>
</thead>
<tbody>
<tr>
<td>Directorate:</td>
<td>Commissioning &amp; Primary Care Directorate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk Appetite:</td>
<td>Moderate</td>
<td>Risk Response:</td>
<td>Mitigate</td>
</tr>
</tbody>
</table>
### Original Score: | Current Score: | Target Score: | Risk Movement:
---|---|---|---
Very High Risk | Very High Risk | High Risk | None
Impact 4 x | Impact 4 x | Impact 4 x | Likelihood 4 | Likelihood 3

### Controls: (What are we doing to mitigate the risk?)
- Diagnosis of issues and plan agreed locally and with regulators, including improvement trajectory
- System wide PMO agreed between Commissioners and LGT
- A&E Delivery Board in place with revised governance structures, with independent chair identified
- External leadership and improvement support resources, including clinicians in place
- A&E Plans considered by IGC, including direct LGT engagement
- Cross system workstreams identified as part of plan with named Senior Responsible Officers
- Alignment of work with SEL STP and Urgent and Emergency Care Network, including delivery of high impact areas
- Better Care Fund (BCF) 17/18 planning
- National capital funds (£1.6m) awarded locally for short term estate changes in UCCs at UHL and QEH

### Assurance Sources:
- A&E Plans to IGC.
- A&E Delivery Board papers and minutes.
- PMO workstreams reports and metrics
- BCF metrics
- STP delivery plan for urgent and emergency care

### Risk Assurances: (What evidence do we have that the controls are working?)
- Jointly agreed A&E revised trajectory.
- Jointly agreed A&E revised trajectory
- PMO established
- Performance Reports to IGC
- Performance Reports to A&E Delivery Board and supporting structures (Programme Steering Group in place for SROs to support reporting to A&E Delivery Board)
- Feedback from monthly escalation meetings with regulators (NHSE/NHSI)
- Implementation against nationally defined areas of high impact changes addressed through Improvement Plan

### Assurance Type:
- Management

### Assurance level:
- Adequate

### Gaps in Risk Controls:
- System OD plan missing
- PMO recruited to priority roles with gaps in data analytics (short term consultancy support commissioned to cover)
- Improvements unable to be tracked back to specific improvement plan interventions
- Workforce plans inadequate from LGT and across system to support agreed changes
- Estate changes implement too late
- Improvement plan not yet costed
- External support (clinical and managerial) resources to
system leave before substantive arrangements are put in place  
Failure to sustain changes results in only short-term impact  
Conflicting BCF/LAs integration plan or financial ability to support CBC changes  
Frontline clinical staff leadership and engagement not sufficiently robust to support changes required at pace needed  
Inadequate demand and capacity model that can cope with complexity of improvement plan changes and/or system support for outcomes from this work  
Sub-optimal governance to hold partners to account

| Actions:             | System OD/workforce workstream agreed, SRO identified but further scoping work to be completed and look for external delivery partner to support by July (Workstream SRO)  
Invest in the capability of the system – skilled staff with access to training to support new ways of working, strong collaborative leadership and adoption of an agreed system improvement.  
System sign-off estate plans for QEH and UHL UCC by early July for work to be contracted, mobilised and completed by October (LGT/workstream SRO)  
Finance meeting being scheduled to agree model required and resource to undertake by July (MW)  
Develop a plan for exiting from external/interim support to stable programme delivery/PMO team  
Borough based BCFs to be checked for alignment to improvement plan through BCF planning by LAs and CCGs (July, COs and Directors of Adult Social Care)  
Community demand and capacity work has been procured and started with delivery in July. There is a need to agree approach across acute and community (A&E Delivery Board)  
Strengthened governance of A&E Delivery Board through appointment of an independent chair (completed). Induction programme put in place for July(MW) |

**Last updated:** Martin Wilkinson 03/07/2017
<table>
<thead>
<tr>
<th>Corporate Objective:</th>
<th>Urgent and Emergency Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk</td>
<td>Transformation of Urgent and Emergency Care Services (Risk ID 80)</td>
</tr>
<tr>
<td>Risk Description: (What is the risk?)</td>
<td>We fail to deliver the transformation required in redesigning the services to prevent people from becoming admitted into hospital</td>
</tr>
<tr>
<td>Caused by:</td>
<td>The Trust does not engage in the process</td>
</tr>
<tr>
<td></td>
<td>The Trust does not agree to CQUIN proposals</td>
</tr>
<tr>
<td></td>
<td>Performance is not adequately monitored as there is no CSU support</td>
</tr>
<tr>
<td></td>
<td>Procurement expertise is not in place to advise on processes to test the market</td>
</tr>
<tr>
<td></td>
<td>In-house capacity is not aligned to enable the delivery of redesign</td>
</tr>
<tr>
<td></td>
<td>The capacity and capability of the provider workforce</td>
</tr>
<tr>
<td></td>
<td>The alignment of CCG and provider priorities</td>
</tr>
<tr>
<td>Leads to:</td>
<td>Emergency admissions to are not reduced</td>
</tr>
<tr>
<td></td>
<td>Emergency Re-admissions are not reduced</td>
</tr>
<tr>
<td></td>
<td>QIPP is not delivered</td>
</tr>
<tr>
<td></td>
<td>Inability to serve improvement notices as part of the contract management process</td>
</tr>
<tr>
<td></td>
<td>Market testing does not happen which results in a procurement not being undertaken</td>
</tr>
<tr>
<td></td>
<td>Transformation of urgent and emergency care services does not occur</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk Owner:</th>
<th>Browne, Alison</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk Manager:</td>
<td>Browne, Alison</td>
</tr>
<tr>
<td>Directorate:</td>
<td>Nursing &amp; Quality Directorate</td>
</tr>
<tr>
<td>Risk Appetite:</td>
<td></td>
</tr>
<tr>
<td>Risk Response:</td>
<td>Mitigate</td>
</tr>
<tr>
<td>Original Score:</td>
<td>Very High Risk</td>
</tr>
<tr>
<td>Current Score:</td>
<td>Very High Risk</td>
</tr>
<tr>
<td>Target Score:</td>
<td>High Risk</td>
</tr>
<tr>
<td>Risk Movement:</td>
<td>None</td>
</tr>
</tbody>
</table>

| Controls: (What are we doing to mitigate the risk?) | Reviewing contract management processes at the moment to potentially bring in house We have commissioned NEL to provide procurement advice |
| Assurance Sources: | LGT Contract Management Board Community Contract meeting monthly |
| **Risk Assurances:** (What evidence do we have that the controls are working?) | Check point data including audits.  
Deep dive of the emergency discharge team (EDT) (July/August 2017)  
Reviewing HRGs at project level to make sure they are in line with anticipated HRGs. |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assurance Type:</strong></td>
<td>Management</td>
</tr>
<tr>
<td><strong>Assurance level:</strong></td>
<td>Limited</td>
</tr>
</tbody>
</table>
| **Gaps in Risk Controls:**  | CSU contract team vacancies  
Lack of continuity in community commissioning approach  
Utilisation of ambulatory care pathway |
| **Actions:**                | Escalate concerns about recruitment difficulties to CMB (completed at CMB, DB)  
Review contract management support arrangements with CSU (July 2017 DB)  
Audit of ambulatory care pathway (TBC, DB)  
Bed capacity and demand review (July 2017, DB) |
<p>| <strong>Last updated:</strong>           | Alison Browne 03/07/2017                                                                                   |</p>
<table>
<thead>
<tr>
<th>Corporate Objective:</th>
<th>Urgent and Emergency Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk</td>
<td>Supported Discharge Initiatives (Risk ID 81)</td>
</tr>
<tr>
<td>Risk Description: (What is the risk?)</td>
<td>Failure to manage the flow through of patients through the hospital who are fit for discharge Caused by: failure to discharge patients who are fit for discharge lack of contract management support from the CSU to manage the process not working efficiently in partnership with LBL to realign services to become community networks Not transforming services, with any appropriate procurements not undertaken The capacity and capability of the provider workforce The alignment of CCG and provider priorities Leads to: bed occupancy increases Ready For Discharge (RFD) list increases through put of patients through the hospital slows down patients waiting for admission stay in A&amp;E resulting in ambulance delays and congestion along the whole pathway Inability to appropriately manage the contract and share risk with LGT Patients are readmitted through inconsistent management of LTCs System transformation does not occur which leads to inefficiencies and a reduction in safety for patients.</td>
</tr>
<tr>
<td>Risk Owner:</td>
<td>Browne, Alison</td>
</tr>
<tr>
<td>Risk Manager:</td>
<td>Browne, Alison</td>
</tr>
<tr>
<td>Directorate:</td>
<td>Nursing &amp; Quality Directorate</td>
</tr>
<tr>
<td>Risk Appetite:</td>
<td></td>
</tr>
<tr>
<td>Risk Response:</td>
<td>Mitigate</td>
</tr>
<tr>
<td>Original Score:</td>
<td>Current Score:</td>
</tr>
<tr>
<td></td>
<td>Target Score:</td>
</tr>
<tr>
<td></td>
<td>Risk Movement:</td>
</tr>
<tr>
<td>Very High Risk</td>
<td>Very High Risk</td>
</tr>
<tr>
<td>Impact 4 x</td>
<td>Impact 4 x</td>
</tr>
<tr>
<td>Likelihood 4</td>
<td>Likelihood 4</td>
</tr>
<tr>
<td>Controls: (What are we doing to mitigate the risk?)</td>
<td>AD Patient Pathways employed on a fixed term contract until 31/3/18. Responsible for RFD list monitoring and demand and capacity review. AD Patient Pathways also working to support the delivery the Discharge to Assess (D2A) model for Lewisham CCG (alongside LBL / LGT), with consideration of ongoing work across BGL</td>
</tr>
<tr>
<td>Assurance</td>
<td>RFD list (one across Trust)</td>
</tr>
<tr>
<td><strong>Sources:</strong></td>
<td>Discharge to Assess (D2A) reporting template</td>
</tr>
<tr>
<td>--------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td><strong>Risk Assurances:</strong> (What evidence do we have that the controls are working?)</td>
<td>Ready for Discharge list is less than 14 patients for LCCG per day, supporting less than 20 on the acute site. Discharge to assess is delivering – mid point evaluation has been completed</td>
</tr>
<tr>
<td><strong>Assurance Type:</strong></td>
<td>Management</td>
</tr>
<tr>
<td><strong>Assurance level:</strong></td>
<td>Limited</td>
</tr>
<tr>
<td><strong>Gaps in Risk Controls:</strong></td>
<td>Fixed term recruitment of the AD for Patient Pathways now in post.</td>
</tr>
<tr>
<td><strong>Actions:</strong></td>
<td>Performance management of the current systems for managing this process (CSU) Audit of ambulatory care pathway (TBC, DB) Bed capacity and demand review (July 2017, DB)</td>
</tr>
<tr>
<td><strong>Last updated:</strong></td>
<td>Alison Browne 03/07/2017</td>
</tr>
</tbody>
</table>
**Corporate Objective:** Planning QIPP Programme for 2018/19

**Risk**

<table>
<thead>
<tr>
<th>Risk Description: (What is the risk?)</th>
<th>QIPP - Planning for 2018/19 and 2019/20 (Risk ID 83)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risk Description:</strong> (What is the risk?)</td>
<td>If the CCG does not deliver a credible two year QIPP Programme this will jeopardise delivery of the financial control total for future years.</td>
</tr>
<tr>
<td>It is caused by:</td>
<td>• Failure to develop Year 2 impact assessment of 2017/18 programmes</td>
</tr>
<tr>
<td></td>
<td>• Lack of identified resource and expertise to develop early programmes</td>
</tr>
<tr>
<td></td>
<td>• The alignment of CCG and provider priorities</td>
</tr>
<tr>
<td>It could lead to:</td>
<td>• Failing to meet planning expectations of IAF for 2018/19</td>
</tr>
<tr>
<td></td>
<td>• Contract mediation and/or arbitration</td>
</tr>
<tr>
<td></td>
<td>• Inability to deliver balanced budget on a planning basis</td>
</tr>
<tr>
<td></td>
<td>• Inability to commit to new investments</td>
</tr>
<tr>
<td></td>
<td>• Loss of reputation</td>
</tr>
</tbody>
</table>

**Risk Owner:** Braithwaite, Diana  
**Risk Manager:** Braithwaite, Diana  
**Directorate:** Commissioning & Primary Care Directorate  
**Risk Appetite:** Low  
**Risk Response:** Mitigate  
**Original Score:** Very High Risk  
**Current Score:** Very High Risk  
**Target Score:** High Risk  
**Risk Movement:** None

| Controls: (What are we doing to mitigate the risk?) | QIPP 2018/19 development will be directed by the Clinical Directors and Senior Management Meetings.  
| | Monthly QIPP Pipeline Clinics  
| Assurance Sources: | Reports from the QIPP Clinic to the Clinical Directors and Senior Management Meeting  
| | DRAFT QIPP 2018/19 Programme Report to Integrated Governance Committee – July 2017  
| | SEL Control Expenditure Programme for the Treatment Access Policy Review  
| Risk Assurances: (What evidence do we have that the controls are working?) | Integrated Governance Committee review of 2018/19 Programme  
| | QIPP 2018/19 Programme included in Commissioning Intentions (September 2017)  
<p>| | QIPP 2018/19 Programme (HRG level) shared with providers (November 2017) |</p>
<table>
<thead>
<tr>
<th>Assurance Type:</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assurance level:</td>
<td>Limited</td>
</tr>
</tbody>
</table>

| Gaps in Risk Controls: | • Implementation of the Deloitte recommendations; (i) Sustained PMO Management to support the co-ordination of QIPP  
  • Interfaces between QIPP as an outcome of integrated programmes as stipulated in the STP are not evident  
  • Lack of appropriate resources to sufficiently interpret benchmarking information (E.g. Right Care etch) to develop large scale interventions to deliver the QIPP targets for 2018/19 and 2019/20 |

| Actions: | • Commission support to develop 2 year QIPP programme recognising the interfaces with the SEL Control Expenditure Programme (WHO: Diana Braithwaite; WHEN: July 2017)  
  • Resource QIPP and Right Care PMO on a sustained basis (SMT; July 2017) |

<p>| Last updated: | Diana Braithwaite 15/06/2017 |</p>
<table>
<thead>
<tr>
<th>Corporate Objective:</th>
<th>All Corporate Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk</td>
<td>Financial Targets 2017/18 (Risk ID 86)</td>
</tr>
<tr>
<td>Risk Description: (What is the risk?)</td>
<td>The CCG fails to meet its statutory financial duties and fails to deliver NHS England’s targeted surplus. It is caused by: The CCG does not have effective arrangements to control expenditure. The CCG does not have effective cash management arrangements. The CCG does not have adequate management and reporting arrangements. The CCG does not fully deliver its QIPP savings plan. Unplanned and unavoidable cost pressures. It could lead to: Failure to manage within Revenue Resource limit. Failure to manage within combined resource limit. Failure to manage within draw down limit. Failure to manage within running cost allowance. Failure to deliver targeted revenue surplus.</td>
</tr>
<tr>
<td>Risk Owner:</td>
<td>Read, Tony</td>
</tr>
<tr>
<td>Risk Manager:</td>
<td>Read, Tony</td>
</tr>
<tr>
<td>Directorate:</td>
<td>Finance Directorate</td>
</tr>
<tr>
<td>Risk Appetite:</td>
<td></td>
</tr>
<tr>
<td>Risk Response:</td>
<td>Mitigate</td>
</tr>
<tr>
<td>Original Score:</td>
<td>High Risk</td>
</tr>
<tr>
<td>Current Score:</td>
<td>High Risk</td>
</tr>
<tr>
<td>Target Score:</td>
<td>High Risk</td>
</tr>
<tr>
<td>Risk Movement:</td>
<td>None</td>
</tr>
<tr>
<td>Impact 4 x</td>
<td>Impact 4 x</td>
</tr>
<tr>
<td>Likelihood 3</td>
<td>Likelihood 2</td>
</tr>
</tbody>
</table>
| Controls: (What are we doing to mitigate the risk?) | Expenditure Controls
Standing Financial Instructions and Financial Policies
Reservation of Powers and Scheme of Delegation
Schedule of Matters Delegated to Officers
Detailed Budget Setting Procedures
Budget approved by Governing Body
Budgets delegated to authorised budget managers
Audit Committee
Finance and Investment Committee investment controls
Integrated Governance Committee scrutiny.
Contracts based on planned activity and expenditure
Financial plan compliant with NHSE business rules
Contingency and reserve Budgets
SBS authorised user controls
Budget changes reported to Governing Body
RRL controls and IAT processes
Contract management processes e.g. claims management |
and validation routines
Cash controls
Maximum cash drawdown
Detailed Cash flow forecasts
Maintenance of minimal cash balances at end of each month
Bank mandates and signatory controls
Monthly Financial Performance Reporting
The CCG has established in year financial performance monitoring at the Integrated Governance Committee and escalation to the Governing Body
Financial performance is monitored at provider level at contract monitoring meetings
Annual Financial control environment self assessment

<table>
<thead>
<tr>
<th>Assurance Sources:</th>
<th>Prime Financial Policies and schemes of delegation approved by GB</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Budget approved by GB</td>
</tr>
<tr>
<td></td>
<td>Financial reporting to Delivery Committee and Governing Body</td>
</tr>
<tr>
<td></td>
<td>Audit Committee Scrutiny</td>
</tr>
<tr>
<td></td>
<td>Finance and Investment Committee Scrutiny</td>
</tr>
<tr>
<td></td>
<td>Internal Audits</td>
</tr>
<tr>
<td></td>
<td>External Audit</td>
</tr>
<tr>
<td></td>
<td>Service Auditor Report on CSU Controls</td>
</tr>
<tr>
<td></td>
<td>Monthly Performance report to Delivery Committee</td>
</tr>
<tr>
<td></td>
<td>Finance report to Governing Body</td>
</tr>
<tr>
<td></td>
<td>Bank account reconciliations</td>
</tr>
<tr>
<td></td>
<td>CFO review meetings with ARC team</td>
</tr>
<tr>
<td></td>
<td>Audit Committee and IA review of financial control</td>
</tr>
<tr>
<td></td>
<td>environment self assessment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk Assurances: (What evidence do we have that the controls are working?)</th>
<th>External Audit of and opinion on 2016/17 Accounts EA+</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Internal Audit report on Financial management (Significant Assurance) 2016/17 EA+</td>
</tr>
<tr>
<td></td>
<td>Service Auditor Report on CSU Controls 2016/17EA+</td>
</tr>
<tr>
<td></td>
<td>Block 2017/18 contract agreements with GSTT and Kings IA+</td>
</tr>
<tr>
<td></td>
<td>Operating plan meets NHSE business rules. EA+</td>
</tr>
<tr>
<td></td>
<td>Financial control environment self assessment 2016/17 IA+</td>
</tr>
<tr>
<td></td>
<td>IA review of FCE assessment evidence 2016/17 EA+</td>
</tr>
<tr>
<td></td>
<td>QIPP plan with no unidentified gaps</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Assurance Type:</th>
<th>Assurance level:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gaps in Risk Controls:</td>
<td>NHSE Assurance on operating plan. Minimal reserves. Negative net risk in plan. Insufficient reserves to meet all potential financial risks. Uncertainty over LGT run rate support payment.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Actions:</th>
<th>De-risk QIPP Plan 17/18 (TR/DB. End June 2017)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fully identify RightCare opportunities. (TR/DB. End August 2017)</td>
</tr>
<tr>
<td></td>
<td>Budget manager sign off of 17/18 budget (end June 2017)</td>
</tr>
</tbody>
</table>

| Last updated:                                                                    | Tony Read 06/06/2017                                               |
## Appendix B – Risk Management Framework

*(Source: Risk Management Framework (ver 3.0) ratified on 22nd September 2015)*

<table>
<thead>
<tr>
<th>Good Governance Institute v2.2</th>
<th>Appendix 4 Risk Appetite for NHS Organisations - A maturity matrix to support better use of risk in decision taking</th>
<th>Developed with Southwark BSU</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risk levels</strong></td>
<td><strong>Key elements</strong></td>
<td><strong>Financial /VFIM</strong></td>
</tr>
<tr>
<td>0 Avoid</td>
<td>2 Minimal (RAIR)</td>
<td>Avoidance of financial loss is a key objective. Only willing to accept the least possible financial loss. VFIM is the primary concern.</td>
</tr>
<tr>
<td>1 Avoid</td>
<td>2 Two factor analysis options that have a low degree of inherent risk and may only have limited potential for reward.</td>
<td>Only prepared to accept the possibility of very limited financial loss. VFIM is the primary concern.</td>
</tr>
<tr>
<td>3 Avoid</td>
<td>3 One factor analysis options that have a low degree of inherent risk and may only have limited potential for reward.</td>
<td>Prepared to accept possibility of some limited financial loss. VFIM is the primary concern.</td>
</tr>
<tr>
<td>4 Accept</td>
<td>4 Seek to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).</td>
<td>Inviting for the best possible return and accepting the possibility of financial loss (with controls in place). Resources allocated with firm guarantee of return – “investment capital” type approach.</td>
</tr>
<tr>
<td>5 Mature</td>
<td>5 Senior decision makers (senior management) will consider all potential business risks and rewards.</td>
<td>Consistently focused on the best possible return for stakeholders. Resources allocated in “social capital” with confidence that a return in real terms can be achieved.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Compliance / regulatory</th>
<th>Innovation / Quality / Outcomes</th>
<th>Reputation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avoid anything which could be challenged, even if unsuccessful. Play safe.</td>
<td>Innovation pursued – desire to break the mould and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of delegated authority – management by it rather than tight control.</td>
<td>No tolerance for any decision that could lead to crisis of, or indeed attention to, the organization. External interest in the organization viewed with concern.</td>
</tr>
<tr>
<td>Want to be very sure we would win any challenge. Similar situations elsewhere have not produced complacency.</td>
<td>Innovation supported, with demonstration of commercial improvements in management control. Systems / technology developments limited to improvements to protection of current operations.</td>
<td>Tolerance for risk taking limited to those events where there is no chance of any significant representation for the organization. Senior management distanced themselves from choice of exposure to action.</td>
</tr>
<tr>
<td>Limited tolerance for taking our neck out. Want to be reasonable. Sure we will win any challenge.</td>
<td>Tendency to stick to the status quo. Innovation is not avoided unless really necessary. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations.</td>
<td>Tolerance for risk taking limited to those events where there is little chance of any significant representation for the organization. Should there be a failure? Mitigations in place for any adverse impact.</td>
</tr>
<tr>
<td>Challenges would be problematic; but we will win any challenge.</td>
<td>Innovation pursued – desire to break the mould and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of delegated authority – management by it rather than tight control.</td>
<td>Appetite to take decisions with potential to expose the organization to additional scrutiny. Interest in prospective management of organization’s reputation.</td>
</tr>
<tr>
<td>Chances of losing any challenge is real and consequences would be significant.</td>
<td>Innovation supported, with demonstration of commercial improvements in management control. Systems / technology developments limited to improvements to protection of current operations.</td>
<td>Appetite to take decisions with potential to expose the organization to additional scrutiny. Interest in prospective management of organization’s reputation.</td>
</tr>
<tr>
<td>Consistently pushing back on regulator. Enter into approach informed by better regulation.</td>
<td>Consistently pushing back on regulator. Enter into approach informed by better regulation.</td>
<td>Consistently pushing back on regulator. Enter into approach informed by better regulation.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>APPETITE</th>
<th>NONE</th>
<th>LOW</th>
<th>MODERATE</th>
<th>HIGH</th>
<th>SIGNIFICANT</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

*Note: The table above categorizes risk levels and key elements in the context of Risk Management Framework (ver 3.0), developed with Southwark BSU.*
## Glossary of terms: Risk

### Risk Definition

“The combination of the probability of an event and its consequence. Consequences can range from positive to negative.” (Institute of Risk Management)

“A probability or threat of damage, injury, liability, loss, or any other negative occurrence that is caused by external or internal vulnerabilities, and that may be avoided through pre-emptive action.” (Business Dictionary)

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action Required</td>
<td>Work that is required to close assurance gaps</td>
</tr>
<tr>
<td>Action Target Date</td>
<td>The date that the actions are due to be completed</td>
</tr>
<tr>
<td>Assurance Gaps</td>
<td>Where the CCG has no evidence of whether or not its controls are effective</td>
</tr>
<tr>
<td>Assurance Given</td>
<td>The evidence that controls are effective or not</td>
</tr>
<tr>
<td>Assurance Level</td>
<td>The strength of the evidence; None, Limited, Adequate, Significant</td>
</tr>
<tr>
<td>Assurance Source</td>
<td>Where the CCG finds evidence that its controls are effective</td>
</tr>
<tr>
<td>Assurance Type</td>
<td>Whether the evidence was generated and collated by management (Internal Assurance shown as IA+ for positive assurance and IA- in red text for negative assurance) or by an independent body (External Assurance shown as EA+ for positive assurance and EA- in red text for negative assurance)</td>
</tr>
<tr>
<td>Controls</td>
<td>What the CCG has put in place to lessen the impact of the risk should it occur and reduce the likelihood of it occurring</td>
</tr>
<tr>
<td>Current Score</td>
<td>The Current (‘residual’) risk score which is the most recent risk assessment</td>
</tr>
</tbody>
</table>
**Original Score**
The score that has been assessed at the beginning of the financial year

**Response**
What the CCG has decided to do about the risk: mitigate, accept, transfer or close.

**Risk Appetite**
‘The amount and type of risk that an organisation is willing to take in order to meet their strategic objectives.” (Institute of Risk Management)

Risk appetite is normally smaller or less than risk tolerance.

“The amount and type of risk than an organisation is prepared to seek, accept or tolerate.” (BS 31100:2008)

“The amount of risk, on a broad level, that an organisation is willing to take on in pursuit of value.” (KPMG)

<table>
<thead>
<tr>
<th>Risk Scores</th>
<th>Risk Scoring Matrix</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Likelihood</strong></td>
<td><strong>Risk Matrix</strong></td>
</tr>
<tr>
<td>Almost certain 5</td>
<td>Negligible 1</td>
</tr>
<tr>
<td>Likely 4</td>
<td>Minor 2</td>
</tr>
<tr>
<td>Possible 3</td>
<td>Moderate</td>
</tr>
<tr>
<td>Unlikely 2</td>
<td>Moderate</td>
</tr>
<tr>
<td>Rare 1</td>
<td>Moderate</td>
</tr>
</tbody>
</table>

NHS Lewisham CCG uses the standard NHS 5*5 risk scoring matrix shown above. The impact or consequence of the risk should it occur is measured on the x axis and the likelihood of the risk occurring is measured on the y axis.

Risks are evaluated using the matrix x * y, shown as I * L (Impact * Likelihood), and scored as:

- 1 - 3 (green) Low Risk
- 4 - 6 (yellow) Moderate Risk
• 9 - 12 (amber) High Risk
• 15 - 25 (red) Very High Risk.

**Risk Tolerance**

“While risk appetite is about the pursuit of risk, risk tolerance is about what an organisation can deal with.” (Institute of Risk Management)

The organisation’s readiness to bear the risk after risk treatments in order to achieve its objectives. (BS 31100:2008)

“Risk thresholds, or risk tolerances, are the typical measures of risk used to monitor exposure compared with the stated risk appetite.”

The following pages have been copied from Institute of Risk Management (2011), “Risk Appetite and Tolerance. Executive Summary.” Institute of Risk Management, London.

<table>
<thead>
<tr>
<th>T</th>
<th>Target Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Target risk score is the level of risk which the CCG Board has deemed acceptable level, reflecting the CCG’s risk appetite and which the CCG plans to achieve once all the controls are fully applied and proved to be effective.</td>
<td></td>
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</tbody>
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A meeting of the Governing Body
13 July 2017

PROPOSALS FOR OTC SELF CARE AND CESSION OF SUPPLY OF ANTIMALARIALS ON PRESCRIPTION

<table>
<thead>
<tr>
<th>CLINICAL LEAD:</th>
<th>Drs J McLeod and A Razzaque</th>
<th>Post: CCG Clinical Directors</th>
</tr>
</thead>
<tbody>
<tr>
<td>MANAGERIAL LEAD:</td>
<td>Alison Browne</td>
<td>Post: Director of Nursing and Quality</td>
</tr>
<tr>
<td>AUTHOR:</td>
<td>Eileen White</td>
<td>Post: Head of Medicines Management</td>
</tr>
</tbody>
</table>

RECOMMENDATIONS:
The Governing Body is asked to consider:

- the proposed changes to the prescribing of OTC medicines and those of limited clinical value in Lewisham and proceed to consultation.

- the proposed changes to existing local guidance and to no longer support availability of medicines for malaria prophylaxis on NHS prescription and proceed to consultation.

SUMMARY:
This document highlights proposals to revise prescribing guidance in Lewisham for GPs for:

- Over the counter medications
- Malaria prophylaxis

To ensure that NHS prescriptions are not routinely provided for the treatment of acute, self-limiting conditions and minor ailments for which self-care remedies can be purchased over the counter.

In addition NHS prescriptions for malaria prophylaxis (prevention) for travel will no longer be offered on an NHS prescription (this will bring Lewisham in line with national NHS policy).

KEY ISSUES:
NHS England is currently leading a review of low value prescription items from and there are plans to introduce new guidance for CCGs with a view to substantially saving NHS expenditure. In light of the financial challenges faced by the NHS, further work will consider other medicines which are of relatively low clinical value or priority or are readily...
available 'over the counter' and in some instances, at far lower cost than on prescription.

Lewisham CCG spends over £1.6m each year on GP prescribing of medicines that have limited clinical value, for which there is little evidence or can be bought over the counter (OTC) considerably cheaper than it costs the NHS to provide. The proposal is to promote self-care and to no longer support prescribing of these medicines for acute illnesses that will get better over time and health supplements.

The benefits of the proposed action will be to foster a culture of self-care and the self-management of minor and self-limiting conditions and will unnecessary demand on GP time as well as support the CCG to contain the costs of medicines on the local budget contributing to the Quality, Innovation, Productivity and Prevention (QIPP) programme.

### CORPORATE AND STRATEGIC OBJECTIVES

- Free up GP time for management of people with long term conditions
- Contribute to QIPP and GRIP on contract management

### CONSULTATION HISTORY INCLUDING MEMBERS ENGAGEMENT:

The Draft report has been considered by the Prescribing and Medicines Optimisation Group (PMOG); Membership Forum and Currently being considered at Neighbourhood meetings

### PUBLIC ENGAGEMENT

- Proposed changes were considered at the Public Reference Group meeting in May
- PMOG has lay member representation from Healthwatch
- If approval is gained from Governing Body the proposals will go forward to formal public consultation

### HEALTH INEQUALITY DUTY

- The report considers the consequences that may arise due to reduced ability to access certain medicines

### PUBLIC SECTOR EQUALITY DUTY

- The report considers the public sector equality implications of a reduced ability to access certain medicines. All protected groups will still have access to the products that are no longer available on prescription by either from pharmacies or from GP travel clinics.
- Any substantial amendments to the service will be assessed against the Equality Analysis Screening Tool to determine if a full Equality Impact Assessment is required.
<table>
<thead>
<tr>
<th>RESPONSIBLE MANAGERIAL LEAD CONTACT:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Name:</strong> Alison Browne</td>
</tr>
<tr>
<td><strong>E-Mail:</strong> <a href="mailto:alison.browne@nhs.net">alison.browne@nhs.net</a></td>
</tr>
<tr>
<td><strong>Telephone:</strong> 0203 049 2639</td>
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</table>

<table>
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<tr>
<th>AUTHOR CONTACT:</th>
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</thead>
<tbody>
<tr>
<td><strong>Name:</strong> Eileen White</td>
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<tr>
<td><strong>E-Mail:</strong> <a href="mailto:eileenwhite1@nhs.net">eileenwhite1@nhs.net</a></td>
</tr>
<tr>
<td><strong>Telephone:</strong> 0207 206 3296</td>
</tr>
</tbody>
</table>
Proposed changes to Prescribing in Lewisham

Part A: Promoting Self-care for Medicines

1. Background

1.1. National Context

NHS England is currently leading a review of low value prescription items and there are plans to introduce new guidance for Clinical Commissioning Groups (CCGs) with a view to substantially saving NHS expenditure in this area. It follows extensive work by NHS Clinical Commissioners which identified significant areas where potential savings can be made, up to potentially £400m per year.

NHS England will work with clinicians and CCGs to develop guidelines initially around medicines which are ineffective, unnecessary, inappropriate for prescription on the NHS, or indeed unsafe, and that together cost the NHS £128m per year. In developing the guidance, the views of patient groups, clinicians, commissioners and providers across the NHS will be sought.

In light of the financial challenges faced by the NHS, further work will consider other medicines which are of relatively low clinical value or priority or are readily available ‘over the counter’ and in some instances, at far lower cost than on prescription, such as treatments for coughs and colds, antihistamines, indigestion and heartburn medication and sun cream.

1.2. Local Context

Self-care medications are products that can be purchased without a prescription from a pharmacy or supermarket. Lewisham CCG spends over £1.6m each year on GP prescribing of medicines that have limited clinical value, for which there is little evidence or can be bought over the counter (OTC) considerably cheaper than it costs the NHS to provide. The proposal is to promote self-care and to no longer support prescribing of health supplements and medicines for acute illnesses that will get better over time.

Lewisham CCG also has a challenging QIPP target with additional savings required through the Capped Expenditure Programme (CEP) meaning that a further £2.3m in savings is required so original schemes identified need to be stretched.

1.3. Supporting Evidence

Greenwich CCG implemented a similar approach to encouraging self-care during 2016, although there is no evaluation report to date, Greenwich GPs have reported an improvement in access for patients and they estimate savings of around 10% on prescription spend on OTC medicines.

This paper outlines the groups of medicines that may be considered for inclusion and exclusion to the over the counter self-care medicines proposal.
2. Rationale for initiative

- Empowering people with the confidence and information to look after themselves when they can, and visit the GP when they need to, gives people greater control of their own health and wellbeing and encourages healthy behaviour that prevents ill health in the long term.

- In many cases people can take care of their minor ailments, reducing the number of GP consultations and enabling GPs to focus on caring for higher risk individuals, such as those with multiple illnesses, the very young and elderly, managing long-term conditions and providing new services.

- As well as community pharmacists, the public have available an increasing range of resources for advice on medicines use e.g. NHS Choices website, NHS 111.

3. Aims of the promoting self-care medicines initiative

- Free up GP practice time.

- Empower people to self-manage minor and self-limiting conditions without accessing General Practice, out of hours services, or hospital services.

- Reduce NHS expenditure on treatments that are available without prescription.

4. What is included in the proposals?

- Treatments for minor ailments that are self-limiting and will clear up without a medicine e.g. coughs and colds.

- Treatments that can be purchased without a prescription (OTC):
  - General Sales List (GSL) items can be purchased from any retailer, supermarket and discount stores which are generally cheaper than pharmacies.
  - Pharmacy only (P) items can only be purchased from pharmacies. Buying ‘own brand’ or generic items are usually more cost effective than originator brands.

- Treatments for self-limiting conditions or for relatively short-term use e.g. hayfever medicines.

5. Potential therapeutic areas/groups of medicines for self-care OTC purchase:

- Appendix 1 outlines the main therapeutic areas/groups of medicines which could be considered for inclusion in self-care management.

- The annual total spend for all these areas together is over £1.6 million, however it is important to note that many of these medicines may be used for both long term conditions and for short term symptomatic relief e.g. analgesia for long term pain control, laxatives/diarrhoea medicines for Inflammatory Bowel Disease.
6. Experience elsewhere

- NHS Greenwich CCG implemented a similar approach to encouraging self-care during 2016, their position statement says that Greenwich CCG does not support prescribing of medicines of limited clinical value and those that could be bought cheaply over the counter (OTC). There is no report available at this time detailing outcomes of this recommendation. Anecdotally, however, GPs have reported an improvement in access for patients and Greenwich estimate savings of around 10% on prescription spend on OTC medicines.

- Other CCGs within SE London and across the country are in the process of developing and implementing similar approaches to self-care and purchase of OTC medicines.

- Bromley CCG has obtained legal advice on behalf of all 6 South East London CCGs.

Part B. Proposed Changes to Malarial Prophylaxis on Prescription

7. Background

Malaria is an infection transmitted by the bite of an infected female anopheles mosquito. It is endemic in over 100 countries, with around half the world’s population at risk, most commonly throughout Africa, Central and South America, Asia and Oceania. The use of chemoprophylaxis before travel to a malarious area is recommended by the World Health Organisation.

7.1. National Context

Department of Health guidance from 1995 (FHSL (95) 7) gave GPs the power to charge patients for prescribing or providing anti-malarial prophylaxis for travel abroad. Lambeth, Southwark and Lewisham Health Authority, decided at the time not to implement the new regulations due to the fear that the already high incidence of imported malaria cases would increase further.

Malaria chemoprophylaxis continues to be available on an FP10 prescription in Lambeth, Southwark and Lewisham and residents exempt from prescription charges pay no cost. However, in view of the current financial climate and NHS reform, the rationale and ability to justify the policy is now under review in all three boroughs by CCGs and Public Health. Overall numbers of malaria cases have been falling over recent years however this serious and preventable imported infection remains an on-going concern.

There is known under-reporting of malaria as illustrated in a study that showed the Malaria Reference Laboratory only captured around 62% of London cases. Of those cases reported for the UK (1,400) London accounted for 49% of national reports with Lambeth, Lewisham, Southwark accounting for 3%, 4% and 5% respectively.

Previous work to improve completeness of reporting in Lewisham in 2013 resulted in an increase from 37 -> 70 cases reported between 2013 and 2014, again highlighting potential under-reporting.
7.2. Local Context

Lambeth (11.6%), Southwark (16.4%) and Lewisham (11.6%) have large ‘Black African’ communities. Hackney (11.4%), Croydon (8.0%) and Greenwich (13.8%) are close on the nearest neighbour model and have similarities in ethnic profile.

Patterns in country of travel, and reason for travel were similar in malaria cases from comparator areas (mainly Nigeria and visiting friends and family).

Impact of antimalarial prophylaxis prescribing policy is difficult to assess for a number of reasons e.g. patterns of travel for comparator areas not available, known under-reporting.

![Chart showing total malaria reports 2013-2015 for Greenwich, Lambeth, Lewisham, Southwark, Hackney and Croydon.](chart.png)

8.0. Options

8.1. Option 1 - Continue with current arrangements:

Malaria chemoprophylaxis is prescribed on an NHS prescription for any patient registered with a GP practice in Lambeth, Southwark or Lewisham. Patients usually pay a prescription charge of £8.60 or may be exempt from paying a prescription charge.
8.2. **Option 2 – malaria chemoprophylaxis not available on NHS**

This would involve discontinuing prescribing of malaria chemoprophylaxis on an NHS prescription for any patient registered with a GP practice in Lambeth, Southwark or Lewisham to bring the three boroughs in line with:

a) the amendments to the NHS (General Medical Services) 1992 outlined in NHS Executive circular FHSL (95)7 14 February 1995 - Malaria Prophylaxis: regulation permitting GPs to charge for prescribing or providing anti-malarial drugs; and

b) prescribing practice across England and Wales since 1995.

9. **Summary**

- Reported rate of imported malaria cases decreased in past 4 years across the UK including London and LSL.
- Decrease in reported malaria cases can be associated with:
  - Under reporting of malaria cases.
  - Increased use of chemoprophylaxis or other prevention method. However no information is available about trend of malaria chemoprophylaxis in travelers from the UK.
  - Decrease risk of being infected by the parasite when visiting endemic countries. While incidence has decreased in Africa, number of travels from the UK to West Africa has increased, and the number of residents from Black African origin may have increased.
- It is difficult to come to any firm conclusion about the impact of the chemoprophylaxis policy:
  - Reported cases by borough are small numbers
  - There is no evident and significant difference in reported cases between LSL and Hackney
  - Information on travel patterns and adherence to chemoprophylaxis at borough level is not available
- Estimating cases prevented by LSL policy of free access to malaria chemoprophylaxis is not easily available are depends on a number of assumptions
- Any change in access to malaria chemoprophylaxis will require:
  - Assessing completeness of reporting of imported malaria diagnosis to the PHE database
  - Raising awareness of the importance of prevention against mosquito bites
  - Providing information to the population most at risk of contracting malaria about alternative access to quality controlled malaria chemoprophylaxis.
10. Patient and Public Engagement

- A communications and engagement plan was developed by the Head of Communications and Engagement in March.

- Timescales for the consultation Process are shown below:

<table>
<thead>
<tr>
<th>Event</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication Plan developed</td>
<td>March 2017</td>
</tr>
<tr>
<td>Prescribing and Medicines Optimisation Group</td>
<td>April 2017</td>
</tr>
<tr>
<td>Clinical Directors/ Senior Management Team meeting</td>
<td>May 2017</td>
</tr>
<tr>
<td>Public reference group</td>
<td>May 2017</td>
</tr>
<tr>
<td>Neighbourhood Meetings</td>
<td>July 2017</td>
</tr>
<tr>
<td>Governing Body</td>
<td>July 2017</td>
</tr>
<tr>
<td>Healthier Communities Select Committee - Preliminary discussion</td>
<td>July 2017</td>
</tr>
</tbody>
</table>

A public consultation is planned and will include various stakeholders. Material will include:

- Consultation document and summary leaflet
- FAQ
- Website information
- Press release
- Survey questions
- Public meetings

11. Recommendations

The Governing Body is asked to consider the proposed changes to the prescribing of OTC medicines, health supplements and malaria prophylaxis in Lewisham and proceed to consultation.
### Appendix 1 – Main categories of self-care medication that could be to be included for consideration and health supplements

<table>
<thead>
<tr>
<th>Section</th>
<th>Product Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>Vitamins and Minerals</strong>&lt;br&gt;1. All vitamins and minerals&lt;br&gt;2. Bitters and tonics&lt;br&gt;3. Compound Vit/Mineral formulations&lt;br&gt;4. Other health supplements&lt;br&gt;5. Health supplements - VSL, Symprove, Co-enzyme Q10</td>
</tr>
<tr>
<td>2</td>
<td><strong>Analgesic Treatment</strong>&lt;br&gt;1. Paracetamol tabs/liquid&lt;br&gt;2. Ibupofen tabs/liquid&lt;br&gt;3. Topical analgesics (NSAIDs/Rubefacients)</td>
</tr>
<tr>
<td>3</td>
<td><strong>Hayfever treatments</strong>&lt;br&gt;1. Chlorphenamine 4mg tabs &amp; 2mg/5mml liq&lt;br&gt;2. Loratadine 10mg tablets and 5mg/5ml solution&lt;br&gt;3. Cetirizine 10mg tablets and 1mg/ml solution&lt;br&gt;4. Sodium cromoglycate 2% eye drops/nasal drops&lt;br&gt;5. Beclometasone dipropionate nasal inhalers&lt;br&gt;6. Fluticasone nasal inhalers</td>
</tr>
<tr>
<td>4</td>
<td><strong>Antifungal Treatment</strong>&lt;br&gt;1. Clotrimazole 1%/2%/10% cream/pessary&lt;br&gt;2. Econazole 1% cream&lt;br&gt;3. Ketoconazole (Nizoral) dandruff 2% shampoo&lt;br&gt;4. Miconazole 2% cream/powder/ 0.16% spray&lt;br&gt;5. Terbinafine 1% cream (Lamisal AT)&lt;br&gt;6. Fluconazole 150mg capsule&lt;br&gt;7. Amorolfine</td>
</tr>
<tr>
<td>5</td>
<td><strong>Indigestion Remedies</strong>&lt;br&gt;1. Medicines for dyspepsia and GORD</td>
</tr>
<tr>
<td>6</td>
<td>*<em>Laxatives</em> (for short term use)**&lt;br&gt;1. Senna tablets&lt;br&gt;2. Ispaghula husk sachets&lt;br&gt;3. Docusate sodium 100mg capsules&lt;br&gt;4. Lactulose solution</td>
</tr>
<tr>
<td>7</td>
<td><strong>Topical steroids for short term use (up to 1 week) for contact dermatitis/insect bites and stings</strong>&lt;br&gt;1. Hydrocortisone 1% cream/ointment</td>
</tr>
<tr>
<td>8</td>
<td><strong>Cough and Cold Remedies</strong>&lt;br&gt;1. All cough and cold remedies</td>
</tr>
<tr>
<td>9</td>
<td><strong>Mouth Treatment</strong>&lt;br&gt;1. Choline salicylate gel&lt;br&gt;2. Benzydamine 0.15% spray/wash&lt;br&gt;3. Hydrocortisone 2.5mg buccal tabs&lt;br&gt;4. Chlorhexidine 0.2% mouthwash&lt;br&gt;5. Flurbiprofen lozenges</td>
</tr>
<tr>
<td>10</td>
<td><strong>Anti-diarrhoeal medication for short term use</strong>&lt;br&gt;1. Loperamide capsules/liquid&lt;br&gt;2. Oral rehydration therapy</td>
</tr>
<tr>
<td>11</td>
<td><strong>Head Lice Treatment Scabies Treatment</strong>&lt;br&gt;1. Dimeticone 4% lotion/spray&lt;br&gt;2. Malathion 0.5% liquid</td>
</tr>
</tbody>
</table>
| **12** | Piles (Haemorrhoids) for short term use (5 to 7 days) | 1. Anusol cream/ointment/suppository  
2. Anusol HC cream/ointment/suppository  
3. Germoloids cream |
|---|---|---|
| **13** | Eye Treatments/Lubricating Products | 1. Chloramphenicol 0.5% eye drops/1% eye ointment  
2. Liquifilm, Snotears, Clinitas, Hylo-tear, Systane etc |
| **14** | Warts and Verruca Treatments | 1. Salicylic acid 26% solution  
2. Salicylic acid/lactic acid 11% /4% |
| **15** | Acne Treatment | 1. Benzoyl peroxide 2.5% /4% /5% /10% gel/cream/wash |
| **16** | Cold Sore Treatment | 1. Aciclovir 5% cream |
| **17** | Sun Creams | 1. Sun Creams |
| **18** | Ear Wax Removers | 1. Docusate sodium  
2. Oils for the ear  
3. Sodium bicarbonate  
4. Isopropyl alcohol  
5. Urea hydrogen peroxide |
| **19** | Covering Cream/Powder | 1. Cosmetics |
| **20** | Nappy rash treatment | 1. Metanium nappy rash ointment  
2. Topical steroids as above |
| **21** | Threadworm Tablets | 1. Mebendazole 100mg tablets/suspension |
| **22** | Colic Treatment | 1. Dentinox infant colic drops  
2. Colief infant drops  
3. Infacol  
4. Woodwards |
| **23** | Antiperspirants | 1. Anhydrol 20% solution/spray  
2. Driclor 20% solution/spray |
| **24** | Herbal and Complimentary Supplements | 1. Homeopathic preparations |

* Some prescribing will be appropriate to prescribe on the NHS e.g. laxatives for people with Inflammatory Bowel Disease.*
Main Issues discussed

The workshop reviewed key the strategic areas of mental health services and Lewisham Health and Care Partners (LHCP), with particular discussion to agree a strategic position on investment in an information platform to support population health commissioning.

- **Mental Health**

  The report looked at current and future levels of serious mental health and the requirements for inpatient beds. This included activity levels, average length of stay, and work that is being undertaken to redesign the mental health older adults pathway. Subsequent discussion included the development of mental health within the community based care programme, and handovers between the mental health service teams and GPs. The over-representation of black men in inpatient services was highlighted.

  It was noted that the June meeting of the Integrated Governance Committee was looking at mental health service performance.

- **Lewisham Health and Care Partners Update**

  The update on LHCP looked at the governance arrangements in particular with Lewisham’s Health and Wellbeing Board, the programme to maximise the utilisation of the public estate in Lewisham, the use of information technology, and improving multi-disciplinary working. The workshop also reviewed the role of the CCG within the partnership arrangements of the LHCP and the relationship with the CCG governing body.

  A future report to the workshop was requested that would include more detail on the direction of travel, the work plan and timescales for the programme.

- **Lewisham Health and Care Partners Population Health System**

  The workshop looked at a case for investment in an information system that would support prevention and early intervention in health and care, including sharing information and improving the ability to plan for the future population. This could include a population health data repository with feeds from social care, primary care, mental health, community and acute date sources, create common records, support care pathways and risk stratification to deliver common programmes, analytical tools to utilise ‘big data’ from the repository to support health and social care planning, service delivery and research, and individual citizen access.

  Having discussed the features of the system and how it could be used, governance and information governance issues, and risks such as data quality, the workshop remitted the
investment case for further consideration by the Governing Body.

Achievements

The Enhanced Dementia pathway pilot, described in the mental health update, will increase nursing assessment capacity and support in primary care, social care assessment, a befriending service and establish a dedicated respite service to facilitate early discharge from acute care for those patients that can return home.

Challenges

The mental health update described the higher and increasing rates of serious mental health illness, and increases in under 65s requiring continuous needs for dementia services. Aligning priorities and arrangements between the partners

Inequality & Fairness

The workshop discussion on mental health highlighted the over-representation of black men in inpatient services, and recognised that this is a national issue, but that more work was needed to get a fuller understanding of how it arose and could be addressed. The improved analysis of health inequalities and outcomes was highlighted as one of the needs that could be met through the population health system for LHCP.
A meeting of the Governing Body
Thursday 13th July 2017

Urgent Care Review: New Cross Walk-in Centre

CLINICAL LEAD/S: Dr David Abraham, Clinical Director – Urgent Care Lead and Dr Jacky McLeod, Clinical Director – Primary Care Lead
MANAGERIAL LEAD: Diana Braithwaite, Director of Commissioning & Primary Care

REPORT AUTHOR/S: Kerry Lipsitz, Interim Head of Urgent Care & Commissioning and Diana Braithwaite, Director of Commissioning & Primary Care

RECOMMENDATIONS:
Members of the CCG Governing Body are recommended to approve that;
1. The CCG commences formal consultation on the future of the New Cross Walk-in Centre service.
2. The CCG Chief Officer is delegated to assure the consultation plan includes the key stakeholders that will be directly engaged and the supporting materials that will be used.

SUMMARY:
Both nationally and locally it is recognised that the urgent and emergency care system is under considerable pressure to meet current and growing demands. The Royal College of Emergency Medicine has reported a steady deterioration in urgent and emergency care with the NHS now facing the worst four hour A&E performance target in almost 15 years.¹

In Lewisham, the number of patients using urgent and emergency care services for non-urgent or non-life threatening conditions is increasing and putting a strain on local A&E services.² In addition, demographics are changing across London, with the Office for National Statistics estimating that the population in Lewisham will grow by 14.4% by 2024.

As a result, primary and urgent care services across Lewisham need to change to provide the right care in the right place by the most appropriate professional and obtain better value for money – to meet future demands.

In the refreshed Primary Care Strategy – Developing GP Services approved by the Governing Body in October 2016, the CCG set out its vision and the changes required to improve access to primary care services.

Delivery of the Integrated Primary & Urgent Care Model commenced in October 2016 with commissioning of the Primary Care Assessment Pilot, currently provided by SELDOC. The service supports with managing the flows of patients to the Urgent Care Centre (UCC) and Emergency Department by assessing and treating patients with primary care needs at the front end of UCC or directing patients to an alternative care provider or self-care advice.

The CCG has also commissioned the local GP Federation (One Health Lewisham) to deliver its GP Extended Access Service, which provides bookable appointments 7 days a week, 8am to 8pm through the patient’s registered practice, via Integrated Urgent Care (formerly NHS 111), through redirection from the Urgent Care Centre and in future via direct online patient booking. The service has access to patient’s medical records, which will support improved access and continuity of care. This service commenced in April 2017. Patients have access to a GP and Nurse for face to face appointments and can also access a GP via Video Consultation.

¹ https://www.rcem.ac.uk/RCEM/News/News_2017/Emergency_Care_is_in_crisis.aspx
The CCG has conducted an initial review of access to primary and urgent care services in light of these new services and the need to provide clarity for our population on the most appropriate way to access primary and urgent care; cognisant of the multiple ‘front doors’ to services. Currently, urgent care in Lewisham is accessed through a number of services; the Urgent Care Centre located at the University Hospital Lewisham, the Primary Care Assessment Service also located at the same site, GP Extended Access also located at the same site, through their GP practice, the New Cross Walk-in Centre, via Integrated Urgent Care (formerly NHS 111) or high street pharmacies. This provides confused messages and consequently patients are not always seen in the right care setting and not always seen at the right time.

The CCG adopted commissioning responsibilities for the New Cross Walk-in Centre from NHS England in 2015, when the GP register was disaggregated from the Walk in Centre. On the 1st January 2016 a new contract was issued to the Hurley Group (incumbent provider) of the New Cross Walk-in Centre, located in the Waldron Health Centre for a period of 24 months.

Based on the above position and the summary of headline findings from a review of the walk in centre (see key issue below) it is recommended that the contract for this service should not be automatically renewed when the contract expires on the 31st December 2017. Instead it is recommended that a review and formal consultation be undertaken to inform the future commissioning intentions for this service in the context of the delivery of the CCG’s approved strategy for primary and urgent care services.

**KEY ISSUES:**

1. **Commissioning Intentions**
   1.1 The CCGs commissioning intentions as set out in its approved Primary Care Strategy includes the development of an Integrated Primary & Urgent Care on the University Hospital Lewisham site.
   1.2 The GP Extended Access Service will provide our population with access to an additional **25,425** bookable appointments in 2017/18, increasing to **29,194** in 2018/19 – the CCG has invested £1.5m in this service in 2016/ and 2017/ at a full year cost of £1.2m.
   1.3 The Primary Care Assessment Pilot saw **7,881** patients from October 2016 to May 2017. The CCG has invested £0.6m per annum in this service and there are plans to maintain services post the pilot stage.
   1.4 An independent evaluation of the pilot identified the following key findings – between October 2016 and January 2017;
      - A total of 3653 patients were seen during the period of 3rd October 2016 – 31st January 2017
      - Pilot activity equates to approximately 9% (30-35 per day) of total Urgent Care Centre/Emergency Department activity.
      - An average of 2.7 patients per hour were seen which was in line with the key assumptions of 2.5 to 3 per hour.
      - 64% (up to 25 patients per day) of pilot activity did not go to the Urgent Care Centre or Emergency Department for further investigation or treatment. These patients received either immediate treatment, management at point of assessment, signposted to an alternative setting appropriate for their health care needs e.g. their own GP, Early Pregnancy Unit, Sexual Health etc. or provided with verbal and/or written clinical advice.

2. **The New Cross Walk-in Centre**
   2.1 The New Cross Walk-in Centre contract is due to expire on the 31st December 2017. A summary of headline findings from a review of the walk in centre are provided below;
      - In 2016/17 the Walk-in Centre saw **29,528** patients at cost of approximately **£748k** to Lewisham CCG.
      - Of those attending the Walk-in Centre less than half **(43.5% or 12,726)** can be identified as
registered with a Lewisham GP.

- Of those Lewisham residents registered with a GP, 28.5% (3,638) of the patients using the Walk-in Centre were already registered with one of the four GP Practices located in the Waldron Health Centre.
- 28.6% (8,367) of patients who attended the Walk-in Centre cannot be attributed to any CCG; at a cost to the CCG of approximately £296k in 2016/17.
- 45.6% of patients surveyed by NHS Lewisham CCG reported that they went directly to the Walk-in Centre without attempting to book a GP appointment, as they did not believe they would be able to get appointment at their GP practice.
- 82.2% of patients’ surveyed by NHS Lewisham CCG reported they would consider using another service which offered bookable appointments at another location, if their own GP practice did not have available appointments.
- Walk-in Centres by their very nature provide access to all. Lewisham is the only remaining CCG in SEL that commissions a Walk-in Centre that provides access to patients from outside of the Borough. Neighbouring CCGs such as Southwark, Lambeth and Greenwich have all closed their Walk-in Centres and replaced them with GP Extended Access Hubs, which are predominantly used by patients registered within the respective boroughs.
- In 2016/17, 17.5% of patients using Walk-in Centre were from neighbouring South East London Boroughs; Southwark 12.5%; Greenwich 2.7%; and Lambeth 1.3%.

3. Consultation and Timelines (Indicative)

3.1 A formal and comprehensive public, patient and stakeholder consultation programme will be developed to enable views and comments to be sought from July 2017 to September 2017. An interim report to the Governing Body will be submitted in September 2017 with a final report by November 2017. This will include (but is not limited to) consultation with the following constituent groups;

- Patient Participation Groups (PPG) associated to the four local practices based in the Waldron Centre
- Elected Member/s (Vicky Foxcroft MP)
- Local residents, patients, NHS staff and users of the New Cross Walk-in Centre
- Local voluntary organisations
- NHS Staff/other staff at the Waldron Centre
- Healthwatch
- The four GP practices located in the Waldron Centre and neighbouring practices
- Neighbouring CCGs (Southwark, Lambeth and Greenwich)
- Lewisham & Greenwich Trust
- Local Medical Committee
- Integrated Urgent Care Service (formerly NHS 111)

3.2 The timeline is indicative and provides detail of the key milestones required for formal consultation to ensure that the CCG complies with its statutory responsibilities. In 2010, the Secretary set out four key tests against which NHS service reconfigurations (significant changes to services) have to be assessed. These tests were set out in the Revision to the Operating Framework for the NHS in England 2010/12. This requires reconfiguration proposals to demonstrate;

a) support from GP commissioners;
b) strengthened public and patient engagement;
c) clarity on the clinical evidence base; and
d) consistency with current and prospective patient choice.

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**CORPORATE AND STRATEGIC OBJECTIVES:**

- Our Healthier South East London Sustainability Transformation Plan – Community Based Care
- CCG Primary Care Strategy
- CCG Estates Strategy
- Corporate Objectives 2017/18: Urgent & Emergency Care – Review access to Urgent Care to streamline the number of ‘front doors’, including the Urgent Care Centre, new integrated primary care and Integrated Urgent Care (formerly NHS 111) and the New Cross Walk-in Centre

**CONSULTATION HISTORY:**

- CCG Clinical Directors and Senior Management Team May 2017.

**PUBLIC ENGAGEMENT:**

The CCG has interviewed patients at the Walk-in Centre. A formal and comprehensive public, patient and stakeholder consultation programme will be undertaken.

**HEALTH INEQUALITY & PUBLIC SECTOR EQUALITY:**

- All services commissioned will have due regard to; (i) **eliminate unlawful discrimination**, harassment, victimisation and any other conduct prohibited by the Equality Act 2010; (ii) **advance equality of opportunity** between people who share a protected characteristic and people who do not share it; and (iii) **foster good relations** between people who share a protected characteristic and people who do not share it.
- The Equalities screening tool has been used for an early assessment on the recommendation to consult and there are no immediate changes during this process. However, the potential outcome would require a full Equalities Impact Assessment (EIA). Therefore, it is recommended that a full conducted before formal consultation. This should also include a patient transport survey.

**AUTHOR/RESPONSIBLE MANAGERIAL LEAD CONTACT:**

Name: Diana Braithwaite; Email: diana.braithwaite@nhs.net
Strengthening Lewisham’s Governance and Partnership Arrangements for the Delivery of Community Based Care

**CLINICAL LEAD:** Dr Marc Rowland  
**MANAGERIAL LEAD:** Martin Wilkinson

**AUTHOR:** Sarah Wainer

**RECOMMENDATIONS:**
The CCG Governing Body is asked:

- to support and endorse the intended direction of travel to strengthen the governance and partnership arrangements for the delivery of community based care as part of an accountable care system;
- to note that further work is being undertaken to identify the legal frameworks or agreements that could be used to formalise any such governance and partnership arrangements and that a further report on this would be presented to the Health and Wellbeing Board and through the governance of each sovereign organisation;
- to note the interim steps that are being taken to adopt stronger and more collaborative working within existing governance and partnership arrangements.

**SUMMARY:**
This report is being presented to the Health and Wellbeing Board on 6th July on the planned next steps to strengthen Lewisham’s governance and partnership arrangements for the delivery of Community Based Care, as part of the direction of travel towards a population based accountable care system.

The meeting is taking place at the same time as despatch of the CCG Governing Body papers so the response by the Health and Wellbeing Board will be reported verbally.

**KEY ISSUES:**
Lewisham Health and Care Partners (LHCP)* have recognised that to address local health and care, equality, quality and efficiency challenges more effectively, organisations and their partners should explore closer integration towards an accountable care system. An accountable care system is a system which commissions and delivers health and care, working across organisations and in partnership, with the potential to share governance and
accountability and to pool budgets against strategically commissioned outcomes

As a first step, LHCP plan to strengthen the governance and partnership arrangements for community based care to secure benefits across the system as outlined in the attached report to the Health and Wellbeing Board.

The attached report seeks agreement from the Health and Wellbeing Board to take these first steps and to explore the legal frameworks and statutory arrangements which could be used should sovereign bodies want to formalise such arrangements. This includes considering the further steps which could be taken to improve collaborative and joint working across the CCG and the Council to strengthen the integrated strategic commissioning function, as well as establishing an alliance of providers.

No changes to formal governance and partnership arrangements can be made without the full agreement from each sovereign organisation, particularly if delegated authority is being proposed. Further work is needed to see how any proposals in relation to new governance or partnership arrangements would affect each existing organisation’s governance arrangements. Once this detail is available, further consultation will take place with existing governance groups and committees on any changes proposed and final proposals presented to the Health and Wellbeing Board, Healthier Communities Select Committee and to each partners’ governance arrangements for comment and approval.

While further work is taking place to explore the legal framework and statutory arrangements, Lewisham Health and Care Partners are of the view that much can be done, both from a commissioner and provider perspective, within current governance arrangements to reshape existing groups and model the new ways of working.

*LHCP includes representatives from Lewisham CCG, Lewisham and Greenwich NHS Trust, One Health Lewisham, Lewisham Council and South London and Maudsley NHS Foundation Trust.

CORPORATE AND STRATEGIC OBJECTIVES

The planned next steps outlined in the report reflect the emphasis given in the Next Steps on the NHS Five Year Forward View to move to further integration across health and care, through Sustainability and Transformation Partnerships, and, for some, through the creation of accountable care systems.

The Partnership Commissioning Intentions (2017/18 and 2018/19) set out the overall commissioning ambition to develop Community Based Care by commissioning advice, support and care that is proactive and preventative, accessible to all and co-ordinated. This ambition will be strengthened by the proposals to improve collaboration and joint working across the CCG and Council.
**CONSULTATION HISTORY:**
Feedback on the work of Lewisham Health and Care Partners has been provided to the Governing Body via Chair and Chief Officer updates. Discussions have also taken place at Strategy and Development Workshops and the Membership Forum.

**PUBLIC ENGAGEMENT**
The whole system work by Lewisham Health and Care Partners is regularly reported to the Health and Wellbeing Board and is publicly available, including the report presented here. At this stage no specific public engagement has taken place on the next steps to strengthen governance and partnership arrangements as no formal changes are being proposed. As progress is made towards a population based accountable care system, engagement with the public will take place on future proposals.

**HEALTH INEQUALITY DUTY/PUBLIC SECTOR EQUALITY DUTY**
As outlined in the attached report, although there are no specific equalities implications arising from this report, the development of any new health and care governance and partnership arrangements will continue to focus on improving health and care outcomes and reducing inequalities across the borough.

**RESPONSIBLE MANAGERIAL LEAD CONTACT:**
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1. Purpose

1.1 This report sets out Lewisham Health and Care Partners’ planned next steps to strengthen the governance and partnership arrangements for the development and delivery of Community Based Care as part of their proposed direction of travel towards a population based accountable care system for Lewisham. An accountable care system is a system which commissions and delivers health and care, working across organisations and in partnership, with the potential to share governance and accountability and to pool budgets against strategically commissioned outcomes. The report seeks the Board’s support for this approach.

2. Recommendation

2.1 Board members are asked:

- to support and endorse the intended direction of travel to strengthen the governance and partnership arrangements for the delivery of community based care as part of an accountable care system;
- to note that further work is being undertaken to identify the legal frameworks or agreements that could be used to formalise any such governance and partnership arrangements and that a further report on this would be presented to the Health and Wellbeing Board and through the governance of each sovereign organisation;
- to note the interim steps that are being taken to adopt stronger and more collaborative working within existing governance and partnership arrangements.

3. Strategic Context

3.1 The activity of the Health and Wellbeing Board is focused on delivering the strategic vision for Lewisham as established in Shaping our Future – Lewisham’s Sustainable Community Strategy, and by Lewisham’s Health and Wellbeing Strategy.

3.2 The work of the Board directly contributes to Shaping our Future’s priority outcome that communities in Lewisham should be Healthy, active and enjoyable - where people can actively participate in maintaining and improving their health and wellbeing.
3.3 The Health and Social Care Act 2012 placed a duty on Health and Wellbeing Boards to prepare and publish joint health and wellbeing strategies to meet the needs identified in their joint strategic needs assessments. Lewisham’s Health and Wellbeing Strategy was published in 2013 and refreshed in 2016.

3.4 The Health and Social Care Act 2012 also requires Health and Wellbeing Boards to encourage persons who arrange for the provision of any health or social services in the area to work in an integrated manner, for the purpose of advancing the health and wellbeing of the area.

3.5 The NHS Five Year Forward View was published on 23 October 2014 and sets out a new shared vision for the future of the NHS based around new models of care.

3.6 Planning guidance was published on 22 December 2015 which set out the requirement for the NHS to produce five year Sustainability and Transformation Plans (STP). These are place based, whole system plans driving the Five Year Forward View locally. The Next Steps on the NHS Five Year Forward View highlights the need to move to further integration across health and care, through Sustainability and Transformation Partnerships and, for some, through the creation of accountable care systems.

4. Background

4.1 For many years, health and care partners across Lewisham have worked together to plan and deliver care in a more accessible, integrated and sustainable way. Supporting the Health and Wellbeing Board, Lewisham’s Health and Care Partners Executive Board (LHCPEB) currently provides the joint strategic direction for this work where it requires a whole system approach. The framework provided by the South East London STP Our Healthier South East London has informed the development of local transformation and integration plans.

4.2 A key area of focus for LHCPEB has been on the improvement, development and delivery of Community Based Care. Partners want the support and care that is provided in the community, outside a traditional hospital setting, to be more accessible, proactive, preventative and coordinated. By working together on the development and delivery of Community Based Care, partners aim to maintain and improve people’s health and wellbeing, increase their independence and resilience, reduce the risk of admission to hospital and facilitate the timely discharge of patients.

4.3 Although examples of good practice already exist across the borough, the Lewisham Health and Care Partners Executive Board agreed that they should look at ways in which the governance and partnership arrangements around the development and delivery of community based care could be strengthened to accelerate progress, achieve faster decision making and clarify accountabilities. This has included exploring the development of a locally based accountable care system.

4.4 To support the LHCP in this work, the Board engaged the support of external consultants to help them review Lewisham’s current governance and arrangements, to explore good
practice adopted established elsewhere in the country, and to present a report to the Board recommending possible arrangements to achieve the desired outcomes in Lewisham.

4.5 The report made a number of recommendations for the LHCP to consider. The report recommended establishing a system oversight board, a strategic commissioning function and an alliance of providers.

5. Rationale

5.1 Although partners across the system currently seek to carry out commissioning and provider functions in partnership, they recognise that something different is needed to secure collective leadership and to enable partners to work together. They recognise that to address local health and care, equality, quality and efficiency challenges more effectively, organisations and their partners should explore and work towards an accountable care system. These place based health and care systems work across organisations and partnerships with pooled budgets, shared governance and accountability.

5.2 As a first step, LHCP believe that the strengthening of governance and partnership arrangements for community based care will secure benefits across the system. These include delivering an agreed partnership vision for community based care, providing clarification of the roles and responsibilities between commissioners and providers in the development and delivery of community based care, ensuring there is joint agreement on the intermediate and long term health and care outcomes based on the population health needs assessment, aligning priority areas for action and resources, and fully engaging with the system wide workforce. Where challenges and obstacles arise that would delay or disrupt plans, the new arrangements are expected to support partners across the system to reach a speedier resolution.

5.3 The government has previously stated that it wants to see the integration of health and social care, in every area of England, by 2020, supported by the Better Care Fund. The proposed direction of travel outlined in this report also aligns with the expectations set out in the NHS Five Year Forward View which called for better integration across the health and care system and for an acceleration of local integration and partnership arrangements. The need to bring organisations more closely together and address the fragmentation and duplication across the system is further reiterated in Our Healthier South East London, the Sustainability and Transformation Plan (STP) for South East London.

6. The Proposed Governance and Partnership Arrangements for Community Based Care

6.1 The external consultants presented a conceptual illustration for how the governance and partnership arrangements for community based care could be arranged. This is shown at Annex A.

6.2 The proposed arrangements illustrate the strong relationship between three key elements which are necessary for the successful delivery of community based care: collective decision making and oversight; accountability for the public value; and accountability for quality and for delivery with the right capacity and resources.
6.3 If the Health and Wellbeing Board supports this direction of travel, the next steps that health and care partners propose to take towards the establishment of these arrangements are set out in more detail in the following sections.

Next Steps

7. Establishing a system oversight board

7.1 Partners want to explore the establishment of a system oversight board to make shared decisions and be held accountable for the delivery of sustainable, high quality and outcome based population health and care in Lewisham. They want to explore how such a board could best be formed to achieve a clear mandate to identify and agree deliverables, realise benefits, share risks and set clear outcomes within a specified funding envelope. Such a board could act as the executive arm of the Health and Wellbeing Board.

Proposed next steps

7.2 The current LHCP Executive Board will act as a shadow system oversight board continuing to provide strategic oversight and adopting, within existing governance arrangements, the full roles and responsibilities of a system oversight board and testing out how effectively those roles are being executed. Members will work collaboratively to develop and oversee a joint vision and plan for the development and delivery of Community Based Care. In taking this work forward, the Board want to be held jointly accountable to the Health and Wellbeing Board and sovereign bodies for agreed key milestones and key deliverables. This will seek to establish value to the system as a whole and focus on health and care outcomes, quality and efficiency, and the greater co-ordination and integration of health and care for the local population, rather than individual organisational benefit. The LHCP will focus on the key enablers and infrastructure that needs to be in place to support an accountable care system, such as the development of population health IT systems, maximising the use of the health and care estate, undertaking financial modelling, workforce development and improving communication. As part of this the Board will also support the development of the Neighbourhood Hubs.

7.3 Whilst adopting shadow arrangements, members will be asked to review regularly their performance and to judge whether the shadow board has secured improvements in the way they want and has addressed the current challenges in terms of decision-making and accountability. In parallel further work to explore the legal frameworks and statutory arrangements which could be used should sovereign organisations want to formalise such arrangements will be undertaken and presented through each organisation’s governance so that each can consider the specific implications for their own organisation.

7.4 At this time, however, there would be no change to the current governance and accountability of existing sovereign bodies and each partner would need to ensure that the appropriate approval for commissioning or provider plans is secured from their own organisation.
8. Establishing a Strategic Commissioning Function

8.1 Partners want to strengthen the integrated strategic commissioning function between the CCG and the Council to enable health and care commissioners to work collaboratively, possibly under a single arrangement. Commissioning partners want to ensure commissioners across the system work together more closely, share data and information more effectively and maximize opportunities for joint planning and aligning outcomes.

8.2 By working in an integrated way, commissioners would be expected to agree collectively the commissioning intentions for community based care and to define the intermediate health and care system goals and population outcomes.

Proposed next steps

8.3 The LHCP Executive Board has asked commissioners to consider what further steps could be taken to improve collaborative and joint working across the CCG and the Council to deliver strategic commissioning.

9. Establishing an Alliance of Providers

9.1 Provider partners want to strengthen the collaboration between them. One way of doing so is by establishing an alliance of provider organisations to deliver community based care. Such an alliance would enable providers to respond collectively to commissioner contracts and for providers to hold one another to account. An alliance would manage population health risks and develop collaborative operating and management systems. Coming together as equals, providers would take joint responsibility and accountability for the delivery of specified outcomes. Providers could agree shared objectives/targets and identify those areas where they could collaborate and pool budgets.

9.2 As with the strategic commissioning functions, it was felt that an alliance should enable providers to address issues across the full health and care system rather than addressing individual parts. Any alliance model should enable providers to explore solutions that focus on the improvement of population and performance outcomes and on the integration of care.

Proposed Next Steps

9.3 Providers are currently working together to explore the development of an alliance, with key voluntary sector organisations, for the delivery of community based and co-ordinated care. A group has been established to share knowledge and experience to inform the development of future alliance arrangement for CBC. Within this wider CBC provider alliance work, providers are also testing out this approach for mental health provision. This proposed provider alliance approach reflects the interrelated nature of current provision, the desire to deliver holistic and person centred care, and the need to ensure that the impact of increased activity or provision by one provider does not adversely affect another.
10. Seeking formal agreement on joint governance and partnership arrangements

10.1 Although this report proposes a way forward and new ways of working, before the specific changes to existing governance arrangements or accountability can be proposed or implemented, more detail on the legal frameworks and statutory arrangements (e.g., section 75) to deliver stronger partnership arrangements is required. While this work is undertaken, partners are of the view that much can be done within current governance arrangements to reshape existing groups and model the new ways of working.

10.2 No changes to formal governance and partnership arrangements can be made without the full agreement from each sovereign organisation, particularly if delegated authority is being proposed. Further work is needed to see how any proposals in relation to new governance or partnership arrangements would affect each existing organisation’s governance arrangements. Once this detail is available, further consultation will take place with existing governance groups and committees on any changes proposed and final proposals presented to the Health and Wellbeing Board, Healthier Communities Select Committee and to each partners’ governance arrangements for approval.

11. Financial Implications

11.1 There are no financial implications arising from this report. Any proposed activity or commitments arising from activity to support the development of the proposed governance and partnership arrangements for the delivery of community-based care will need to be agreed by the delivery organisations concerned and be subject to confirmation of resources. The funding available in future years will of course need to take account of any required savings or any other reduction in overall budgets and national NHS planning guidance.

12. Legal implications

12.1 As part of their statutory functions, members are required to encourage persons who arrange for the provision of any health or social services in the area to work in an integrated manner for the purpose of advancing the health and wellbeing of the area, and to encourage persons who arrange for the provision of health-related services in its area to work closely with the Health and Wellbeing Board.

12.2 Where there is an integration of services and/or joint funding, then this is dealt with under an agreement under Section 75 NHS Act 2006 which sets out the governance arrangements for the delivery of services, and where relevant any delegation of functions from one party to another and the respective budget contributions of the local authority and the CCG in relation to the services.

12.3 Any additional legal implications arising from the establishment of more formal governance and partnership arrangements will be fully detailed in future reports and agreement sought from each sovereign body before any formal change is implemented.

13. Crime and Disorder Implications
13.1 There are no specific crime and disorder implications arising from this report or its recommendations.

14. Equalities Implications

14.1 Although there are no specific equalities implications arising from this report, the development of any new health and care governance and partnership arrangements will continue to focus on improving health and care outcomes and reducing inequalities across the borough.

15. Environmental Implications

15.1 There are no specific environmental implications arising from this report or its recommendations.

16. Conclusion

16.1 Members are invited to support the proposed direction of travel and planned next steps as set out in this report.

If you have problems opening this document, please contact: stewart.snellgrove@lewisham.gov.uk (Phone: 020 8314 9308) or if there are any queries on the content of this report please contact sarah.wainer@nhs.net (Phone: 020 3049 1880).
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Integrated strategic commissioning function: Accountability for the public value

System Oversight Board
Shared health and care system wide leadership
Collective decision-making and oversight

Health & Well-Being Board

Alliance of providers collaboratively delivering CBC:
Accountability for quality and delivery of the right balance of capacity and resources to deliver the public value

Authorising environment

Governance of partners sovereign orgs
Select Committee
Regulators
The public

Contractual relationship
AUDIT COMMITTEE

Minutes of the meeting held 25 April 2017
Room 1 Cantilever House

PRESENT
Ray Warburton OBE (RW) Lay Deputy Chair (Chair), LCCG
Shelagh Kirkland (SK) Lay Member, LCCG
Dr Faruk Majid (FM) Senior Clinical Director, LCCG

IN ATTENDANCE
Lesley Aitken (LA) Board Secretary (minutes), LCCG
Lakshmi Forster (LF) Executive, Grant Thornton
Sarah Howe (SH) Manager, RSM
Charles Malcolm-Smith (CMS) Deputy Director (Strategy & OD) (until item 17/46)
Paul McAuliffe (PM) Head of Finance, LCCG
Tony Read (TR) Chief Financial Officer, LCCG
Kris Stewart (KS) Deputy Head of Service, Finance, South East CSU
Martin Wilkinson (MW) Chief Officer, LCCG (until item 17/47)

APOLOGIES
No apologies were received

AC17/40 Welcome and introductions
Introductions were made.

AC17/41 Declarations of Interest
There were no new interests declared by members which would knowingly affect the business of the meeting.

AC17/42 Minutes of the last meeting
The minutes of the meeting held on 28 March 2017 were agreed as a correct record subject to the amendment;

Page 9 – RW asked if it was manageable and sensible to have so many individual schemes in the QIPP

To clarify that ISA was the abbreviation for International Standard of Accounting.

AC17/43 Matters arising
43.1 Action Log

The action log was updated and revised.

24.1 SK and RW gave detailed comments on the draft Annual Accounts in advance therefore it was deemed not necessary to hold the walk through the accounts session. This action was now closed.

30.2 Staff briefing session to be held on enabling staff to whistle blow on fraud issues to be arranged for May 2017. Action: Tony Read/Lesley Aitken

21.1 The deep dive on how VfM was aimed for and achieved to be scheduled into the forward planner. ACTION: Lesley Aitken and relevant manager to build the VfM deep dive into the annual programme of deep dives.

43.2 Any matters not covered on the action log

There were no any other matters not covered on the agenda.

43.3 Glossary of Terms

The glossary was received and additions noted. RW requested that any further additions or requests for clarifications to be sent to LA.

AC17/44 Governing Body Recruitment

MW reported that the appointment to the post of Lay Member for Public and Patient Engagement (PPE) had been ratified by the Membership Forum. The appointment would commence on 8 May. The Secondary Care Doctor appointment was out to advert with a closing date of 9 May.

AC17/45 Draft Annual Report 2016/17

Following the last meeting of the Audit Committee on 29 March, CMS confirmed that a draft Annual Report had been submitted to NHS England on time before the deadline on 21 April. This was achieved based on original and further comments from Audit Committee members, and Chair's Action, on behalf of the Governing Body.

RW thanked CMS for all the work towards producing the draft Annual Report 2016/17 and for taking into account most of the comments made by the Audit Committee into the draft submitted to NHS England, and with remaining comments to be incorporated into the final version.

CMS described how:

- The Steering Group were working on the feedback and comments received.
- The Overview Section would go to the Readers Panel for feedback on language and readability.
Case studies to be added to the ‘Summary Annual Report’ including Ambulatory Care, GP triaging, GP online services, Adult Mental Health, Children’s and Young People’s Community Team and Leg Ulcers.

The final Annual Review document would have more in-depth case studies.

There would be more clarity on the areas; complaints and response times, care homes and private providers and recovery plans against the NHS Constitutional Standards.

The next iteration of the Annual Report would come back to the Committee on 25 May.

RW added that the balance between good news and challenges in the report was right. CMS was asked to look at the report where on one page there was positive news and on the next the same area was reported as not so positive. This needed to be brought together. Also the challenges going forward needed to be summarised. MW agreed with this and added that the priorities would be included and the delivery on the financial sustainability linked with the STP.

Responding to a comment from RW on the challenges to be faced, MW said that the conversation with the Clinical Directors on the reality of going forward with CBC would be highlighted.

The Committee NOTED the report

AC17/46  Draft Unaudited Annual Account 2016/17

TR stated that the Governing Body had delegated responsibility to the Audit Committee to review and approved the draft Annual Report and Accounts 2016/17 for submission to NHSE the deadline for which was 9am Wednesday 26 April 2017. The accounts would then be sent onto External Audit for their audit.

RW reported that comments on the draft Accounts from SK and RW had been responded to by TR and listed on a Question and Answer (Q&A) log which for information was attached to these minutes. TR added that some comments raised had not been addressed as part of the accounts and had therefore been taken away for addressing by the Management Team.

The Q&A was referred to with TR highlighting that:

- The CCG had met its financial performance targets
- Staff costs had risen by £1.4m; this would be reflected on by Management Team. There was 10 extra staff this year which resulted in a higher average pay bill. There had been a negative balance between interim and permanent staff since 31 March 2016.
- Liabilities; there had been movement of payments with an increase of £4.4m ease due to the change in cash process this year. The 1% risk reserve had been removed and £1.75m incurred because of the TSA transaction. There was a cost of £720k against GPIT.
Responding to RW regarding the cash pressures in relation to system risk reserve, LF said that the CCG was still working within limits set. Treatment overall had been correctly accounted for.

The contractual issues around the TSA had been given to Grant Thornton as External Auditors for 2016/17 for review. LF added that how this was presented in the Accounts may need another note. How this was presented across the other CCGs would be looked at for consistency.

RW, referring to the audit undertaken by KPMG on the STP, asked for clarity on governance including how to show the Better Care Fund arrangements in the Accounts for transparency. TR responded that Section 75 arrangements for Adult and Children’s services were not shown unless there was a pooled budget; there was more detail in the monthly finance reports. This could be shown in the Annual Report with further clarity in the monthly reports. The reports would be circulated to the Audit Committee.

ACTION: Tony Read

FM asked if there could be a breakdown of spend on all clinical services. TR would review the relationship between spend and head count.

SK referred to the actuarial valuation of the NHS Pension Scheme and asked for the website shown to be taken off the accounts. TR explained that this was published every four years, LF explained that March 2016 would be backdated and that a reference would go in next year’s Annual Accounts. PM added that the Gov UK info showed 2012 valuation but not 2016. KS added that evidence had not been found of a subsequent evaluation.

RW thanked the Finance Team on all their work in producing the draft unaudited Accounts, against very challenging deadlines.

The unaudited Accounts would be submitted to NHSE by 9am Wednesday 26 April 2017 and then released to Grant Thornton for their audit. Queries from Grant Thornton would be responded to with the audited Accounts coming to the 25 May meeting along with the final Head of Internal Audit Opinion.

The Audit Committee REVIEWED the draft unaudited accounts on behalf of the Governing Body and APPROVED the submission of the draft unaudited accounts to NHS England.

AC17/47 Log of Losses, Special Payment, Waivers of SFIs and Consultancy Contracts over £50k and Interims over £600 a day

TR reported that there had been nothing to report since the last meeting.

The Committee NOTED the report

AC17/48 Business of other committees and review inter-relationships

None had been recorded at this meeting.

AC17/49 Summary of key messages to report to the Governing Body
The following would be reported to the Governing Body:

- On behalf of the Governing Body that the Audit Committee had approved the submission of the Unaudited Accounts 2016/17.

AC17/50 Any other business

There was no any other business reported at this meeting.

AC17/51 Financial Statement for year end 31 March 2017 – understanding how the Audit Committee gains assurance from Management

RW explained that the Financial Statement was his, as Chair of the Audit Committee, response to questions posed by Grant Thornton as External Auditor. This was standard practice.

The Audit Committee NOTED the report for information only.

AC 17/52 Date of next meeting

25 May 2017; 14:00 – 17:00 at Cantilever House
### Comments on the Draft Annual Accounts for 2016/17

<table>
<thead>
<tr>
<th>Reference</th>
<th>Note</th>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Page 3 of 52 of the Draft Annual Accounts</td>
<td>SOCNE</td>
<td>Total Operational Expenditure rose by 4% but Staff Costs rose by 22%. Why?</td>
<td>Staff costs are a very small proportion of total expenditure and there is not a direct relationship between the two ratios. See also Note 4</td>
</tr>
<tr>
<td>SOCNE and Note 4</td>
<td>SOCNE</td>
<td>It would seem that ‘Staff costs’ are the same thing as Employee Benefits. Is this true?</td>
<td>Yes</td>
</tr>
</tbody>
</table>
| | | And why the different name? | Possibly to do with IAS 19: Employee Benefits which defines employee benefits as including:

- (a) short-term employee benefits, such as wages, salaries and social security contributions, paid annual leave and paid sick leave, profit-sharing and bonuses (if payable within twelve months of the end of the period) and non-monetary benefits (such as medical care, housing, cars and free or subsidised goods or services) for current employees;
- (b) post-employment benefits such as pensions, other retirement benefits, post-employment life insurance and post-employment medical care;
- (c) other long-term employee benefits, including long-service leave or sabbatical leave, jubilee or other long-service benefits, long-term disability benefits and, if they are not payable wholly within twelve months after the end of the period, profit-sharing, bonuses and deferred compensation; and
- (d) termination benefits.” |
| SOCNE | SOCNE | Other Operational Expenditure fell markedly from 2015/16. Why? | There was a formula error on the national accounts template that included premises costs in 205/196 but excluded premises costs in 2016/17. This has been corrected and restated as follows: 2016/17 Other Operating Expenditure increased by £336k |
### Reference
- **SOFP**

### Question
1. Statement of financial position – 2015/16 figs slightly our – trade receivables 4,154 (note 17 NHS Prepayments 2217 not 2218) Trade payables 23,860 (note 23 non NHS accruals 13,076 not 13,075) = TOTALS don't need changing

### Answer
Rounding has been corrected

---

### Reference
- **SOFP**

### Question
Between 2015/16 and 2016/17, total Current Assets rose by 13%, while Cash and Cash Equivalents rose by 242%. Why?

### Answer
Cash and cash equivalents amounts to the cash held at close of play on 31 March. The cash balance can fluctuate between £NIL and a limit set by the DoH which was £570k for the CCG this year; being 1.25% of the opening March main cash drawdown value (£45.7m). So, whilst 242% is relatively large it is not a material variance in absolute terms.

Current assets (£4,850k) includes trade debtors (£4,453k) and cash (£397k). Total current assets is mainly influenced by NHS Receivables, NHS Prepayments and NHS Accrued Income. Increases in debts outstanding from NHSE and reductions in Maternity WIP (work in progress) and other acute inpatient spells are the main reasons for this change. We would want trade debtors to decrease ideally. A small increase of circa £300k does not cause concern.

---

### Reference
- **SCF**

### Question
There were marked changes in Inventories and Trade & Other Payables. Why?

### Answer
There are no changes in inventories – NIL values in both years. The changes are in Trade and other receivables (not inventories) Significant NHS payables at 31
<table>
<thead>
<tr>
<th>Reference</th>
<th>Note</th>
<th>Question</th>
<th>Answer</th>
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</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td>March 2017 include SLaM £1.9m and Guy’s for HLP £450k. The increase in payables is driven by the availability of cash during the year relative to expenditure commitments. In 2016/17 the CCG paid LGT £1.75m intended to be funded from the 1% system risk reserve. However NHSE deducted the full 1% cash from our MCD creating a £1.75m cash pressure. Also included in the year end payables is £720k relating to GPIT capital which is recharged to NHSE and for which the CCG has not received the cash by way of invoice payment (receivable) at 31 March 2017. And Trade and Other Payables (see SOFP above).</td>
</tr>
<tr>
<td>Note 1.17</td>
<td>Note 17</td>
<td>Note 12 and does not refer to Note 17</td>
<td>Note 17 (Leases) refers to Note 12 and does not refer to Note 17. Note 1.23 (Risk Pooling) does not refer to Note 23.</td>
</tr>
<tr>
<td>Note 1.23</td>
<td>Note 23</td>
<td></td>
<td>Note 1.17 (Leases) refers to Note 12 and does not refer to Note 17. Note 1.23 (Risk Pooling) does not refer to Note 23.</td>
</tr>
<tr>
<td>Note 2</td>
<td></td>
<td>Between 2015/16 and 2016/17, there was a marked fall in Education, Training and Research from £151,000 to £64,000. Why? Table 2 refers.</td>
<td>The route for HEE funding to the Community Education Provider Network (CEPN) has changed. In 15/16 the CCG received £100k and passed this on whereas in 1617 this sum was paid directly to providers by HEE.</td>
</tr>
<tr>
<td>Note 2</td>
<td></td>
<td>During the same period there was a marked rise in Non-patient Care Services to Other Bodies from £2,526,000 to £3,898,000. Why? Table 2 refers.</td>
<td>These relate to £0.5m increase in HLP funding and £0.7m increase in GP IT funding (see SCF and Note 23).</td>
</tr>
<tr>
<td>Note 3</td>
<td>Note 2</td>
<td></td>
<td>Note 2 – why is there such a large increase to non patient care to other bodies 2,526 to 3,898.</td>
</tr>
<tr>
<td>Note 3</td>
<td></td>
<td></td>
<td>Note 3 = think totals from services should read 4,119, 136, 3,964 – 2015/16 OK. 2016/17 Rounding differences will be corrected before completion of audit.</td>
</tr>
<tr>
<td>Note 4.1.1</td>
<td></td>
<td></td>
<td>Page 15 of 52</td>
</tr>
<tr>
<td>Reference</td>
<td>Note</td>
<td>Question</td>
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</tr>
<tr>
<td>52</td>
<td></td>
<td>£2,464,000 among the Employee Benefits of £5,420,000? Table 4.1.1 refers.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Compared with 2015/16, the ratio of permanent employees to other employers has tilted heavily in favour of other employers. Who are they, and why?</td>
<td>Agency and contract staff</td>
</tr>
<tr>
<td>Note 4.2</td>
<td></td>
<td>Looking at Table 4.2 on page 17, where the numbers of permanent to other staff are given, it might seem that spend on Other Staff per staff is very high. Combining data on pages 16 and 17, it's £98,560 per staff member compared with £54,700 per staff member.</td>
<td></td>
</tr>
<tr>
<td>Note 4.2</td>
<td></td>
<td>why staff numbers increased by 10 = note permanent staff reduced from 59-54 ( 1 person from long term sick? . 2 agreed re exit package plus 1 normal resignation ? ) but increase in Other staff from 10-25?</td>
<td></td>
</tr>
<tr>
<td>Note 4</td>
<td></td>
<td>No of days lost from ill health – is the person who was on sick leave for all of 2015/16 and noted in last years account off sick for most of this year too until they retired ? is this why figures for days lost still at 9?</td>
<td>Yes it’s the same person. See also below</td>
</tr>
<tr>
<td>Page 17 of 52</td>
<td>Note 4.4</td>
<td>What did Exit Packages in 2016/17 designated as ‘Other agreed departures’ cover? From page 18, it seems it was two contractual payment in lieu of notice. One such payment amounted to £16,206. Was this money well spent?</td>
<td>Both instances relate to payment of annual leave due but not taken when the staff employment ended. The higher value (£13,910) relates to annual leave not taken due to long term illness of one member of staff spanning 2 financial years. The staff member retired due to ill health during 2016/17.</td>
</tr>
<tr>
<td>Page 18</td>
<td>Note 4.4</td>
<td>need commas in figures at top . Not sure where the # note related to in table above , not sure * note relates to the * on last line of table = many of the notes can be deleted as not relevant</td>
<td>Commas inserted Notes will be “tidied up”</td>
</tr>
<tr>
<td>Reference</td>
<td>Note</td>
<td>Question</td>
<td>Answer</td>
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<tr>
<td>Note 4.5.1</td>
<td>Should the March 16 actuarial valuation be available and hence should be referenced not to March 12</td>
<td>Current belief is March 2012 was latest actuarial review used.</td>
<td></td>
</tr>
<tr>
<td>Note 5</td>
<td>We have commissioned a lot more from private sector – 46k this year 40k last?</td>
<td>The increases includes Adult CHC £1.7m, Childrens CHC £261k, YPD £1.6m, FNC (tariff increase) £0.6m, HLP £440k, GPFV £450k and RSS £300k</td>
<td></td>
</tr>
<tr>
<td>Note 5</td>
<td>Why have premises costs fallen from 489k to 336k?</td>
<td>We received a credit note from CHP for the Waldron Centre</td>
<td></td>
</tr>
<tr>
<td>Note 5</td>
<td>Why training so low – 236k- 60k</td>
<td>The route for HEE funding to the Community Education Provider Network (CEPN) has changed. In 15/16 the CCG received £100k and passed this on whereas in 1617 this sum was paid directly to providers</td>
<td></td>
</tr>
<tr>
<td>Note 5</td>
<td>Are the GPMS/APMS and PCTMS cost line for additional services? Did we not commission as many of these as in previous year?</td>
<td>Some services have been recommissioned as part of the new GP Federation contract and this spend shows as services from non NHS providers.</td>
<td></td>
</tr>
<tr>
<td>Note 5</td>
<td>Provisions – ( see note 30 – think this should be 225 not 224 – then total would add to 415,079 ) note 30 – P/l items 323 -98 = 225</td>
<td>Roundings will be corrected</td>
<td></td>
</tr>
<tr>
<td>Page 20 of 52</td>
<td>Prescribing cost have held steady. In 2016/17 they were c £38m. Is this the good news given in-year challenges? I think it is?</td>
<td>Yes a good performance. However Rightcare data indicates a further savings opportunity in prescribing costs (up to £5m)</td>
<td></td>
</tr>
<tr>
<td>Page 21 of 52</td>
<td>The BPPC results are very good. We're any providers slower than others to pay us in good time?</td>
<td>We receive very few payments from providers. The majority of our income comes from other CCGs. There are no issues with payment times for non-trivial value invoices (i.e. over £250k).</td>
<td></td>
</tr>
<tr>
<td>Pages 22, 24 to 30, 32, 34, 35, 36, 37, 38, 40, 41, 42, 43, 44, 46,</td>
<td>Are these pages needed? They are full of zeroes and just clutter up the accounts.</td>
<td>These will be condensed as per previous years.</td>
<td></td>
</tr>
<tr>
<td>Note 12</td>
<td>check print settings as 2015/16 total figures did not print</td>
<td>will amend</td>
<td></td>
</tr>
<tr>
<td>Page 31 of 52</td>
<td>What NHS pre-payments were</td>
<td>The £2.1m NHS pre-payments</td>
<td></td>
</tr>
<tr>
<td>Reference</td>
<td>Note</td>
<td>Question</td>
<td>Answer</td>
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<td></td>
<td></td>
<td>made? And to whom? Table 17 refers.</td>
<td>relates to Maternity Pathway - Work in progress. A payment of c£2k is made to a hospital each time an expectant mother registers at the start of the pregnancy. At 31st March, many of these pregnancies will still be current (pre birth) and an estimate is made of the amount by which the full term of the pathway has been prepaid. £1.7m is to LGT and £350k to KCH.</td>
</tr>
<tr>
<td>Page 33 of 52</td>
<td>Note 20</td>
<td>Why the large percentage increase in cash marked the ‘Government Banking Service’? From 2015/16 to 2016/17 this amount rose from £116,000 to £397,000?</td>
<td>The Government Banking Service is the CCG’s banker. £116k and £397k are the values of cash held at 31 March 2016 and 2017 respectively. These are both within maximum cash targets.</td>
</tr>
<tr>
<td>Note 20</td>
<td></td>
<td>note re cash in hand can be deleted</td>
<td>Agreed</td>
</tr>
<tr>
<td>Page 39 of 52</td>
<td>Note 23</td>
<td>A reminder please of what the spend under Trade and Other Payables amounts to. Table 23 refers.</td>
<td>Amounts owed to suppliers and providers at 31 March – not yet paid.</td>
</tr>
<tr>
<td>Note 23</td>
<td></td>
<td>Why the large increase in NHS Payables: Revenue from 2015/16 to 2016/17?</td>
<td>Significant NHS payables at 31 March 2017 include SLaM £1.9m and Guy’s for HLP £450k. The increase in payables is driven by the availability of cash during the year relative to expenditure commitments. In 2016/17 the CCG paid LGT £1.75m intended to be funded from the 1% system risk reserve. However NHSE deducted the full 1% cash from our MCD creating a £1.75m cash pressure. Also included in the year end payables is £720k relating to GPIT capital which is recharged to NHSE and for which the CCG has not received the cash by way of invoice payment (receivable) at 31 March 2017.</td>
</tr>
<tr>
<td>Note 23</td>
<td></td>
<td>What is WGA?</td>
<td>Whole Government Accounts</td>
</tr>
<tr>
<td>Reference</td>
<td>Note</td>
<td>Question</td>
<td>Answer</td>
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<tr>
<td>Page 45 of 52</td>
<td>Note 30</td>
<td>The trebling of spend on continuing care is alarming, to its 2016/17 level of £323,000. What is being done to tackle it?</td>
<td>Note 30 discloses the value of provisions made at 31 March; or future liabilities of uncertain timing or amount. The increase reflects an increase in the number of CHC cases between 31 March 2016 and 2017 with uncertain payment values and/or dates – for example due to appeals or ongoing validation. There is a significant increase in CHC costs that is contained with the values in Note 5. The CCG is reviewing the CHC assessment pathway and also using some of the Deloitte QIPP days to bolster the CCG’s QIPP plans.</td>
</tr>
<tr>
<td>Page 48 of 52</td>
<td>Note 33.2</td>
<td>Please can the ‘Loans and receivables’ in Table 33.2 be explained.</td>
<td>The values for ‘Receivables: NHS’, in 2016-17, comprises ‘NHS receivables’ and ‘NHS accrued income’ in Note 17 and likewise for ‘Receivables: Non-NHS’. The purpose of this note is to disclose any risks that the CCG faces due to the creation of, or change in, financial instruments during the period. The CCG has limited powers to borrow or invest surplus funds, and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the CCG in undertaking its activities. For the CCG, there are two types of risk: Credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note and replicated in Note 33.2 and Note 17.</td>
</tr>
<tr>
<td>Reference</td>
<td>Note</td>
<td>Question</td>
<td>Answer</td>
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</tr>
<tr>
<td>Page 49 of 52</td>
<td>Note 34</td>
<td>This page on Operating Segments will leave most readers in the dark.</td>
<td>The note and tables will be replaced by “The clinical commissioning group and consolidated group consider they have only one segment commissioning of healthcare services.”</td>
</tr>
<tr>
<td>Page 50 of 52</td>
<td>Note 35</td>
<td>This page is blank as we have no pooled budget arrangements.</td>
<td>Note 35 is not blank. The national template lacks detail and will be replaced by a fuller disclosure as was the case in 2015/16. Note 36 on page 50 is blank and will be condensed. These are reported as Operating expenses in Note 5</td>
</tr>
<tr>
<td>Page 51 of 52</td>
<td>Note 37</td>
<td>I think – and have always thought – that Table 37 could be better explained. Can we give it a go?</td>
<td>Will do</td>
</tr>
<tr>
<td>Page 52 of 52</td>
<td></td>
<td>The Financial Performance data look good. How might they be impacted upon by the inclusion and auditing of the £1.75m expected by NHSE.</td>
<td>See email explanation sent 24 April 2017.</td>
</tr>
</tbody>
</table>
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Present
Martin Wilkinson (MW) Chief Officer (Chair)
Dr David Abraham (DA) Clinical Director
Diana Braithwaite (DB) Director of Commissioning and Primary Care
Alison Browne (AB) Nursing and Quality Director
Dr Charles Gostling (CG) Clinical Director
Dr Faruk Majid (FM) Clinical Director
Jacky McLeod (JM) Clinical Director
Corinne Moocarme (CM) Joint Commissioning Lead, Community Support and Care
Dr Sebastian Kalwij (SK) Clinical Director
Shelagh Kirkland (Ski) Lay Member
Dr Angelika Razzaque (AR) Clinical Director
Tony Read (TR) Chief Financial Officer
Dr Marc Rowland (MR) Chair
Ray Warburton (RW) Lay Member

Attending
Mike Hellier (MH) Head of System Intelligence
Graham Hewett (GH) Associate Director of Quality
Susanna Masters Corporate Director
Michelle Rahman (MRa) CSU - Partner – Head of Contracts SEL MDTs
Hannah Reeves (HR) Corporate Services Administrative Manager

Apologies
Dee Carlin (DC) Head of Joint Commissioning

1. Welcome and Introductions
MW welcomed all to the meeting.

2. Apologies for Absence
Apologies were taken and noted.

It was noted that Corinne Moocarme is in attendance at the IGC on behalf of Dee Carlin.

3. Declaration of Interests (DoI)
There were no new interests declared. However the Committee considered whether there was a potential for a conflict of interest for Clinical Directors as members of SELDOC in relation to Integrated Urgent Care (formerly SEL 111). It was confirmed as there was no financial information contained in the document for decision and therefore there was no pecuniary interest and this mitigated any perceived conflicts.

4. Minutes of Previous Meeting (23rd March 2017)
The minutes were agreed, subject to the following amendments:

“A positive achievement for the last two months is that Cancer Waiting Time two week waits for first assessment is now being met as is the same for breast symptoms.”

“6.2.4 …It was agreed it would be important to work together with Healthwatch to try and align this work with the CCG agenda”

“Action: CCG to compose a response to Healthwatch"
Healthwatch action / work plan to be sent to LCCG as a way to commence working together.”

“…The culture of ’save to invest’ continued to be evident…”

4.1 Review of Action Log/Tracker

The action log was reviewed and updated.

5. Matters Arising

There were no matters arising at the meeting.

6. Integrated Performance Report

6.1 Quality Report

6.1.1 Diabetic Eye Screening

The Committee was informed of a recent incident raised by the South East London Diabetic Eye Screening Programme in relation to the discovery, following an audit, of a patient who lost her sight due to diabetic retinopathy and who may not have been invited for screening at the appropriate intervals. GH confirmed to the Committee that the recent investigations into this case have so far confirmed that all processes were followed by Lewisham and Greenwich NHS Trust and the CCG has received assurance that the patient had in fact declined the appointments offered.

The Committee was informed that this incident does not meet the threshold to be raised as a serious incident, however the Committee queried whether the SI panel were assured that all aspects of the patient’s physical and mental health had been taken into consideration and if more could have been done to improve communication between departments, especially for those patient’s with chaotic lifestyles. It was agreed that GH would liaise with a Clinical Director to discuss further.

Action: GH and a Clinical Director to seek assurance that any potential lessons to be learned from the case are identified and shared by providers.

6.1.2 New born and Infant Physical Examination Screening (LGT)

The Committee heard of a routine audit which had identified seven babies born in late 2016 who were at risk of development dysplasia of the hip (DDH) and who met the requirements for ultrasound hip screening but referrals to radiology were not made.

GH informed the Committee that all seven babies have now been scanned and are reported to be fine, in addition to this it was confirmed that at this time the incidents do not meet the threshold for reporting a serious incident under the 2015 framework.

The Committee was informed that the root cause analyses have not yet been received, however, under a recommendation from NHS England and the Screening Quality Assurance Team, LGT are undertaking a two year look back at all births across both UHL and QEH. The Committee heard that as there are over 20,000 sets of notes that will require being manually reviewed the approach has been agreed as:

In the first instance the Trust will review babies identified as high risk on the New born and Infant Physical Examination Screening computer system and cross reference to ensure all of those identified were referred for an ultrasound screening. It has been agreed the Trust will report on this process to NHSE and the CCGs within 5 weeks.

The Trust will also manually review a sample of notes to review any breech presentations at 36 weeks and then cross reference to check that these babies were subsequently offered a scan. The sample of notes will be taken from the last weeks of October, November and December 2016. It has been
agreed the Trust will report back on this process to NHSE and CCGs within 8 weeks, it will then be decided whether the sampling needs to be expanded.

It was confirmed to the Committee that the Clinical Quality Review Group has been informed of the issue and will continue to be informed via a robust action plan, which has yet to be received. It was confirmed that once the CCG has sight of the results from the cross referencing, a statistician will be required to determine if further sampling is warranted. It was also confirmed that LGT are clear on the expectations of both NHSE and CCGs.

The Committee highlighted the importance of ensuring that all Locums are informed of processes or policies implemented.

It was recommended that GH discusses the situation with the SEL Maternity Network, who recently held a Serious Incident event to share learning.

6.2 Month 7 Integrated Performance Quality (Acute)

The Committee received the integrated performance reporting dashboards for month 7, focusing on acute quality. The Committee was informed that the reduction in the number of serious incidents being reported is being driven by a reduction in the incidence of pressure ulcers and changes in reporting.

The Committee discussed the indicators currently being reported to IGC through the dashboard and whether these are the correct indicators to provide the Committee with assurance. It was agreed that GSTT information should be added to the dashboard for reporting on the Friends and Family Tests.

It was agreed that whilst this style of reporting is useful, it would be beneficial to have more narrative, especially focusing on analysing why quality issues have arisen and what actions are in place to mitigate.

Action: GSTT information to be added to the dashboard for reporting to IGC
Action: Discussions, surrounding the type of reporting required and the quality indicators to be included, to be held.

6.2.1 LGT Quarterly Workforce and Education Report

Following a request from the Committee at the January 2017 IGC a report was received at the meeting focusing on how LCCG can be assured the appropriate actions are in place to improve the performance of the LGT workforce indicators.

The main factors highlighted to the Committee is that there have been unacceptable delays in getting contracts in place for newly qualified Nurses, wishing to work in the Community rather than going straight into hospitals. It was commented that more support should / could be provided for student nurses to encourage community based jobs.

The Committee queried the electronic rota system in relation to bank nursing staff and whether agency checks are up to standard and are appropriately checking to ensure their staff are ‘fit to work’. In addition to this the Committee questioned whether LGT have their own checks which are up to standard for checking agency staff, in relation to the amount of shifts worked.

The Committee questioned whether there is any more that can be done to monitor and challenge the amount of money spent on bank and agency staff and whether there could be an indication of spend by ward / specialty to see whether there are areas that require additional investigation and support.

The Committee commented that whilst useful, the report does not highlight or analyse why there is a staffing issue.

The Committee agreed the following actions:
• Segmentation of issues by service area and staff to be requested
• CCG to seek assurance that LGT have an effective process for the proactive management of checks regarding bank and agencies
• CCG to seek assurance of where this sits on the LGT risk register and what priority level this is for LGT
• Using the next steps following the Board to Board meeting to offer support for these issues

The Committee highlighted that against the Workforce Race Equality Standard (WRES), the LGT Board is not indicative of the workforce or population it serves, it was queried whether some may find this ‘off putting’ in relation to applying for jobs within the Trust.

RW confirmed he would be attending the LGT Board Meeting in public, so will report back on discussions relating to workforce issues.

6.2.2 “Assuring the quality of services at LGT” - A briefing for the IGC

Following the March meeting of the IGC it was requested that all reports, outcomes and actions from peer reviews recently undertaken (Trauma and Critical Care) as well as the CQC Inspections, be triangulated for this meeting. The report received at enclosure 2 appendix 2a aimed to satisfy this request.

The Committee noted that despite the peer review outcomes having a negative position, the same is not true for feedback from patients through Healthwatch. The Committee also noted the rating improvement between the two CQC visits.

It was confirmed that Safeguarding Leads would be visiting the services / areas of concern.

The Committee requested that an action tracker be completed to show the status and maturity of the actions and how these actions have been embedded.

Action: Action tracker to be created to show the status and maturity of the actions and how these actions have been embedded.

The Committee was informed that executive staff from LGT will be visiting Epsom and St Helier University Hospitals NHS Trust, to further understand methods used and processes in place which promote good practice, especially within the A&E department. The Committee queried whether it would be beneficial for DA to attend this meeting as the CCG lead.

Action: Date of visit to Epsom and St Helier University Hospitals NHS Trust to be confirmed.
Action: DA to contact LGT staff to register his interest in attending the visit.

The Committee questioned whether the IGC can be assured that quality issues raised at the Clinical Quality Review Group (CQRG) are appropriately considered at the Contract Monitoring Board (CMB).
It was confirmed to the Committee that contract and quality leads are working together to ensure no silo working and to also ensure that quality issues are then added to our contracting.

Action: IGC to receive an example of a CQRG report to CMB

It was agreed that the Improvement Plans following the 2014 and 2016 inspections need to be reviewed and actions traced back to ensure all have been completed or are in progress.

7. NHS Constitutional Standards – Performance Reporting

The Committee was informed that to date the standard for RTT remains just under 88%. The Committee heard that diagnostic performance is starting to recover; however, it is unlikely this will reach the standard.
The Committee was informed that the 62 days standard is now at 75%, it was requested that the SEL plan for GSTT and LGT be circulated and for IGC to receive confirmation that the CMB is picking this up.

The Committee heard that, due to the high risk of not recovering performance to the STF trajectory in Q4 for A&E 4 Hour, London Ambulance Service (Red1), Cancer Waiting Times 62 Days and Referral to Treatment Times, it is increasingly likely that NHS Lewisham CCG will receive no Quality Premium for 2016-17.

The Committee was informed that for Improving Access to Psychological Therapies, the CCG is now meeting all standards. The CCG is on its plan for the Recovery Rate and local data indicates that the CCG is above the 50% standard for Q4 16-17 as agreed. It was proposed and agreed by the Committee that the exception report will not be included going forwards expect in the event a new exception arises.

In relation to the A&E standard, the Committee queried what more could be done in terms of public engagement to help support the improvement work, it was agreed that MW would speak to Russell Cartwright, Head of Communications and Engagement, to discuss further.

**Action:** MW to discuss with RC the potential for further public engagement regarding A&E attendance.

8. **Activity Report**

MRa summarised the overview of contractual performance for month 11, informing the Committee that for A&E the run rate trend has been upwards, however, since October 16 it has been reducing year on year, with a particular decrease in month 11.

The Committee heard that the upward trend in spells for emergency activity has stopped with reductions in month 11 for all main providers. MRa went on to explain that Out Patient First Attendances increases continue, still noting the issue over Cerner which effected 2015 / 16, this has been reflected contractually at LGT and GSTT. The Committee was informed that the contract values for OPFA include community based activity.

9. **Finance**

The Committee was informed by TR that block contracts have been agreed with GSTT and KCH for 2017 / 18 and that whilst the risks have been managed for 2017 / 18 there has been an increase in spend for activity.

TR confirmed that the draft unaudited yearend accounts have been submitted. The results (£10.03m surplus) and are in line with previous finance reports received by the IGC. TR went on to inform the Committee that LCCG has met NHS England’s national and London control total expectations and have hit statutory financial duties (subject to audit).

The final accounts are currently being externally audited. A Month 12 report will come back to the IGC once year end accounts are completed.

10. **SEL 111 and GP Out of Hours Memorandum of Understanding**

The Committee was joined by Claire Goodey (CGo), SEL 111 Contract and Service Redesign Manager NELCSU and received the report regarding the memorandum of understanding which the Committee was asked to approve.

CGo informed the Committee that currently the Providers are also reviewing the MOU and are also being asked to sign up to it and that all financial details will come back for approval.

The Committee heard that when procurement first opened there were 24 bidders interested, however, this number decreased significantly to 1 bidder, who then withdrew. The procurement has now closed and engagement work is being undertaken to understand why providers withdrew. Following this
engagement if the service specification changes, it will go back through the governance procedures and the Committee could expect to be asked to approve again in November. CGo confirmed that the MOU will help to evolve the service towards the desired position.

CGo confirmed to the Committee that the model is currently being used in the West Midlands and is reported to be working well.

The Committee raised questions for CGo:

1. **What is the extent of Public Engagement that has been undertaken?**

   CGo responded by informing the Committee that there have been patient events and questionnaires have been circulated to patient groups. Following the specification changes from NHS England the public were re-engaged so all were aware of the changes. CGo went on to explain that particular identified groups were targeted and changes were made following feedback from the public.

2. **Is there appropriate Patient Representation?**

   CGo confirmed that 2 representatives from the OHSEL Patient Advisory Group have been involved. CGo informed the Committee that should further changes be made, the public will be consulted again. She added that once the specification is in place there will be marketing and promotional work undertaken, which may commence as early as this winter – The Committee confirmed that Lewisham CCG would support this approach.

3. **How do the different groups within the governance structure cohere?**

   CGo confirmed to the Committee that she is the link person between all the groups and that all actions resulting from meetings are combined into one action tracker for ease of reference and tracking.

   CGo informed the Committee that in relation to IT being an enabler, especially considering the importance of patient record sharing, a working group has been established, working with the ETTF team and linking this with 111 telephony services. In terms of interoperability, CGo confirmed that this would be launching soon and is currently being reviewed to see whether a separate task group needs to be established to manage this work.

In relation to the dropping out of bidders, the Committee queried whether the complexity of the specification may have played a leading role in providers not continuing with their bids. CGo stated that it may be because there is an issue surrounding whether there are enough GPs within the system and in addition to this the lack of funding to employ new GPs. CGo added that there is a different interpretation of requirements compared to how this is running in the West Midlands and the SEL specification is very prescriptive, which may have caused bidders to drop out.

The Committee approved the Memorandum of Understanding and confirmed they are happy for MW to sign on behalf of Lewisham CCG.

11. **Infection Prevention and Control – Quarter 3 Report**

   The Committee was joined by Juliet Magee (JMa), Assistant Director Infection Prevention and Control (NELCSU), to discuss the quarter 3 infection prevention and control report. JMa outlined the key issues to the Committee, covering the mandatory reporting to Public Health England regarding C.Diff, E.Coli, MRSA and MSSA. The report aims to provide assurance that everything possible is being done to prevent outbreaks and how assurance is gained from LGT. JMa informed the Committee that when a case is reported LGT are required to complete an investigation which is then reported into the MDT meeting.

   **C.Diff** – JMa informed the Committee that currently the strains being seen are not causing long term damage and that issues surrounding community acquired cases is a national issue and that a report is currently being produced. JMa added that the work with GPs regarding anti-biotic work is having a positive impact.
The Committee queried whether any education plans are being extended to Social Care workers.

**MRSA** – JMa informed the Committee that the Infection Prevention and Control Team are currently assured regarding cases of MRSA, stating that recently there have only been sporadic cases with little learning to be had, in addition JMa informed the Committee that thematic learning and data analysis is currently being completed.

**MSSA** – JMa informed the Committee that the current actions in place for reducing MRSA cases are not having an impact on MSSA infections and that this is a national issue. JMa added that as a Country this infection is currently only being measured to try and understand the strain better.

**E.Coli** - The Committee was informed that, worryingly, many strains of E.Coli are becoming resistant to antibiotics. JMa informed the Committee of a new improvement drive to reduce the number of E coli bacteraemias by 10% in 2017/18. This will be part of the Quality Premium for the year. In addition to this JMa informed the Committee that Public Health England have announced plans for 50% reduction in cases by 2021. JMa noted that further guidance for CCGs is due to be circulated.

JMa informed the Committee that as part of the quality premium the link between E.Coli and catheter care is being reviewed to identify any impacts that can be achieved. The key message that has been discussed is keeping people hydrated, especially for the elderly population who lose their sense of thirst as they age.

It was agreed that further discussions are required to link this work to the admissions avoidance work and how this can fit into the CCGs priority areas, linking into Community Based Care work.

**Action:** **JMa to join a meeting of the Clinical Directors, with AB and the Medicines Management Team to discuss further the link between the infection control work and admissions avoidance.**

The Committee requested further information regarding the service, delivery and action plans in place for work to combat cases of E.Coli and the potential link to Rightcare work. It was stated that it would be imperative to look at how this work can dovetail into the CCG priority working.

Following the report the Committee raised the following questions:

1. Which Hospitals are comparable?

JMa confirmed that Public Health England publish rates annually which may be more useful for comparing hospitals. This data is to be added to the next report to IGC.

**Action: Public Health England data to be added to the next report.**

2. In relation to variation - is there an issue with data quality?

JMa confirmed that the variation in the report between hospitals is due to the numbers relating to overall beds and that there is an issue with data quality. The Committee commented it would be beneficial to see what LCCG could learn from comparable hospitals performing well.

3. The link between this work and equalities impact reporting

JMa confirmed that the equalities reporting is being reviewed.

4. Are any other protected characteristics, other than age, more vulnerable?

JMa stated that age is a very relevant characteristic and that other protected characteristics are not routinely recorded as they are not necessarily relevant. It was commented that this data may be useful in relation to access to care and that broader data sets may help to support prevention and intervention work.
It was queried whether linking work between the Infection prevention and control team and District Nurses may be an impactful short term piece of work.

12. **A&E Recovery Programme Progress Report**

The Committee received the A&E Recovery Plan update report and were asked to note the progress detailed. MW informed the Committee of the next National meeting with Simon Stevens and Jim Mackey is scheduled for 22nd May 2017.

The Committee was informed that whilst progress is just ahead of the recovery trajectory, LCCG remains not assured regarding the overall progress, especially taking into account the action plan has yet to be completed.

The Committee heard that the 6th April letter to Tim Higginson and MW, from NHS England and NHS Improvement, highlighted the key areas of focus. Following receipt of this letter MW confirmed to the Committee that a system oversight group has been formed and the governance structure for the A&E Delivery Group is being reviewed.

MW informed the Committee that the Easter period had been positive, with good predictions going into the bank holiday and good performance during. It was confirmed that so far quarter one of this year is looking more positive than quarter four of the previous year. The Committee requested that more information be provided on the contribution to the positive period over the Easter bank holiday and that learning be taken from this and carried forward if appropriate.

The importance of engaging in clinician to clinician conversations and the avoidance of silo working was highlighted to the Committee.

It was confirmed to the Committee that LGT are signed up to this work and recognise the significance and that the action plan will be linked to the contract. The IGC were requested to consider this work an absolute priority for LCCG.

The Committee queried the cost implication linked to the improvement plan and whether further information regarding this could be provided to the IGC. It was added that it would be more beneficial to ‘add’ money to long term sustainable services, such as RRT, rather than short term items. The Committee also requested clarity regarding timelines.

**Action:** It was agreed that the IGC meeting for May would be moved to take place before the national meeting scheduled for the 22nd May 2017 and that the meeting should focus on A&E, with members of the CSU team invited to the meeting and potentially inviting a representative from LGT, for assurance.

13. **Any other business**

There was no other business raised.

The Chair declared the meeting closed.
Minutes of the meeting of the Strategy & Development Committee held on
Thursday, 6th April, 2017
Rooms 1 & 2 Cantilever House

Members
Dr David Abraham (DA) Senior Clinical Director
Magna Aidoo (MA) Healthwatch Representative
Alison Browne (ABr) Registered Nurse Member
Aileen Buckton (AB) Executive Director Local Authority
Dr Charles Gostling (CG) Clinical Director
Shelagh Kirkland (SKi) Lay Member
Dr Faruk Majid (FM) Senior Clinical Director
Susanna Masters Corporate Director
Dr Jacqueline McLeod (JM) Clinical Director
Dr Angelika Razzaque (AR) Clinical Director
Tony Read (TR) Chief Financial Officer
Ray Warburton OBE (RW) Lay Member
Martin Wilkinson (MW) Chief Officer

In Attendance
Dee Carlin (DC) Head of Joint Commissioning
Russell Cartwright (RC) Head of Communications and Engagement
Tom Henderson (TH) OHSEL
Matt Knight (MK) EY
Charles Malcolm-Smith (CMS) Deputy Director (Strategy & Organisational Development)
Catherine Mbema (CM) Acting Consultant in Public Health
Hannah Reeves (HR) Corporate Services Administrative Manager
Sarah Wainer (SW) Programme Lead, Whole System Model of Care

Apologies
Dr Mark Hamilton Secondary Care Doctor
Dr Sebastian Kalwij (SK) Clinical Director

1  Introductions and Welcome
The Chair welcomed all to the meeting.

2  Declarations of Interest
The Chair reminded members of their obligation to declare any interest they may have on any
issues arising at committee meetings which might conflict with the business of Lewisham Clinical
Commissioning Group. Declarations declared by members of the Strategy and Development
Workshop are listed in the CCG’s Register of Interests. The Register is available either via the
Corporate Services Officer or the CCG website.

The following update was received at the meeting:

With reference to the agenda item 12 to be discussed at the meeting, CG declared that a close
family member is currently employed by Healthy London Partnership. In order to mitigate this
conflict, it was agreed that CG would leave the room for this agenda item.
3 **Summary notes of the workshop on 2nd February 2017**

The minutes of the previous meeting were reviewed and agreed as an accurate record.

The action log was reviewed and updated.

4 **Aims of the workshop**

The Chair summarised the aim of the workshop would be to review key strategic change areas and priorities for 2017 / 18.

5 **Elective Orthopaedic Care Update**

Tom Henderson (TH), from OHSEL and Matt Knight (MK), from EY, were welcomed by the group to provide an update on the elective orthopaedic centre proposals.

TH informed the group that, as agreed by the Committee in Common in November 2016, providers have submitted proposals to create two elective orthopaedic centres that would operate as part of a single clinical network. Following subsequent stakeholder feedback, a fourth proposal is being developed to describe how providers could collaborate across three sites to deliver elective orthopaedic inpatient care.

In response to the presentation the group raised concerns regarding the financial criteria / objectives and what would be considered as “sufficient financial criteria”, to which TH confirmed that presently the focus is still on quality. The group queried whether it would be possible to have further information on what the bids are being analysed against and what ‘good’ looks like.

It was confirmed to the group that close work between OHSEL and the providers is continuing to ensure the data is more comparable. TH commented that collaborative work between the providers is being looked at, to ensure that no provider feels they will ‘lose out’.

It was highlighted that, whilst the update had been very useful, a further meeting would be required to better understand the governance, formal processes and financial criteria.

**Action:** Further meeting to be arranged to cover governance, formal processes and financial criteria.

6 **LGT Board to Board reflections**

The group reflected on the Board to Board meeting with Lewisham and Greenwich NHS Trust, which took place on Tuesday 4th April 2017.

It was commented that whilst there were not many Clinicians present the group were encouraged by the comments made regarding the importance of clinical dialogue. It was stated that it might be beneficial to hold MDT meetings with Board members as well as clinical staff in order to ‘test’ any future agreed approaches.

The group highlighted that much of the LGT Board focus for discussions on Community Based Care had been around estates work and not necessarily the holistic view, however, the group were informed that this was a resulting action from the Lewisham Health and Care Partners requesting estates work be a priority. It was commented that it would be important for us to communicate with LGT if this is now not the correct direction of travel.
The group recognised that more work would be required to ensure alignment of priorities between LGT and LCCG.

It was agreed that clarity regarding next steps and follow up actions is required, which should be communicated with LGT as soon as possible. It was agreed MR would write to the Chair of LGT to thank them for the meeting and laying out the actions resulting from the meeting, with a separate letter to be sent from MW to Tim Higginson which will feature LCCGs commitment to work with LGT.

It was agreed the context of the response to LGT should cover:

- developing stronger clinical dialogue
- agreeing common messages for our patients, population, staff and GP members
- exploration into how we might manage financial risk differently
- delivering community based care ambitions including upstream initiatives to avoid unnecessary attendances and admissions to support hospital flow, building towards an integrated and simplified model
- further development of plans for neighbourhood care hubs

The group also agreed that potentially a more ‘informal’ lunch would be beneficial.

**Action:** MR to write to LGT Chair to be followed by a letter on tangible actions from MW to LGT CEO.

### 7 CCG Priorities for 2017 / 18

The group was informed that following the recent CQC visit at LGT and the resulting quality concerns, for which a risk summit has been held, that work with NHSE and NHSI is underway to support whole system A&E delivery. The group heard how this equates to a changing landscape for LCCG, with the focus now very much on what the next 6 months and what the main priorities should be.

Following conversations at the earlier Joint Clinical Directors and Senior Management Team that morning, the Clinical Directors had been tasked with identifying immediate priorities for delivering Community Based Care:

1. **Rapid Response**

It was identified that admissions avoidance is variable across the patch and that reviewing the Rapid Response Team and extending the scope of the Lewisham Winter Assessment Team (LWAT) should be looked into.

**Action:** Service Specification for the RRT requested, to be circulated.

2. **Community Beds**

It was questioned what level of provision should be available and whether this could be used for those who may otherwise result in a hospital admission, entailing that the beds could be accessed by the Ambulatory Care Unit or LWAT team.

It was stated that the step up service does not currently work as expected, as most feel they are unable to access effectively.

It was queried whether the use of Brymore House and the Sapphire Ward could be redefined and controlled via community or Primary Care.
3. Community Nursing

It was stated that the implementation of case management and risk stratification, utilising information from other sources such as admissions into hospital within the last 12 months, would be a beneficial move.

It was queried whether the District Nurses could move to more ‘task orientated’ to support the step down from the LWAT service.

4. COPD / Diabetes

It was queried whether there are specific areas of diabetic care that could offer ‘quick wins’ if looked at as a priority, linking into the idea of specific case management.

It was questioned whether more could be done for those patients, not necessarily with diabetes or COPD, in relation to common reasons for hospital admissions; such as catheter issues.

Although the presentation did not specifically mention Mental Health, it was stated that there is the potential for dementia care to be considered as part of the ‘quick win’ work.

Following the Clinical Directors presentation, the group received a presentation from the SMT:

8 Organisational Sustainability – CCG Immediate Priorities

It was agreed that the terminology regarding “Grip and QIPP” would be reviewed in line with planned communication to staff and membership.

The presentation suggested the immediate priorities for Q1 and Q2 should focus on 4 key areas:

1. Whole System A&E delivery – ensuring consistent community offers across 3 boroughs
2. Contract Grip – to ensure agreements made are delivered in 2017 / 18
3. De-risk and deliver 17 / 18 QIPP programme
4. QIPP Planning for 2018 / 19

It was discussed that, if agreed, the adjusted priorities for Q1 and Q2 would need to be reviewed from a risk point of view and if appropriate, risks added to the LCCG risk register and Board Assurance Framework.

Following comments from the group, it was confirmed that whilst the priorities, approach to achieving and pace may have changed, the direction of travel overall remains the same.

It was agreed that, to help drive work forward regarding MDT working and to also ensure no work is being duplicated; a meeting between the Clinical Directors and the Executive Director for Community Services, along with relevant team members would be required.

Action: Meeting to be set up with CDs and ABu to discuss MDT working.

It was noted by the group that any decision to decommission a service would still have to follow due process, which will affect the pace at which change can take place.

Following the presentations the following actions were agreed:
• The two presentations will be combined
• Work will now commence to add more detail behind the identified direction of travel
• These will serve as the updated Corporate Objectives for the next 6 months
• Risk identification work will now take place

It was requested that a timeline should be produced, which includes timescales for identifying QIPP opportunities.

The Strategy and Development Workshop members agreed the direction of travel and that the detail in the presentations should be utilised as the refreshed corporate objectives for the next 6 months of 2017.

9 Conclusions

In conclusion the group agreed the refocused priorities, as a change of approach not a change of direction and agreed the executive team should now work on the detail underpinning the agreed priorities and the potential risks involved.

It was agreed that any highlighted risks should be included in the risk register and if appropriate entered into the Board Assurance Framework, ahead of the next Governing Body meeting on 11th May 2017.

It was agreed that MR, as Chair, would write to the Chair of LGT with some initial reflections on the Board to Board meeting, with a follow up letter from MW to the CEO of LGT to highlight any actions, requirements, expectations and next steps.

It was agreed that more communication was needed regarding plans for community based care between the Clinical Directors, Commissioning leads and the Local Authority, to ensure joined up working without duplication.

10 Any Other Business

There were no additional items of business.

11 Healthy London Partnership Update

COI – For this item CG left the room, in order to mitigate the conflict of interest.

The group received the Healthy London Partnership Update which provided an update to CCGs of the continued progress of the Healthy London Partnership (HLP) programme and of HLP planning for 2017/18, including a recommendation to proceed with the proposed programme on the basis that the strategic function and embedded resource costs are agreed for the next two financial years and project costs are agreed for one year with an annual planning cycle to be taken forward.

The need for a more Lewisham centred report from the team was discussed, with the group agreeing that it would be beneficial for the HLP measures be included in the Integrated Governance Committee integrated performance reporting.

The group approved the recommendations as stated in the update, with the understanding that further Lewisham specific information will be requested.
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Committee in Common: Draft Minutes

Tuesday 29 November, 09.00 – 11:00
Venue: Imagine 2 Room, London Bridge-Propero House, 241 Borough High Street
London, SE1 1GA
Chair: Paul Minton

Members in attendance
Paul Minton (PM) Independent Chair
Andrew Bland (ABI) Southwark CCG CO
Richard Gibbs (RGi) Southwark Governing Body Member
Jonty Heaversedge (JH) Southwark CCG Chair
Andrew Eyres (AE) Lambeth CCG CO
Adrian McLachlan (AM) Lambeth CCG Chair
Graham Laylee (GL) Lambeth CCG (for Sue Gallagher)
Martin Wilkinson (MW) Lewisham CCG CO
Marc Rowland (MR) Lewisham CCG Chair
Ray Warburton (RW) Lewisham CCG Deputy Chair
Angela Bhan (ABh) Bromley CCG CO
Harvey Guntrip (HG) Bromley Governing Body Member
Jo Murfitt (JM) Greenwich CCG CO
Ellen Wright (EW) Greenwich CCG Chair
James Wintour (JW) Greenwich Governing Body Member
Sarah Blow (SB) Bexley CCG CO
Nikita Kanani (NK) Bexley CCG Chair
Mary Currie (MC) Bexley Governing Body Member
John King (JK) Patient and Public Voice
Jane Fryer (JF) NHS England (acting DCO for Matthew Trainer)
Rikki Garcia (RGa) Healthwatch
Mark Easton (ME) OHSEL Programme Director

Other attendees:
Rory Hegarty (RH) OHSEL Communications Lead
Sam Ridge (SR) OHSEL Communications Team
Jill Mulelly (JMull) OHSEL Communications Team
Lucy Ing (LI) OHSEL
Tom Henderson (TH) OHSEL
Deepa Master (DM) OHSEL
Nick Jones (NJ) PwC
Chris Williams (CW) PwC
Paul Brown (PB) Member of Public
Ian Fair (IF) Member of Public
Tony O’Sullivan (TOS) Member of Public
Moh Okrekson (MO) Member of Public
Eileen Smith (ES) Member of Public
Sarah Willoughby (SWi) Member of Public
Olivia O’Sullivan (OOS) Member of Public
Elizabeth Rylance-Watson (ERW) Member of Public
Michael Corden (MC) Member of Public
Philip Lingard (PL) Member of Public
Bob Skelly (BS) Member of Public
Russell Cartwright (RC) Member of Public
Frances Hook (FH) Member of Public
John Fraser (JFr) Member of Public
Stephen Warren (SWa) Member of Public

Apologies:
Andrew Parson (AP) Bexley CCG Chair
Rosemarie Ramsey (RR) Lewisham Governing Body Member
Sue Gallaher (SG) Lambeth Governing Body Member
Matthew Trainer (MT) NHS England

Actions from previous meeting (23rd June 2016)

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<tr>
<th>ID</th>
<th>Type</th>
<th>Risk / Issue / Action / Decision Description</th>
<th>Owner</th>
<th>Meeting</th>
<th>Due Date</th>
<th>Status</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>6</td>
<td>Action</td>
<td>Sarah Blow to circulate updated timeline for stage 2 submission and evaluation process.</td>
<td>Sarah Blow</td>
<td>23 June</td>
<td>23 June</td>
<td>Closed</td>
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<td>7</td>
<td>Action</td>
<td>Programme team to update the following sentence on page 11: “It was agreed that there will [not] be enough demand for consolidating services across more than 2 sites”.</td>
<td>Programme team</td>
<td>23 June</td>
<td>30 June</td>
<td>Closed</td>
<td></td>
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<tr>
<td>8</td>
<td>Action</td>
<td>ME to make sure the section on transforming care is included in the STP.</td>
<td>Mark Easton</td>
<td>23 June</td>
<td>23 June</td>
<td>Closed</td>
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<tr>
<td>9</td>
<td>Action</td>
<td>John King requested a jargon buster is created to address the acronyms.</td>
<td>Programme Team</td>
<td>23 June</td>
<td>29 November</td>
<td>Closed</td>
<td>Available on OHSEL website</td>
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Actions from this meeting (29th November 2016)
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<tr>
<th>ID</th>
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<tr>
<td>10</td>
<td>Action</td>
<td>Publish updated declaration of interest on the OHSEL website.</td>
<td>Programme Team</td>
<td>29 Nov</td>
<td></td>
<td>Open</td>
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<td>11</td>
<td>Action</td>
<td>Discuss with Providers to discuss the extent to which they can work together as part of the enhanced status-quo (3 site model).</td>
<td>Programme Team</td>
<td>29 Nov</td>
<td></td>
<td>Open</td>
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<td>12</td>
<td>Action</td>
<td>CiC to receive recommendations for the final decision making process taking into account financial criteria.</td>
<td>Programme Team</td>
<td>29 Nov</td>
<td></td>
<td>Open</td>
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<td>13</td>
<td>Action</td>
<td>Share updated Consultation document with PPAG.</td>
<td>Programme Team</td>
<td>29 Nov</td>
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<td>Open</td>
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<td>14</td>
<td>Action</td>
<td>RH to add a note to question 5a in the consultation document which outlines the travel support which will be available.</td>
<td>Rory Hegarty</td>
<td>29 Nov</td>
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1. **Welcome and introductions:**
1.1 Paul Minton (PM) welcomed the Committee and asked attendees to introduce themselves.
1.2 Mark Easton (ME) highlighted apologies and noted that the quorum was not currently met as an additional member was required from Bromley. It was highlighted that Angela Bhan (ABh) and Harvey Guntrip (HG) would be joining shortly and therefore the quorum would be met. (Bromley representatives joined the meeting when previous minutes were being reviewed and thus the meeting became quorate).
1.3 ME distributed the declarations of interest form. Committee members reviewed the declarations of interest and the following corrections were highlighted:
- Adrian McLachlan (AM) noted that there were some updates for him but that none were material for this group.
- Andrew Bland (ABI), John King (JK), PM, Ellen Wright (EW) and Mary Currie (MC) noted that this version needed to be updated for them.
- Ray Warburton (RW), who was deputising for Rosemary Ramsey, noted he was not included but had nothing which he would need to declare.

1.4 Action: update and agree a revised declaration of interest, with those who noted changes were needed, and publish on the OHSEL website.

2. Minutes of previous meeting
2.1 PM ran through the previous meeting minutes. No corrections or changes were raised.
2.2 Mark Easton (ME) went through the previous meeting actions. ME noted that actions 6, 7 and 8 had been addressed through updating the STP and Orthopaedic documentation. ME noted in reference to action 9 that there was now a detailed ‘jargon buster’ available on the OHSEL website.

3. Brief public questions
3.1 PM introduced the section of the meeting dedicated to public questions. PM emphasised the importance of holding these meetings in public and noted that this meeting was specifically focused around Elective Orthopaedic Centres. PM noted that they have received a number of questions in advance and that they will now look to address these. PM noted that any additional questions should be passed to one of the members of the OHSEL communications team, who are sitting in the audience, and can ensure these are answered following the meeting.

3.2 Moh Okrenson (MO) asked the first question relating to an article in the London Metro, on the 21st November 2016, in which the head of the British Medical Association was credited with a statement suggesting that concentrating services at fewer sites was a cover for delivering cuts. The Committee was asked to respond to these claims and reassure the general public that concentrating services, such as elective orthopaedic planned care centres, was not a smokescreen for delivering cuts.

3.3 ME said that there are essentially two directions outlined in the STP, in which services can be taken. The first direction is to pursue, for the more specialised services, whether there are opportunities for centralisation to see if cost reduction and quality improvements can be realised. The second direction is looking at decentralising services through Community Based Care (CBC) and
making more services available locally. ME said that in terms of Orthopaedics the proposal is to increase capacity, increase quality and lower cost and that where these three elements are met there is an argument for centralisation. ME emphasised that it is not about making cuts but ensuring the system is getting the best value out of every pound and taking opportunities to improve quality.

3.4 Eileen Smith (ES) asked the CiC to confirm that there had been no bias towards the two site model and asked where the evidence base is for better outcomes, lower infection rates and cancellations over the last 5 years. ES said that this information was required to enable the public to make an informed choice.

3.5 Jonty Heaversedge (JH) responded that it is really important at this stage that we re-iterate the case for change and the rationale for proposing this change. JH said that within the Pre-Consultation Business Case there is considerable material which outlines information on areas such as cancellation and infection rates. JH said that some of the outcomes data used in the case for change is national (e.g. Getting it Right The First Time - GiRFT) and looks at South East London compared with South West London, where a collective orthopaedic centre is in place. JH said that the Royal Colleges point towards the value of separating out elective and non-elective orthopaedic work and how this has benefits such as reducing cancellations.

3.6 Sarah Blow (SB) added that following the Joint Health Overview and Scrutiny Committee (JHOSC) on the 28th November an action was taken to include more information surrounding this data as part of the consultation documentation.

3.7 Ian Fair (IF) asked whether we can have a full assessment in any consultative document of the option of consolidating inpatient orthopaedic work on 3 sites with ring-fenced beds backed by an effective SE London orthopaedic network. IF said this should set out the advantages, of which there are a number, as well as the perceived disadvantages. IF said that he understood this had been an agreed action from the JHSOSC and that in effect this would become a fourth option taken forward.

3.8 SB replied that the enhanced status-quo option is the three site option as currently 75% of the activity is carried out across three sites and that the activity which sits outside this is generally not inside SEL. SB said that it was agreed at JHOSC that the three site model would be put forward as a fourth option. SB noted that whilst they are proposing including this as an option the Evaluation Group are still recommending the 2 site model as the preferred option.
3.9 IF added that it is important when considering the three site model that we include the positives (e.g. travel and less upheaval) of this approach as well as the perceived negatives.

3.10 Paul Brown (PB) introduced the comment by Lewisham and Greenwich Trust in their submission that the loss of orthopaedic in-patient work at Lewisham would “deplete the number and skill of the remaining workforce and jeopardise trauma and theatre services” because orthopaedics constitutes such a large proportion of the hospital’s activity. PB asked if the Committee is satisfied that evaluation criterion 12 on ensuring the “on-going financial and organisational viability of individual providers” has been met for all the options under consideration.

3.11 ME responded that there has been independent assurance proposed to ensure that both the on-going financial and organisational viability tests are met. ME said that there has been a jointly commissioned study in to the financial implications of the centralisation and what mitigating actions may need to be taken to have a commercial model that works for everyone. ME noted that they are continuing to work with the trauma network and clinical senate in assessing the clinical impact. ME highlighted that the full quotation from Lewisham and Greenwich’s submission goes on to say that this situation would occur if there is a TUPE transfer of staff which is not what is being proposed. ME said that it is being proposed that staff would still be employed by their original hospital and that activity would still be owned by the original Trusts. ME said that this issue will need to be monitored and if it becomes apparent that this change will destabilise any of the organisations the proposal will not be taken forward. ME highlighted that NHSE will also be carrying out ongoing assurance to ensure that none of the organisations are made unsustainable.

3.12 Tony O’Sullivan (TOS) said that it was unclear what the enhanced status-quo option meant. TOS said that the enhanced status-quo option needed to explore what a network for elective orthopaedic care would look like if each of the three trusts retained their elective inpatient surgery but enhanced this to avoid disruption to the pathway from emergency work and improved pre- and post-operative work and rehabilitation through investment. TOS said without having this option available, as part of the options appraisal, it was incomplete.

3.13 SB responded that the enhanced status-quo option, which is used as the baseline option, is exactly this. SB said that the enhanced status-quo includes having in place the network and the additional work the Trust’s need to do surrounding GiRFT.

3.14 JH reiterated that the enhanced status-quo option was not a do nothing option and that it was made very clear by the Evaluation Panel that this was an enhanced option.
3.15 TOS said that this needed to be made public as it was currently not clear that the enhanced status-quo was a collaborative venture.
3.16 SB said that they have asked the Trust’s for a collaborative model but they said they were unable to put forward a collaborative option that would work. SB said that, as an action from the JHOSC, they will review the information which has been circulated publically and ensure that this provides a complete picture.
3.17 ME noted that there should be an action taken to go back to Providers to talk to them about the extent to which they envisage they can work together as part of the enhanced status-quo option.
3.18 **Action: discuss with providers the extent to which they can work together as part of the enhanced status-quo (3 site model).**
3.19 ES reiterated that the consultation document needed to spell out exactly what the enhanced status-quo was.
3.20 SB said that this would be addressed as one of the actions from the JHOSC meeting.
3.21 ME said, based on a question he had received earlier, that there was no formal future submission dates for the STP but that operating plans for the next two years needed to be submitted by the 23rd December.

4. **Elective Orthopaedic Centres (EOC) – Introduction and Overview**
4.1 SB provided an update and overview of the activity which has taken place since the Committee in Common (CiC) last met. SB said that since the Committee last met the following items have been reviewed by the Orthopaedic Evaluation Group:
   - Completed financial analysis;
   - More detailed travel analysis;
   - Updated quality analysis information;
4.2 SB noted that the programme team has engaged with the JHOSC and consulted with individual borough councillors regarding the Consultation documentation.
4.3 SB said that following the JHOSC meeting, on the 28th November, changes were needed to the Consultation document but that the recommendation to the CiC would not change as a result of these. SB noted that the design of the Consultation document was taken to JHOSC and was positively received.
4.4 SB highlighted that there was an assurance meeting with NHSE later that day (29th November) to discuss the Pre-Consultation Business Case (PCBC).
4.5 SB said that initially the timeline to start consultation was the 5th December but that this was likely to be moved back to allow time to embed the requests from JHOSC.
4.6 SB outlined the following actions which arose from the JHOSC meeting, on the 28th November:

- Re-ordering of the Consultation document questions following feedback;
- Including the enhanced status-qu quo option as a fourth option for Consultation;
- Ensuring that the word hospital is included in all references to Queen Mary’s Hospital;
- Re-word the question relating to the impact the Orthopaedic Centres will have on A&E so that it is not misleading;
- Provide greater clarity and detail on the financial analysis which has taken place in the documentation;
- Ensure that the language in the documentation shows that the public are being listened to whilst making it clear it is not a vote;
- Provide JHOSC with the independent review which will be carried out by the University of Kent following consultation;
- Put in place a follow up meeting with JHOSC mid-consultation to give feedback on the process;
- Provide JHOSC with further information surrounding the quality comparisons with SWLEOC on areas such as infection rates.

SB highlighted that the impact of these changes was that they would not be asking the CiC to sign-off the final consultation document today. SB proposed instead that they would be asking the CiC to sign-off whether they agree we should be going to consultation. SB suggested that, following another conversation with JHOSC to confirm the points above have been addressed, that the CiC could then verify via CCG Chairs’ action the wording of the consultation documentation.

5. Elective Orthopaedic Centres – Recommendation of the Elective Orthopaedic Group

5.1 JH introduced the recommendation from the Evaluation Group and gave an outline of the process used by the group for the non-financial criteria.

5.2 JH mentioned that the case for change and proposed models had been reviewed and agreed by the CiC previously. JH emphasised the importance of referencing these throughout the consultation documentation so that it is clear the path that was taken to get to where we are now.

5.3 JH referred to the detailed process which was taken by the Evaluation Group to come to the recommendation (agenda item C).
5.4 JH noted that the Evaluation Group was made up of voting members from each of the CCGs, an expert clinician, social care and patient representatives.

5.5 JH explained that the initial stage for the Evaluation Group was to assess the four site options (King’s, Lewisham, Guy’s, Queen Mary’s Hospital) based on a series of hurdle criteria questions. JH said that at this point it became apparent that the Queen Mary’s Hospital site did not pass two of the hurdle criteria, specifically surrounding being able to accommodate 50% of SEL activity and being able to deliver on complex procedures due to a lack of a critical care unit. JH therefore said that the recommendation is that the Queen Mary’s Hospital option is not taken forward to consultation as a site option.

5.6 JH said that one of the hurdle criteria was surrounding accessibility and having one inner and outer London site. JH said that following much consideration the Evaluation Group thought that the best way to think about the sites accessibility was not based on geographical or administrative boundaries but on the impact on travel times for patients across SEL. As such the Lewisham and Guy’s option, which could be considered to have two inner sites, was not excluded at this stage.

5.7 JH said that as part of the hurdle criteria the importance of not destabilising any of the organisations was discussed. JH emphasised that the model being proposed was a network model and as such the activity would still be owned by the organisations who do not host the EOC. JH said that it is crucial that the commercial model, which is still being developed, allows for no single organisation to be destabilised and for the system to be sustainable and stable going forward.

5.8 JH said that the scoring system used was against an enhanced status-quo and that options could score either positively or negatively against this i.e. for accessibility all options scored negatively against the enhanced status-quo as travel times will increase if there are fewer sites.

5.9 JH explained that they heard presentations from King’s, Lewisham and Guy’s and had the opportunity to ask them questions surrounding areas such as how they were proposing to work as part of a network model.

5.10 JH noted that the scoring process involved reaching a consensus as a panel on the score that should be given for each of the non-financial criteria. JH stated that all three options received an overall positive score against the enhanced status-quo option, on the non-financial criteria, with the Guy’s and Orpington option scoring highest.

5.11 Nick Jones (NJ) provided an outline of the approach which was taken to assess the financial criteria.
5.12 NJ explained that they worked closely with the Trust finance teams to develop submissions for the following three scenarios:
- The base case, with elective orthopaedic services continuing to be provided according to the current configuration, whilst meeting expected growth in patient demand and delivering GiRFT recommendations;
- Cost associated with hosting the EOC;
- Cost associated with not hosting the EOC.

5.13 NJ said that follow up sessions took place with each of the Trusts to help ensure that there was consistency in the approach that was being taken across all the sites.

5.14 NJ said that over the five-year-period to FY20/21 that all three options are marginally more expensive in total than the enhanced status-quo option but that they all present a position that is a lower recurrent cost by that end point. Thus they position the system at a lower expenditure for the longer term. NJ added that the amount by which the options are a lower cost to the system varies between the options with option 1 being just under £9m, option 2 just over £2m and option 3 between the two.

5.15 JH provided a summary of the findings and the recommendations to the CiC.

5.16 JH emphasised that they have heard that there is non-financial benefits from all the options as well as long term financial benefits for the system from all the options.

5.17 JH stated that based on both the financial and non-financial criteria the recommendation from the Evaluation Group is that all three options, should be considered as part of the consultation as the preferred options, but that the enhanced status-quo option should also be described.

5.18 ME confirmed that whilst the Evaluation group are recommending to the CiC that they take the enhanced status-quo option through consultation as option 4, that the consolidated two-site model was the preferred option.

5.19 The floor was then opened for comments and questions from the Committee.

5.20 James Wintour (JW) said that Greenwich supports the recommendation that is being put forward and proposed a suggestion that, as part of the next phase, the financial criteria is also weighted in the same way as the non-financials have been. JW said that so far we have had a hurdle criteria for the finances but that when it comes to the final decision for which sites to use the financial savings should act as a criteria, which is weighted with the non-financials, and factored in accordingly.

5.21 JW noted that the other two comments which he was going to raise have been addressed earlier but were surrounding the financial and operational viability of
the individual providers needing to be set out more clearly and the enhanced status-quo being quantified more obviously.

5.22 Marc Rowland (MR) said that he felt further clarity was required on the financial analysis so that it is clear what exactly the objectives and requirements are. MR said that it needed to apparent what the financial imperatives are and how these are being managed in conjunction with the non-financial criteria.

5.23 SB responded on this question emphasising that initially it was viewed, by the CiC, that the non-financial options should be viewed as the most important and that any option that was financially viable should therefore be assessed on the non-financial benefits. SB said that whilst this was the approach taken to understand what options should be taken to consultation the CiC should now consider how they wish to incorporate the financial implications of the options as part of the final decision process. SB noted that it may be that the existing approach is then agreed upon or that the financial impacts need to be weighted and incorporated but that the CiC need to take advice on the best way to do this.

5.24 **Action:** CiC to receive recommendations for the final decision making process taking into account financial criteria.

5.25 Ray Warburton (RW) said that he thought that the Orpington site was temporary, in order to deal with pressures at the Denmark Hill site, and therefore was there a consideration regarding the opportunity cost of using the Orpington site as a permanent option.

5.26 Angela Bhan (ABh) responded to this question emphasising that King’s have invested significantly over the last few years in to Orpington and has already consolidated much of the in-patient orthopaedic activity there. ABh said that Orpington now performs very well for patient outcomes, offers a range of specialist services and as such it is a facility which could be used as an option.

5.27 JH said that the opportunity cost of using Orpington as an option has been considered in the same way as it has been for all the options.

5.28 RW asked what the proposal is to measure and assess whether any sites are destabilised as a result of a change in configuration.

5.29 SB responded that she feels there will need to be an on-going process to access the impacts on each of the organisations effected. SB highlighted that there is an external trauma network, amongst others, who will be engaged in the consultation period to look at the likely impacts. SB said that post consultation there will need to be on-going assessments of both the positive and negative clinical and financial impacts of the changes carried out by an external body.
5.30 Martin Wilkinson (MW) said that it is important that whilst we emphasise this is about improving quality we are also clear in the documentation on the financial objectives of the proposals in relation to the STP. MW said that it is important to bring out the context of the financial implications and that questions on these should be included in the consultation documentation.

5.31 SB said it was clear from JHOSC that more needs to be done to get further clarity and visibility of the financial objectives and implications of the options. SB said that one follow up from JHSOSC is to discuss, with NJ, how to do best do this.

5.32 Harvey Guntrip (HG) asked how we are going to ensure post-decision that all the organisations are appropriately feeding in elective care patients and releasing staff as expected.

5.33 SB responded that they are working with the Trusts to develop a collaborative business model which supports this post the decision being made. SB emphasised that the clinicians do support this and that she anticipates once a decision is made that they will be able to progress positively towards this model. SB said that they achieved this model in South West London and it benefits all the Trusts there.

5.34 JH said that he feels that this is a very real challenge for the STP to address as a whole and it is particularly difficult when looking at one area in isolation. JH said that by getting other opportunities, where consolidation and collaboration is required, moving alongside Orthopaedics some of the competitive tensions should be mitigated.

5.35 SB noted that providers are working collaboratively across productivity and that work has begun to look which areas can be taken forward alongside Orthopaedics to ensure all organisations remain stable.

5.36 John King (JK) asked that the changes which are being made to the consultation documentation are shared as soon as possible with PPAG.

5.37 **Action:** share updated consultation document with PPAG.

5.38 JK asked if there was any scope for including providers on the CiC.

5.39 ME responded that the CiC is set up to be a commissioner led forum and that the Strategic Planning Group is where Providers and Commissioners meet. ME said that the Strategic Planning Group is meeting on 2nd December and will discuss orthopaedics there.

5.40 ME said that it is important to remember that it is the commissioning arrangements which will underpin the Planned Care Orthopaedics activity and whilst we need to work with the Trusts to get them aligned with this it is the contracts let that will ultimately drive the change.
5.41 Mary Currie (MC) added that in order for successful implementation robust governance needs to be in place to ensure quality, performance and access is managed for all those who need access.

5.42 MR raised concern about the scale of the capital requirements that were needed for the proposals and the ability to access this.

5.43 ME responded that they have been working very closely with NHSE and NHSI colleagues to make sure they are sighted on the capital requirements. ME said that the capital requirements for all three options are within a range that would be expected to be supported, as long as the business cases are viable, but that this has not been confirmed by NHSE at this time.

5.44 JH raised that his governing body had expressed concern surrounding the general instability which many providers are experiencing currently and how this is being factored in.

5.45 ME said that as part of the consultation process they should return to the question of deliverability to ensure that they are confident that the chosen sites can deliver the proposal. JH said that hopefully at that point, during consultation, there will be a developed commercial model which should support further understanding of how the models will be delivered.

5.46 JH noted that the other two comments which he was going to raise have been addressed earlier but were surrounding the importance of ensuring the sustainability of all the organisations and including the case for change throughout the consultation documentation.

5.47 PM confirmed with the CiC that they:

- AGREED once the Consultation document is updated to include the actions from JHOSC that they will review the updated wording and agree via a Chair’s action. (ref. minute 4.15);
- AGREED with the recommendation of the Evaluation Group that the three site option should be in the consultation document as option four but that the three consolidated two-site options should be the preferred options. (Lewisham and Guy’s, Guy’s and Orpington, Lewisham and Orpington) (ref. minute 5.17);
- AGREED that they need to decide as a Committee the criteria, for both the non-financial and financial impacts, for the final decision process (ref. minute 5.22).

6. Elective Orthopaedic Centres – Pre-Consultation Business Case
6.1 SB introduced the Pre-Consultation Business Case (PCBC) drawing attention to the summary slides which had been provided (agenda item D).

6.2 SB noted that there have already been conversations at the CiC surrounding the case for change and the two-site model and that they are now at the stage where a document (the PCBC) has been created.

6.3 SB noted that they have provided the PCBC to NHSE and will meet on the 29th November to discuss assurance surrounding how they reached the preferred option of a consolidated two site model. SB said that NHSE will be looking for assurance on the four tests of service reconfiguration:

- Strong public and patient engagement;
- Consistency with current and prospective need for patient choice;
- A clear clinical evidence base;
- Support for proposals from clinical commissioners.

6.4 SB said that they feel they have addressed the four tests and that there is a robust evidence base for how they have done this.

6.5 PM confirmed with the CiC that they AGREED that the programme should move to launch of a consultation on elective orthopaedic centres, subject to NHSE assurance.

7. Elective Orthopaedic Centres – Consultation plan and Consultation document

7.1 Rory Hegarty (RH) introduced the Consultation plan (agenda item E).

7.2 RH said that the plan has been tested with a range of stakeholder groups including PPAG, Stakeholder Reference Group, Planned Care Reference Group and JHOSC.

7.3 RH outlined the following activities that would take place as part of the Consultation Plan:

- Focus Groups for those with protected characteristics, including those classed as deprived or as carers;
- Deliberative events for members of the public;
- Public events on hospital sites;
- Consultation hearing mid-way through the consultation process where attendees can submit evidence for and against the proposals;
- Briefings with key stakeholders such as Healthwatch and interest groups;
- Planned Care Reference Group meetings;
- Service user engagement to reach past, present and future users;
- Existing networks and groups which the programme currently utilises.

7.4 RH said that a range of communication channels have been created including media, social media, websites, the programme newsletter and targeted advertisements.

7.5 RH noted that the timeline for the consultation plan was 14 weeks and was intended to begin in December.

7.6 The floor was then opened for comments and questions from the Committee.

7.7 Richard Gibbs (RGi) said that he supported the plan and stressed the importance of ensuring there is sufficient participation from clinicians. RGi emphasised that in his experience it is the clinicians who the public will truly value being able to question and hear from throughout the consultation plan.

7.8 RH responded that he agreed that this is key and that they have looked to incorporate clinical involvement throughout the plan to provide the public with the opportunity to discuss with clinicians the patient impacts.

7.9 SB highlighted that clinicians have been helpful in the process to date engaging with PPAG and JHOSC showing their support for the model. SB added that Tim Briggs (National Director for Clinical Quality) has also been vocal in his support for the model.

7.10 Nikita Kanani (NK) highlighted her support for the plan and raised the importance of ensuring that it uses the 6 local Healthwatchs, which are in place across SEL, to reach the community.

7.11 RH agreed and emphasised that they are in regular communication with Healthwatch organisations and will be looking for their support throughout the consultation plan.

7.12 Rikki Garcia (RGa) reinforced the importance of engaging with the Healthwatch’s but noted that the consultation plan should not rely entirely on them to reach out to everyone in the community. RGa said he was pleased to see that carers are being addressed as part of the plan but that he thought this could be clearer in the documentation. RGa stated the importance of making sure that the focus groups were spread out across the SEL community. RGa added that the consultation document needed to be available in an easy read format and that the dates for the meetings are advertised as soon as possible.

7.13 RW said that he welcomed the approach to the consultation and in particular how it addresses those with protected characteristics. RW stated the importance of engaging as wider population as possible throughout the process and clearly being able to articulate and talk through the issues. RW said that in particular with the financial criteria it may be that further support and explanation is required.
7.14 RH said that he is discussing with NJ the possibility of creating a summary document on the finances which could be shared alongside the other documentation.

7.15 HG suggested developing a video as a practical solution to ensuring that clinician’s perspectives can be shared at the meetings even when a clinician is unable to attend in person.

7.16 RH responded that a video, as well as other animations, are being developed and will include clinician input. RH also noted that the consulting hearing will be broadcast.

7.17 JH re-emphasised that the readability of the document is crucial, in particular surrounding the finances. JH said that the case for change needs to be made clear throughout the consultation document as it is vital that people understand why we are doing what is proposed.

7.18 AM said that he feels it is crucial to the success of the plan to ensure that local people are part of the local presentations as it is them who will have the required credibility.

7.19 RH responded that the aim is get local feedback throughout consultation and to supplement the central team, who are closer to the detail, with this throughout the engagement.

7.20 SB re-emphasised the importance of this and said that it is crucial that the CCGs own this and take this forward in to their boroughs.

7.21 RGa said that he felt that question 5a in the consultation document should include additional information so that it is clear what additional travel could be expected.

7.22 SB agreed that a note should be included to outline the travel support that will be offered and who it will be offered to as part of the revised model.

7.23 **Action:** RH to add a note to question 5a in the consultation document which outlines the travel support which will be available.

7.24 RW said that it would be useful to articulate what could arise from the consultation process that would prevent the proposals going ahead, cause the process to pause or confirm the desire to progress.

7.25 ME said that the justification for stopping the process would be if there was a justifiable threat to organisational viability, evidence the clinical benefits will not be realised or evidence the financial benefits will not be realised.

7.26 **PM confirmed with the CiC that they AGRED the consultation plan.**

7.27 PM thanked attendees and noted the next meeting will be scheduled for after consultation.
A partnership of providers and Clinical Commissioning Groups serving the boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark with NHS England