AGENDA
A meeting of the Governing Body in public

Date: 10 September 2015
Time: 9:30 – 11:00
Venue: Civic Suite, Lewisham Town Hall, Catford, London SE6 4RU
Chair: Dr Marc Rowland

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

Voting Members

Dr Marc Rowland  Chair  Lewisham CCG
Dr David Abraham  Senior Clinical Director  Lewisham CCG
Prof. Ami David MBE  Registered Nurse Member  Lewisham CCG
Dr Sebastian Kalwij  Clinical Director  Lewisham CCG
Dr Faruk Majid  Senior Clinical Director  Lewisham CCG
Dr Jacky McLeod  Clinical Director  Lewisham CCG
Dr Angelika Razzaque  Clinical Director  Lewisham CCG
Mr Tony Read  Chief Financial Officer  Lewisham CCG
Ms Diana Robbins  Lay Member  Lewisham CCG
Vacancy  Secondary Care Doctor  Lewisham CCG
Mr Ray Warburton OBE  Deputy Chair, Lay Member  Lewisham CCG
Mr Martin Wilkinson  Chief Officer  Lewisham CCG

Non-Voting Members

Ms Aileen Buckton  Executive Director, Community Services, Lewisham Council
Dr Brian Fisher  Healthwatch Lewisham
Dr Simon Parton  Chair of Local Medical Council
Dr Danny Ruta  Public Health Director, Lewisham Council
Ms Rosemarie Ramsay MBE  Lay Member Designate

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.
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.

<table>
<thead>
<tr>
<th>Time</th>
<th>Item</th>
<th>Papers</th>
<th>Presented by</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. 9:30</td>
<td>Welcome and introductions</td>
<td></td>
<td>Chair</td>
</tr>
<tr>
<td>2.</td>
<td>Apologies for absence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Declarations of Interest</td>
<td>Enc 1</td>
<td>Chair</td>
</tr>
<tr>
<td></td>
<td><em>Members should discuss any potential conflicts of interest with the Chair prior to the meeting</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. 9:35</td>
<td>To agree minutes of previous meeting and review the action log</td>
<td>Enc 2</td>
<td>Chair</td>
</tr>
<tr>
<td>5.</td>
<td>Matters arising</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. 9:40</td>
<td>Chair’s Report</td>
<td>Enc 3</td>
<td>Dr Marc Rowland</td>
</tr>
<tr>
<td></td>
<td><em>To receive and note for information</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. 9:50</td>
<td>Chief Officer’s Report</td>
<td>Enc 4</td>
<td>Martin Wilkinson</td>
</tr>
<tr>
<td></td>
<td><em>To receive and note for information</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Audit Committee Chair’s report – no report as no meeting held since 7 July 2015</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. 10:00</td>
<td>Finance and Investment Committee – from meeting on 21 July 2015</td>
<td>Enc 5</td>
<td>Prof Ami David</td>
</tr>
</tbody>
</table>

INTEGRATED GOVERNANCE

<table>
<thead>
<tr>
<th>Time</th>
<th>Item</th>
<th>Papers</th>
<th>Presented by</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. 10:10</td>
<td>Board Assurance Framework 2015/16</td>
<td>Enc 6</td>
<td>Martin Wilkinson</td>
</tr>
<tr>
<td></td>
<td><em>To receive and agree</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. 10:20</td>
<td>Delivery Committee – Chair’s report from the meetings held on July and August 2015</td>
<td>Enc 7</td>
<td>Martin Wilkinson</td>
</tr>
<tr>
<td></td>
<td><em>Integrated Performance Report Including Quality, Finance, QIPP and Performance</em></td>
<td>Enc 8</td>
<td>Martin Wilkinson</td>
</tr>
<tr>
<td></td>
<td><em>To receive and endorse the reports</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. 10:40</td>
<td>Questions in relation to agenda items from members of the public</td>
<td></td>
<td>Chair</td>
</tr>
</tbody>
</table>
## STRATEGY AND PLANNING

| 13. | 10:45 | **Strategy and Development** – Chair’s report from meeting held on 4 June 2015 | Enc 9 | Dr David Abraham |
| 14. | | **Potential Audit and Risk Management Issues**  
*To identify any issues which the Governing Body consider would benefit further scrutiny by the Audit Committee* | Chair |
| 15. | | **Any Other Business** | |
| 16. | 10:55 | **Questions from members of the public** | |

### FOR INFORMATION ONLY

| 17. | | **Approved Committee minutes for information only**  
*Audit Committee* (May 2015)  
*Delivery Committee* (June and July 2015)  
*Strategy and Development* (June 2015)  
*Health and Well Being Board* (May 2015)  
*Clinical Strategy Committee* (July 2015)  
*Primary Care Joint Committee* (June 2015) | Enc 10  
Enc 11  
Enc 12  
Enc 13  
Enc 14 follows  
Enc 15 |
| 18. | 11:00 | **Date of next meeting:** 12 November 2015; 9:30 – 12:00  
Forest Hill Methodist Centre, Normanton Road, London SE23 2DS | |

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

13. 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.

14. 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.

15. 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.

16. 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).

17. 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.

18. 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.

19. 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.

20. 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.

21. These arrangements will be recorded in the minutes.
<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Organisation/Role</th>
<th>Dates</th>
<th>Other Specific Interests</th>
<th>Other Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surname</td>
<td>Warburton</td>
<td>Director of Ray Warburton</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Surname</td>
<td>Wilkinson</td>
<td>Member of the NHS Equality and Diversity</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Surname</td>
<td>Read</td>
<td>Member of IFR panel and is remunerated for</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Surname</td>
<td>Entwistle</td>
<td>GP Appraiser, NHS SE London, GP Triager Referral Support</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Surname</td>
<td>Ramsay</td>
<td>Chair of London Clinical Commissioning Council</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Surname</td>
<td>Parton</td>
<td>Director AD Community Nursing</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Surname</td>
<td>Abraham</td>
<td>Director of Adult Social Care</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Surname</td>
<td>McLeod</td>
<td>Secondary Care Doctor</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>First Name</td>
<td>Ian</td>
<td>Clinical Director</td>
<td>05/08/20015</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>First Name</td>
<td>Tony</td>
<td>Clinical Director</td>
<td>tbc</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>First Name</td>
<td>Angelika</td>
<td>Senior Clinical Director</td>
<td>18/06/2015</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>First Name</td>
<td>Jackie</td>
<td>Senior Clinical Director</td>
<td>18/06/2015</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>First Name</td>
<td>Farulk</td>
<td>Senior Clinical Director</td>
<td>18/06/2015</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>First Name</td>
<td>Rosemarie</td>
<td>Senior Clinical Director</td>
<td>18/06/2015</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>First Name</td>
<td>Diana</td>
<td>Senior Clinical Director</td>
<td>18/06/2015</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>First Name</td>
<td>Danny</td>
<td>Senior Clinical Director</td>
<td>18/06/2015</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>First Name</td>
<td>Rose</td>
<td>Senior Clinical Director</td>
<td>18/06/2015</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>First Name</td>
<td>Mark</td>
<td>Senior Clinical Director</td>
<td>18/06/2015</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>First Name</td>
<td>Sarah</td>
<td>Senior Clinical Director</td>
<td>18/06/2015</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>First Name</td>
<td>Anthony</td>
<td>Senior Clinical Director</td>
<td>18/06/2015</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>First Name</td>
<td>Susan</td>
<td>Senior Clinical Director</td>
<td>18/06/2015</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>First Name</td>
<td>Andrew</td>
<td>Senior Clinical Director</td>
<td>18/06/2015</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>First Name</td>
<td>Adrian</td>
<td>Senior Clinical Director</td>
<td>18/06/2015</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>First Name</td>
<td>Ian</td>
<td>Clinical Director</td>
<td>05/08/20015</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>First Name</td>
<td>Tony</td>
<td>Clinical Director</td>
<td>tbc</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>First Name</td>
<td>Angelika</td>
<td>Senior Clinical Director</td>
<td>18/06/2015</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>First Name</td>
<td>Jackie</td>
<td>Senior Clinical Director</td>
<td>18/06/2015</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>First Name</td>
<td>Farulk</td>
<td>Senior Clinical Director</td>
<td>18/06/2015</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>First Name</td>
<td>Rosemarie</td>
<td>Senior Clinical Director</td>
<td>18/06/2015</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>First Name</td>
<td>Diana</td>
<td>Senior Clinical Director</td>
<td>18/06/2015</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>First Name</td>
<td>Danny</td>
<td>Senior Clinical Director</td>
<td>18/06/2015</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>First Name</td>
<td>Rose</td>
<td>Senior Clinical Director</td>
<td>18/06/2015</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>First Name</td>
<td>Mark</td>
<td>Senior Clinical Director</td>
<td>18/06/2015</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>First Name</td>
<td>Sarah</td>
<td>Senior Clinical Director</td>
<td>18/06/2015</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>First Name</td>
<td>Andrew</td>
<td>Senior Clinical Director</td>
<td>18/06/2015</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>First Name</td>
<td>Adrian</td>
<td>Senior Clinical Director</td>
<td>18/06/2015</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>First Name</td>
<td>Ian</td>
<td>Clinical Director</td>
<td>05/08/20015</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>First Name</td>
<td>Tony</td>
<td>Clinical Director</td>
<td>tbc</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>First Name</td>
<td>Angelika</td>
<td>Senior Clinical Director</td>
<td>18/06/2015</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>First Name</td>
<td>Jackie</td>
<td>Senior Clinical Director</td>
<td>18/06/2015</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>First Name</td>
<td>Farulk</td>
<td>Senior Clinical Director</td>
<td>18/06/2015</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>First Name</td>
<td>Rosemarie</td>
<td>Senior Clinical Director</td>
<td>18/06/2015</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>First Name</td>
<td>Diana</td>
<td>Senior Clinical Director</td>
<td>18/06/2015</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>First Name</td>
<td>Danny</td>
<td>Senior Clinical Director</td>
<td>18/06/2015</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>First Name</td>
<td>Rose</td>
<td>Senior Clinical Director</td>
<td>18/06/2015</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>First Name</td>
<td>Mark</td>
<td>Senior Clinical Director</td>
<td>18/06/2015</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>First Name</td>
<td>Sarah</td>
<td>Senior Clinical Director</td>
<td>18/06/2015</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>First Name</td>
<td>Andrew</td>
<td>Senior Clinical Director</td>
<td>18/06/2015</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>First Name</td>
<td>Adrian</td>
<td>Senior Clinical Director</td>
<td>18/06/2015</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>
Chair’s Report to Governing Body
10th September 2015

It is always difficult to write a report two weeks before a Governing Body meeting especially when I will have been away the week before. Generally it has been a quieter period with holidays. It gives a good opportunity to catch up on reading reports although with colleagues on holiday it doesn't always feel that way!

On a practical note: the new secondary care Doctor we appointed to the Governing Body is not now able to take on the role. We will be re-advertising shortly.

On a broader note: London devolution is being looked at in a measured way and proposals will be forthcoming soon. It will be very different to Manchester but the exact form remains to be seen.

On a local note: Primary care is developing at scale around London and nationally and, where done well, this seems to lead to happier workers with a sense of direction to deliver good quality care and retaining the best of ‘old style’ general practice professionalism. We are supporting our membership in looking at ways forward and I hope we can do as well or better than elsewhere. We also need to work with secondary care providers to continue to deliver good quality, sustainable care with a happy and confident workforce. Both developing work will improve some of the inequality of services across Lewisham.

The Governing Body has been looking at how health care will develop in South East London (SEL). We are at the centre of SEL geographically and in the health connections around us, looking mainly into London but also out, especially to Queen Elizabeth Hospital, Woolwich. Our Healthier South East London, a programme that we jointly sponsor with the five other SEL CCGs and NHS England working in partnership with all our local health providers and Local Authorities, is looking at the way care is delivered across SEL. Due to our recent events, this is of great concern to the people of Lewisham and is seen as a threat by many but it is also an opportunity, and the CCG will lead what is needed locally to get the right balance of services for our population. It is a way to improve our working with Lewisham Council, integrating health and social care, integrating physical and mental health services where relevant and working closely with Lewisham and Greenwich Trust, South London & Maudsley and others to deliver services where most appropriate.

We start with the patient:
• How to make living healthier lifestyles easier for our population.
• Then helping to make the communities they live in stronger and more supportive and working better with voluntary organisations.
• We will look to improve all aspects of primary care.
• Design better secondary care pathways, easier for patients making them as integrated with primary and community services, and where appropriate tertiary care, as possible.
• Finally, improving and co-ordinating SEL and London wide services such as 111, LAS and tertiary care pathways.

Lewisham Hospital, like Lewisham’s place in SEL, is central to Lewisham physically and in our commissioning of health services. It is key to allowing us to give our population the best health care we can.

Through the Adult Integrated Care Board, we are working with Lewisham & Greenwich Trust, South London & Maudsley and London Borough of Lewisham to integrate services and improve delivery on a neighbourhood wide basis. This is progressing well and again will lead to Lewisham getting more joined up services, better outcomes and experiences for local people.

On a personal note: As I know from my experience as a GP partner, having the right workforce will be fundamental to delivering our collective goals. We must work to retain existing staff and attract new ones where needed. Some factors we can only try and influence but we must keep Lewisham a good place to work caring for our population and give it a clear, sustainable future.

Dr Marc Rowland
1. Our Healthier South East London Programme (OHSEL) (July/August 2015 update)

Mark Easton is now welcomed as the new Programme Director in August.

1.1 Consolidated Strategy
Following approval at the Governing Body meeting in July, the consolidated OHSEL Strategy was discussed and formally agreed at the Clinical Commissioning Board held in August noting comments from CCG Governing Bodies, patient representatives and provider trusts. This paper will be shared with Governing Body members separately.

1.2 Option Appraisal Process
OHSEL has defined a number of interventions to improve health outcomes for south east London. There are some areas where the impact of the strategy will need further consideration where there is more than one option for delivery which could result in a significant service change. These interventions will need to undergo an options appraisal process. The options appraisal process will aim to identify the best way to deliver the strategy realising its full benefits. It will be designed to identify the options that are recommended for further work and, if appropriate, for formal consultation. Workshops will be held which will focus on the service areas which may require significant change. This will result in a short list of options which could go to consultation. An engagement event on this process was held on 6 July with participants from stakeholders, patients and the public regarding the Options Appraisal Process.

1.3 Engagement
Local engagement on the Issues Paper ‘Help us improve your local NHS; Issues Paper’, is continuing. This will be developed with the publication of a second document with more detail on the emerging models and the consolidated strategy which will be published and distributed during September. Six deliberative engagement events were held in July, one in each borough. Positive feedback was collected from the events, from a range of different participants which will feed into the development of the strategy. CCG engagement plans on the Issues Paper will be going to appropriate local committees during September and October for assurance and information. Reports from the six deliberative engagement events on the Issues Paper and the stakeholder event on options appraisal have been published on the programme website.

The Reading Group has reviewed the You Said, We Did report and the Emerging Models document (which is a follow up to the Issues Paper) and the Equality Analysis report, which was produced by Verve Communications, and flagged up which groups protected under the Equality Act 2010 were likely to be impacted by the south east London strategy.

A paper drafted by Patient and Public Voices entitled Observations from Patient and Public Advisory Groups (PPAG), has been circulated to the Clinical Executive Group for their information, summarising thoughts from the group on the programmes’ direction of travel. The next PPAG will be held on 18 September and will focus on the function of Care Navigation across south east London.

1.4 General Updates
The Clinical Leadership Group membership was invited to a Care Summit on 17 June to review the proposed models and test them against the case for change. It was attended by almost 100 people representing GPs, CCGs, provider clinicians and other staff, voluntary sector colleagues, local authorities, patients and public.
The Clinical Executive Group met on 13 August to approve the clinical models with the group receiving presentations from each Clinical Leadership Group Chair on the models which will be used for the detailed design of the interventions with an opportunity to ask questions and comment. It was also noted that there was a need to undertake further analysis on the benefits during the next phase of the programme.

A programme update has been produced for Overview and Scrutiny Committees and Health and Wellbeing Boards. This will be published on the programme website at www.ourhealthiersel.nhs.uk

2. Primary Care Co-commissioning update

The second Lewisham Primary Care Joint Committee took place on the 6th August 2015. The main agenda items for the meeting relevant to Lewisham CCG included discussions regarding the Governance and Operating Model to support co-commissioning and updates on primary care quality, performance and finance. There was also a discussion on the proposed approach to a review of local PMS contracts to ensure they remain fit for purpose. Further discussions are being held locally with NHSE on the best approach locally to this review which will include local LMC. The plan is to propose commissioning intentions for the next Lewisham Primary Care Joint Committee on 29 September.

Internal CCG governance structures to support the Lewisham Primary Care Joint Committee have been reviewed and will be taken to the next Joint Committee to be held in September.

The approved minutes from the first Primary Care Joint Committee which took place on the 11th June 2015 are attached at enclosure 15 for information.

3. Membership of Committee in Common for Strategic Decision Making

At our Governing Body workshop on the 20th August we discussed the proposed membership from the Governing Body on the Committee in Common for Strategic Decision Making which will form part of the governance structures of the OHSEL programme.

The Governing Body have supported the proposal that we are represented by the CCG Chair, lay member and Chief Officer. This would provide the appropriate balance of membership, independent and executive perspectives, while ensuring that this balance is maintained where other members of the Governing Body may have to deputise, and also recognising the contribution that the whole Governing Body will make in the decision-making processes in advance of the committee meetings which we have started to develop with recent workshops on shared values and priorities.

4. Commissioning Support Services

The CCG is preparing to procure its commissioning support services from 2016/17 using the national Lead Provider Framework. We are working in partnership with other CCGs in south east London to ensure services are appropriately specified, including areas of common interest and requirement, and to invite tenders from CSU providers accredited by the Lead Provider Framework. There are 10 accredited providers, including the South East CSU. It is anticipated that the new contracts will be effective from July 2016 and service mobilisation, where necessary, will be completed within 3 months.

Martin Wilkinson
Chief Officer – Lewisham CCG
Main Issues discussed

Children Community Nursing Team (CCNT) Paediatric Ambulatory Service

The Committee considered a proposal to expand the Lewisham CCNT by an additional five ambulatory nurses from October 2015; in line with SEL Strategy. Lewisham CCG is the lead commissioner of CCNT across LSL provided by LGT to King’s College Hospital and Evelina Hospital.

The Committee requested more work to be undertaken to include
- Scoping additional options
- More detail on proposed models of care
- Greater clarity on financial impacts

TR suggested that the business case is circulated to Committee members for a decision between meetings; with the additional information and the model and case for five being the correct number of nurses and the implications of Lambeth and Southwark CCGs’ intentions.

A decision on the recommendation to allocate funding on a recurrent basis for an ambulatory paediatric team was deferred. Subsequent to the meeting the revised business case was agreed by Committee members at a gross cost of £281k pa (up to £157k in 2014/15)

Lewisham Integrated Medicines Optimisation Service (LIMOS) – extension into care homes

The Committee agreed a proposal to extend the award winning LIMOS pathway into care homes across the borough in line with NICE guidance on Managing Medicine in Care Homes was considered at a gross of £210k pa (up to £110k in 2015/16). The service would be across primary and secondary care, community pharmacists, GPs and social care. It was recognised that there was a need to support the 650 residents of 21 care homes in Lewisham in the management of their medication.

Training has already been provided to care workers which would be rolled out to care homes with the technicians building the infrastructure first. Work would also be undertaken with families and carers. High risk patients, such as new residents, would be prioritised in order to provide an early intervention to encourage, if possible, self-medication.

Commissioning Support Lead Provider Framework Statement of Intent

The Committee reviewed and ratified the CCG’s commissioning intentions for commissioning support services and received an update on progress. The SE CSU contract ends on 31 March 2016. The CCG’s commissioning intentions result from a review of Make/Share/Buy (MSB) options. Bought services will be procured using the national lead provider framework and are expected to be operational from July 2016.
Enclosure 6
Board Assurance Framework

**LEAD:** Martin Wilkinson  
**MANAGERIAL LEAD:** Susanna Masters

<table>
<thead>
<tr>
<th><strong>AUTHOR:</strong></th>
<th>Graham Hewett</th>
<th><strong>Post:</strong> Head of Integrated Governance</th>
</tr>
</thead>
</table>

The Governing Body is asked to:

1. Note the Risk Management Report
2. Approve the Board Assurance Framework (BAF) as evidence that:
   a. the CCG is aware of the significant risks presenting to the Corporate Objectives
   b. that the CCG has adequate controls to mitigate the risks to the Corporate Objectives
   c. where existing controls have not reduced the residual risk score to the target there are credible action plans

Appendices:
Appendix A. Board Assurance Framework

Risk Management Report

1. One new risk (SRG 15) has been added to the Corporate Risk Register and scored at the threshold for inclusion on the BAF. The risk identifies the potential for unexpected care home closures. The circumstances of the case of the recent closure of two homes locally have been shared with FLaG (For Learning Action Group) and initial learning arising. The Delivery Committee have planned a deep dive on continuing healthcare in September which will cover market development issues so an exception report will follow from this high risk area.
2. Governing Body is asked to approve the Board Assurance Framework (BAF) as evidence that:
   a. the CCG is aware of the significant risks presenting to the Corporate Objectives
   b. that the CCG has adequate controls to mitigate the risks to the Corporate Objectives
   c. where existing controls have not reduced the residual risk score to the target there are credible action plans

3. The Board Assurance Framework is attached at Appendix B

**Board Assurance Framework**

4. The Board Assurance Framework lists the “High” (scored at 12) and “Very High” risks to achieving the Governing Body’s Corporate Objectives, grouped by Corporate Objective.

5. NHS Lewisham CCG uses the standard NHS 5*5 risk scoring matrix shown below. The impact (I) of the risk should it occur is measured on the x axis and the likelihood (L) of the risk occurring is measured on the y axis.

6. Risks are evaluated using the matrix \( I \times L \), shown as \( I \times L \) (Impact \times 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 Scoring Matrix

<table>
<thead>
<tr>
<th>Risk Matrix Likelihood</th>
<th>Impact</th>
<th>Negligible</th>
<th>Minor</th>
<th>Moderate</th>
<th>Major</th>
<th>Catastrophic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rare</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unlikely</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Possible</td>
<td>3</td>
<td>6</td>
<td>9</td>
<td>12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Likely</td>
<td>4</td>
<td>8</td>
<td>12</td>
<td>16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Almost Certain</td>
<td>5</td>
<td>10</td>
<td>15</td>
<td>20</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## CORPORATE AND STRATEGIC OBJECTIVES

Governance and Equalities – ensure that robust governance arrangements are in place.

## CONSULTATION HISTORY:

Risk Management Group August 2015.

## PUBLIC ENGAGEMENT

The Board Assurance Framework is based on the CCG’s Corporate Objective for 2015/16 including the risks associated with the delivery of the core objective that public engagement is intrinsic to all commissioning activities.

## 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

The Risk Registers set out the risks to achieving equality and tackle inequalities during 2015/16.

## RESPONSIBLE MANAGERIAL LEAD CONTACT:

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

## AUTHOR CONTACT:

<table>
<thead>
<tr>
<th>Name</th>
<th>Graham Hewett</th>
</tr>
</thead>
<tbody>
<tr>
<td>E-Mail</td>
<td><a href="mailto:graham.hewett@nhs.net">graham.hewett@nhs.net</a></td>
</tr>
</tbody>
</table>
NHS Lewisham Risk Register

Date Printed 03/09/2015

Risk Scoring Matrix

<table>
<thead>
<tr>
<th>Risk Matrix Likelihood</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negligible</td>
<td>Minor (1)</td>
</tr>
<tr>
<td>Likely</td>
<td>Moderate (2)</td>
</tr>
<tr>
<td>Almost Certain</td>
<td>Catastrophic (5)</td>
</tr>
</tbody>
</table>

Key:
- **Risk Matrix**
  - 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.

- **Inherent Score** – the risk score before any controls are applied
- **Residual Score** – the risk score after the controls have been applied
- **Target Score** – the risk score the plans to achieve once all the controls are fully applied and proved to be effective.

**Column Headings**
- **Controls** - what the CCG has put in place to lessen the impact of the risk should it occur and reduce the likelihood of it occurring
- **Response** - what the CCG has decided to do about the risk: mitigate, accept, transfer or close.
- **Assurance Source** - where the CCG finds evidence that its controls are effective
- **Assurance Given** - the evidence that controls are effective or not
- **Assurance Type** - 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)
- **Assurance Level** - the strength of the evidence; None, Limited, Adequate, Significant
- **Assurance Gaps** – where the CCG has no evidence of whether or not its controls are effective
- **Action Required** – work that is required to close assurance gaps
- **Action Target Date** – the date that the actions are due to be completed
- **Residual Score (I*L)** – the risk score after the controls have been applied

**Format**
- Negative assurances, where evidence shows that the controls are not fully effective, are shown in red text
| Ref | Score | Corporate | Risk | Risk Description | Actual Impact and Material Event | Probability | Controls | Compliance Source | Assurance Given | Assurance Level | Assurance Score | Controls & Assurance Sign | Action Required | Action Date |
|-----|-------|-----------|-----|----------------|--------------------------------|------------|----------|------------------|----------------|----------------|----------------|----------------|-----------------------------|----------------|------------|
| 3   | 2     | CHQ       | 1   | Improve independent sector | Common Commissioning Specification for Neighbourhood Community | High       | None     | Risk Management | Red | Red | Red | Risk Management | Not implemented | August 2015 |
| 4   | 2     | CHQ       | 2   | Develop a relationship with adult integrated care | Common Commissioning Specification for Enhanced Care and Support | High       | None     | Risk Management | Red | Red | Red | Risk Management | Not implemented | August 2015 |
| 5   | 2     | CHQ       | 4   | Inability to deliver integrated care | Common Commissioning Specification for Enhanced Care and Support | High       | None     | Risk Management | Red | Red | Red | Risk Management | Not implemented | August 2015 |
| 7   | 2     | CHQ       | 4   | The CCG does not have the capacity to support the development of neighbourhood care networks | Common Commissioning Specification for Enhanced Care and Support | High       | None     | Risk Management | Red | Red | Red | Risk Management | Not implemented | August 2015 |
| 8   | 2     | CHQ       | 4   | The CCG does not have the identified resources to support co-commissioning | Common Commissioning Specification for Enhanced Care and Support | High       | None     | Risk Management | Red | Red | Red | Risk Management | Not implemented | August 2015 |
| 9   | 2     | CHQ       | 4   | The CCG does not have the identified resources to support co-commissioning | Common Commissioning Specification for Enhanced Care and Support | High       | None     | Risk Management | Red | Red | Red | Risk Management | Not implemented | August 2015 |
| 10  | 2     | CHQ       | 4   | The CCG does not have the identified resources to support co-commissioning | Common Commissioning Specification for Enhanced Care and Support | High       | None     | Risk Management | Red | Red | Red | Risk Management | Not implemented | August 2015 |

**Hazard:**
- Developed refreshed
- Developed and agreed governance and commissioning offer in draft form - BAF
- Developed commissioning offer in draft form
- Developed commissioning offer in draft form
- Developed commissioning offer in draft form
- Developed commissioning offer in draft form
- Developed commissioning offer in draft form
- Developed commissioning offer in draft form
- Developed commissioning offer in draft form

**Response Controls:**
- Developed commissioning offer in draft form
- Developed commissioning offer in draft form
- Developed commissioning offer in draft form
- Developed commissioning offer in draft form
- Developed commissioning offer in draft form
- Developed commissioning offer in draft form
- Developed commissioning offer in draft form
- Developed commissioning offer in draft form
- Developed commissioning offer in draft form

**Assurance Source:**
- Risk Management
- Risk Management
- Risk Management
- Risk Management
- Risk Management
- Risk Management
- Risk Management
- Risk Management
- Risk Management

**Assurance Level:**
- Red
- Red
- Red
- Red
- Red
- Red
- Red
- Red
- Red

**Assurance Score:**
- Risk Management
- Risk Management
- Risk Management
- Risk Management
- Risk Management
- Risk Management
- Risk Management
- Risk Management
- Risk Management

**Controls & Assurance Sign:**
- Risk Management
- Risk Management
- Risk Management
- Risk Management
- Risk Management
- Risk Management
- Risk Management
- Risk Management
- Risk Management

**Action Required:**
- Not implemented
- Not implemented
- Not implemented
- Not implemented
- Not implemented
- Not implemented
- Not implemented
- Not implemented
- Not implemented

**Action Date:**
- August 2015
- August 2015
- August 2015
- August 2015
- August 2015
- August 2015
- August 2015
- August 2015
- August 2015
<table>
<thead>
<tr>
<th>Risk</th>
<th>Corporate Objective</th>
<th>Risk Description</th>
<th>Internal Audit Findings</th>
<th>Action Required</th>
<th>Impact of SEL on CSU</th>
<th>CSU Response</th>
<th>Contingency Plan</th>
<th>Action Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>32</td>
<td>Public Engagement</td>
<td>Public Engagement is not perceived to be meaningful</td>
<td>Limited engagement with the Public Engagement Group</td>
<td>Mitigate</td>
<td>Likely</td>
<td>Mitigate</td>
<td>Risk management processes not in place</td>
<td>July 2016</td>
</tr>
<tr>
<td>33</td>
<td>Public Engagement</td>
<td>Lack of communication &amp; engagement</td>
<td>Lack of communication &amp; engagement</td>
<td>Mitigate</td>
<td>Likely</td>
<td>Mitigate</td>
<td>Risk management processes not in place</td>
<td>July 2016</td>
</tr>
<tr>
<td>34</td>
<td>Public Engagement</td>
<td>Loss of reputation</td>
<td>Loss of reputation</td>
<td>Mitigate</td>
<td>Likely</td>
<td>Mitigate</td>
<td>Risk management processes not in place</td>
<td>July 2016</td>
</tr>
<tr>
<td>35</td>
<td>Public Engagement</td>
<td>Failure to meet financial and non-financial statutory requirements</td>
<td>Failure to meet financial and non-financial statutory requirements</td>
<td>Mitigate</td>
<td>Likely</td>
<td>Mitigate</td>
<td>Risk management processes not in place</td>
<td>July 2016</td>
</tr>
<tr>
<td>36</td>
<td>Public Engagement</td>
<td>Harm to patients</td>
<td>Harm to patients</td>
<td>Mitigate</td>
<td>Likely</td>
<td>Mitigate</td>
<td>Risk management processes not in place</td>
<td>July 2016</td>
</tr>
<tr>
<td>37</td>
<td>Public Engagement</td>
<td>Inappropriate staffing</td>
<td>Inappropriate staffing</td>
<td>Mitigate</td>
<td>Likely</td>
<td>Mitigate</td>
<td>Risk management processes not in place</td>
<td>July 2016</td>
</tr>
<tr>
<td>38</td>
<td>Public Engagement</td>
<td>Inequalities are not reduced</td>
<td>Inequalities are not reduced</td>
<td>Mitigate</td>
<td>Likely</td>
<td>Mitigate</td>
<td>Risk management processes not in place</td>
<td>July 2016</td>
</tr>
<tr>
<td>39</td>
<td>Public Engagement</td>
<td>Effect to manage contract variations against performance and quality standards</td>
<td>Effect to manage contract variations against performance and quality standards</td>
<td>Mitigate</td>
<td>Likely</td>
<td>Mitigate</td>
<td>Risk management processes not in place</td>
<td>July 2016</td>
</tr>
<tr>
<td>40</td>
<td>Public Engagement</td>
<td>Poor patient experience</td>
<td>Poor patient experience</td>
<td>Mitigate</td>
<td>Likely</td>
<td>Mitigate</td>
<td>Risk management processes not in place</td>
<td>July 2016</td>
</tr>
<tr>
<td>41</td>
<td>Public Engagement</td>
<td>Abuse or neglect in commissioned services</td>
<td>Abuse or neglect in commissioned services</td>
<td>Mitigate</td>
<td>Likely</td>
<td>Mitigate</td>
<td>Risk management processes not in place</td>
<td>July 2016</td>
</tr>
<tr>
<td>42</td>
<td>Public Engagement</td>
<td>Insufficient robust valid data</td>
<td>Insufficient robust valid data</td>
<td>Mitigate</td>
<td>Likely</td>
<td>Mitigate</td>
<td>Risk management processes not in place</td>
<td>July 2016</td>
</tr>
<tr>
<td>43</td>
<td>Public Engagement</td>
<td>The CCG does not have adequate Quality Assurance Framework</td>
<td>The CCG does not have adequate Quality Assurance Framework</td>
<td>Mitigate</td>
<td>Likely</td>
<td>Mitigate</td>
<td>Risk management processes not in place</td>
<td>July 2016</td>
</tr>
<tr>
<td>44</td>
<td>Public Engagement</td>
<td>The CCG has not met its performance standards</td>
<td>The CCG has not met its performance standards</td>
<td>Mitigate</td>
<td>Likely</td>
<td>Mitigate</td>
<td>Risk management processes not in place</td>
<td>July 2016</td>
</tr>
<tr>
<td>45</td>
<td>Public Engagement</td>
<td>The CCG has not developed an internal control framework</td>
<td>The CCG has not developed an internal control framework</td>
<td>Mitigate</td>
<td>Likely</td>
<td>Mitigate</td>
<td>Risk management processes not in place</td>
<td>July 2016</td>
</tr>
<tr>
<td>46</td>
<td>Public Engagement</td>
<td>The CCG does not have adequate Quality Assurance Framework</td>
<td>The CCG does not have adequate Quality Assurance Framework</td>
<td>Mitigate</td>
<td>Likely</td>
<td>Mitigate</td>
<td>Risk management processes not in place</td>
<td>July 2016</td>
</tr>
<tr>
<td>47</td>
<td>Public Engagement</td>
<td>The CCG does not have adequate Quality Assurance Framework</td>
<td>The CCG does not have adequate Quality Assurance Framework</td>
<td>Mitigate</td>
<td>Likely</td>
<td>Mitigate</td>
<td>Risk management processes not in place</td>
<td>July 2016</td>
</tr>
<tr>
<td>48</td>
<td>Public Engagement</td>
<td>The CCG does not have adequate Quality Assurance Framework</td>
<td>The CCG does not have adequate Quality Assurance Framework</td>
<td>Mitigate</td>
<td>Likely</td>
<td>Mitigate</td>
<td>Risk management processes not in place</td>
<td>July 2016</td>
</tr>
<tr>
<td>49</td>
<td>Public Engagement</td>
<td>The CCG does not have adequate Quality Assurance Framework</td>
<td>The CCG does not have adequate Quality Assurance Framework</td>
<td>Mitigate</td>
<td>Likely</td>
<td>Mitigate</td>
<td>Risk management processes not in place</td>
<td>July 2016</td>
</tr>
<tr>
<td>50</td>
<td>Public Engagement</td>
<td>The CCG does not have adequate Quality Assurance Framework</td>
<td>The CCG does not have adequate Quality Assurance Framework</td>
<td>Mitigate</td>
<td>Likely</td>
<td>Mitigate</td>
<td>Risk management processes not in place</td>
<td>July 2016</td>
</tr>
<tr>
<td>51</td>
<td>Public Engagement</td>
<td>The CCG does not have adequate Quality Assurance Framework</td>
<td>The CCG does not have adequate Quality Assurance Framework</td>
<td>Mitigate</td>
<td>Likely</td>
<td>Mitigate</td>
<td>Risk management processes not in place</td>
<td>July 2016</td>
</tr>
<tr>
<td>52</td>
<td>Public Engagement</td>
<td>The CCG does not have adequate Quality Assurance Framework</td>
<td>The CCG does not have adequate Quality Assurance Framework</td>
<td>Mitigate</td>
<td>Likely</td>
<td>Mitigate</td>
<td>Risk management processes not in place</td>
<td>July 2016</td>
</tr>
<tr>
<td>53</td>
<td>Public Engagement</td>
<td>The CCG does not have adequate Quality Assurance Framework</td>
<td>The CCG does not have adequate Quality Assurance Framework</td>
<td>Mitigate</td>
<td>Likely</td>
<td>Mitigate</td>
<td>Risk management processes not in place</td>
<td>July 2016</td>
</tr>
<tr>
<td>54</td>
<td>Public Engagement</td>
<td>The CCG does not have adequate Quality Assurance Framework</td>
<td>The CCG does not have adequate Quality Assurance Framework</td>
<td>Mitigate</td>
<td>Likely</td>
<td>Mitigate</td>
<td>Risk management processes not in place</td>
<td>July 2016</td>
</tr>
<tr>
<td>55</td>
<td>Public Engagement</td>
<td>The CCG does not have adequate Quality Assurance Framework</td>
<td>The CCG does not have adequate Quality Assurance Framework</td>
<td>Mitigate</td>
<td>Likely</td>
<td>Mitigate</td>
<td>Risk management processes not in place</td>
<td>July 2016</td>
</tr>
<tr>
<td>56</td>
<td>Public Engagement</td>
<td>The CCG does not have adequate Quality Assurance Framework</td>
<td>The CCG does not have adequate Quality Assurance Framework</td>
<td>Mitigate</td>
<td>Likely</td>
<td>Mitigate</td>
<td>Risk management processes not in place</td>
<td>July 2016</td>
</tr>
<tr>
<td>57</td>
<td>Public Engagement</td>
<td>The CCG does not have adequate Quality Assurance Framework</td>
<td>The CCG does not have adequate Quality Assurance Framework</td>
<td>Mitigate</td>
<td>Likely</td>
<td>Mitigate</td>
<td>Risk management processes not in place</td>
<td>July 2016</td>
</tr>
<tr>
<td>58</td>
<td>Public Engagement</td>
<td>The CCG does not have adequate Quality Assurance Framework</td>
<td>The CCG does not have adequate Quality Assurance Framework</td>
<td>Mitigate</td>
<td>Likely</td>
<td>Mitigate</td>
<td>Risk management processes not in place</td>
<td>July 2016</td>
</tr>
<tr>
<td>59</td>
<td>Public Engagement</td>
<td>The CCG does not have adequate Quality Assurance Framework</td>
<td>The CCG does not have adequate Quality Assurance Framework</td>
<td>Mitigate</td>
<td>Likely</td>
<td>Mitigate</td>
<td>Risk management processes not in place</td>
<td>July 2016</td>
</tr>
<tr>
<td>60</td>
<td>Public Engagement</td>
<td>The CCG does not have adequate Quality Assurance Framework</td>
<td>The CCG does not have adequate Quality Assurance Framework</td>
<td>Mitigate</td>
<td>Likely</td>
<td>Mitigate</td>
<td>Risk management processes not in place</td>
<td>July 2016</td>
</tr>
<tr>
<td>61</td>
<td>Public Engagement</td>
<td>The CCG does not have adequate Quality Assurance Framework</td>
<td>The CCG does not have adequate Quality Assurance Framework</td>
<td>Mitigate</td>
<td>Likely</td>
<td>Mitigate</td>
<td>Risk management processes not in place</td>
<td>July 2016</td>
</tr>
<tr>
<td>62</td>
<td>Public Engagement</td>
<td>The CCG does not have adequate Quality Assurance Framework</td>
<td>The CCG does not have adequate Quality Assurance Framework</td>
<td>Mitigate</td>
<td>Likely</td>
<td>Mitigate</td>
<td>Risk management processes not in place</td>
<td>July 2016</td>
</tr>
<tr>
<td>63</td>
<td>Public Engagement</td>
<td>The CCG does not have adequate Quality Assurance Framework</td>
<td>The CCG does not have adequate Quality Assurance Framework</td>
<td>Mitigate</td>
<td>Likely</td>
<td>Mitigate</td>
<td>Risk management processes not in place</td>
<td>July 2016</td>
</tr>
<tr>
<td>64</td>
<td>Public Engagement</td>
<td>The CCG does not have adequate Quality Assurance Framework</td>
<td>The CCG does not have adequate Quality Assurance Framework</td>
<td>Mitigate</td>
<td>Likely</td>
<td>Mitigate</td>
<td>Risk management processes not in place</td>
<td>July 2016</td>
</tr>
<tr>
<td>65</td>
<td>Public Engagement</td>
<td>The CCG does not have adequate Quality Assurance Framework</td>
<td>The CCG does not have adequate Quality Assurance Framework</td>
<td>Mitigate</td>
<td>Likely</td>
<td>Mitigate</td>
<td>Risk management processes not in place</td>
<td>July 2016</td>
</tr>
</tbody>
</table>
1. Main Issues discussed

LAS performance

The Committee welcomed Graham Norton, LAS Assistant Director of Operations (South East), to the August meeting to discuss LAS performance and improvement plans and opportunities.

Key issues relating to current performance are:
- For A8 (75% of category A calls responded to within eight minutes) current performance is below target. The improvement trajectory was hit for Q1 and is behind for Q2. Performance for Lewisham is currently at 63%; below London average.
- For A19 (95% of category A calls responded to within 19 minutes) current performance for Lewisham is meeting the target and currently at 95.24%
- LAS is experiencing increasing numbers of Category A calls (up 6.5%) and higher acuity of patients.
- Staffing challenges are a major contributor to underperformance; for example shortage of paramedics; vacancy and staff retention challenge in London, work pressure, the cost of living in London
- Increased rotas for Central London stations; this reduces the need for stations covering Lewisham to be deployed in other areas.

Mr Norton highlighted some actions being taken to improve performance:
- A recruitment drive in Australia is taking place in September
- The number of paramedic places at universities has increased (3 year programme).
- Business case made to increase the number of staff in outer London stations.
- Mental Health and End of Life nurses available to support crews from clinical hubs.
- More cars are being used, which will increase response time performance. Cars cannot convey a patient to hospital.
- Calls from the Police are reviewed by a paramedic before ambulance dispatch.
- A new management structure.
- A new clinical career structure is being developed.
- A new stakeholder engagement manager has been appointed and part of their role will include reviewing the alternative care pathways.

In response to questions Mr Norton advised that
- The independent review into bullying and harassment was published in July 2015 and an action plan has been developed.
- If all staff applications in progress are successful LAS will be over establishment.
- Performance should start to improve in November when the recruitment from Australia starts to take effect.
- Relationships are good but can be improved and this will be considered by the Stakeholder Engagement Manager.
- There are good handover arrangements in place at Lewisham and previous issues at QE have been resolved by the increase in bed capacity.
- the pathways in place for specific conditions appear to work well for Lewisham patients and LAS receive few queries regarding Lewisham patients being conveyed to inappropriate locations.
It was agreed that more information is required from LAS to understand
- the opportunity for GPs to assist ambulance crews
- any harm to Lewisham patients caused by waits outside performance targets
- the effectiveness of the use of co-ordinate my care

**System Resilience Plan 2015/16**

The Delivery Committee endorsed the approach to the development of the System Resilience Plan for 2015/16 for Bexley, Greenwich and Lewisham. The plan has been developed around 5 key goals:
- Operational Change Programme
- Admission Avoidance
- Supported discharges
- Ambulatory care
- Community resilience

There are 39 schemes within the plan against a total budget of £9m (BGL CCG resource allocations of £5.185m plus £3.680m which CCGs have funded in the LGT contract). £7.1m has been committed to the LGT contract for services to be agreed by the SRG. A total of £1.58m is available for additional community-based initiatives to be shared across the BGL system.

The **Quality Premium 2014/15** forecast is between £320k and £450k. FLAG has been asked to propose priorities to the Delivery Committee for targeted investment of the Quality Premium.

**Performance against NHS Constitutional Standards**

The CCG is on track against most constitutional standards or against the agreed performance improvement trajectories

The Lewisham site of LGT delivered the A&E 4 hour standards in May, June and July 2015 and is above standard year to date. However due to performance on the QE site LGT’s overall performance is below the recovery trajectory for July 2015.

The IAPT service is either meeting its standards or is in advance of the CCG’s plans, where below standard.

The cancer waits (62 days) performance was better than trajectory in June 2015. The major step change to performance is in July 2015 with the standard being delivered from Q3. Performance is currently rated amber on the basis that there are forward risks to the delivery of the cancer waiting times and the LGT trajectory for referring patients to specialist Trusts within 42 days is not being met.

As previously reported there are still some reporting suspensions in place on 18 weeks performance. LGT is committed to resume reporting in September 2015.

**Activity**

Based on month 3 data there has been a higher than planned level of hospital activity (emergency and outpatients)

The Committee commented on the new style of the integrated performance report and support the approach of dashboards and the inclusion of a community contract dashboard, with detailed reports by exception.
2. Key achievements

2.1 The CCG is on track to deliver its financial targets for 2015/16.

2.1.1 There has been significant improvement against the A&E 4 hour standard in the first four months of 2015/16, in particular for the Lewisham Hospital site.

2.2 An update on the progress against the CCG’s EPRR action plan and draft EPRR policy and the Major Incident Plans for Pandemic Influenza, Severe Weather, Fuel Disruption and Infectious Disease identified that good progress has been made to close assurance gaps identified in the CCG’s EPRR 2014/15 assurance review

2.3 The August meeting received learning from Medicines Management initiatives that was requested at the July meeting.

Lewisham Integrated Medicines Optimisation Service (LIMOS) shows:
- Improved outcomes for patients including a number taking medicines as intended
- An estimated reduction of 166 A&E attendances and 29 hospital admissions
- Estimated cost savings opportunity of £650k pa

100% of GP practices and 80% of pharmacies participated in the Medicines Optimisation Education and Training (MOETs) programme

NPSA anticoagulation – 13 community anticoagulation pharmacist (CACPs) accredited to monitor and dose patients on warfarin and educated on New Oral Anticoagulants

3. Key challenges addressed

3.1 Complaints – A report on KCH’s complaints management process and the actions they have taken to improve their complaints performance was noted. Learning will be shared with LGT via the CQRG.

4. Key risks (include assurances received positive and negative)

4.1 A&E: Lewisham and Greenwich Trust will not recover sustainable performance to standard until October 2015.

4.2 Additional activity is being undertaken to assist the delivery of the 18 week standard for admitted patients at Lewisham and Greenwich Trust.

4.3 There are challenges in meeting the 62 day cancer treatment target at Lewisham and Greenwich Trust

4.4 Concern was raised that the mortality rate for LGT was 1.07

4.5 The deployment of Windows 7 across all GP practices has started and should be completed in October.

4.6 Emergency activity is a key pressure and creates additional risk to the CCG’s 2016/17 operational plans. A detailed review of emergency activity will be held at the LGT Contract Management Board.

5. How did the meeting promote quality and safety?
5.1 Through the review of quality reports from FLaG and linking quality to financial and other performance metrics.
5.2 Through dialogue with LAS
5.3 Through review of King’s complaints management

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

6.1 Delivery of the NHS Constitutional standards reduces the risk of unequal access to services
A meeting of the Governing Body
10 September 2015

ENCLOSURE 8
Month 4 Integrated Performance Report

RESPONSIBLE LEAD:    Tony Read, Chief Financial Officer

AUTHOR:    Mike Hellier, Head of System Intelligence
           Tony Read, Chief Financial Officer
           Nick Brown, Head of Financial Management and Planning

RECOMMENDATIONS:
The Committee is asked to:
• Note the Integrated Performance Issues below and the Integrated Performance Report
  Heat map at Appendix 1 encompassing:
  o An overview of Quality, Performance, Finance and Activity and an exception report
  for Cancer Waiting Times 62 Days from GP Referral to Treatment.

SUMMARY

Quality Dashboard
Complaints performance is measured differently between Trusts. All Trusts are red rated on
this issue. Delivery Committee received an exception report on responsiveness to
complaints at Lewisham and Greenwich NHS Trust at its June meeting. On staffing
indicators vacancy rates are now all amber rated for acute trusts and red rated for South
London and Maudsley.

Performance Indicators
The CCG is on track against most standards or against our agreed recovery plans and
performance improvement trajectories.

A&E 4 hour standard (95%)
It is noteworthy that the Lewisham site of Lewisham and Greenwich Trust delivered the A&E
4 hour standard in May, June and July 2015 and is above standard year to date. However,
Lewisham and Greenwich NHS Trust’s overall performance is now below trajectory for July
2015. A report on Winter Plans, co-ordinated by the System Resilience Group, was received
at the June meeting of the Delivery Committee to support delivery of the standard through
winter in line with the Bexley, Greenwich and Lewisham CCGs’ system wide recovery plan to
meet the standard in Q3 and Q4 2015-16.

The main goals are:

Goal 1 - Operational change – Full implementation of the ‘McKinsey’ recommendations within urgent care services including reducing the number people attending for minor conditions by providing information and guidance to alternatives.

Goal 2 - Admission Avoidance – Improving access to community, physical health, social care and mental health to reduce the conversion rate of admissions from people attending.

Goal 3 - Supported Discharges – Improving discharge planning and support to reduce the number of patients Ready for Discharge in acute hospital beds.

Goal 4 - Ambulatory care – Increase the availability of see, diagnose and treat services within 12 hours, so that more patients have access to those services.

Goal 5 - Community/System Resilience – Developing local care networks, investing in the Better Care Fund initiatives in order to reduce the number of people admitted to hospital and reduce the length of stay for people when they are admitted.

The plan is due for sign off by the System Resilience Board.

The Improving Access to Psychological Therapies service is either meeting its standards or is in advance of the CCG’s recovery plans, where below standard.

Cancer Waiting times – 62 days from GP referral to treatment standard (85%)

An exception is cancer waits (62 days) where we are reporting an amber status with performance better than trajectory in June 15. The major step change to performance is in July 2015 with a plan for the standard to be delivered from Q3. An exception report is included on the basis that there are forward risks to delivery of the cancer waiting times recovery action plan and the Lewisham and Greenwich NHS Trust trajectory for referring patients to specialist Trusts within 42 days is currently not being met.

On 18 weeks Referral to Treatment, the standard is only reported on the incomplete treatment standard in line with revised guidance. The CCG has been consistently delivering this standard in 2014/15 and continues to do so. However, for Lewisham and Greenwich NHS Trust, there are significant and rising issues in specialty pathways (Trauma and Orthopaedics, Gynaecology and ENT. The Trust has developed its mitigation plan, although there is more work to do on gynaecology.

The Trust is still validating its Patient Tracking List at the Lewisham site following the introduction of the iCare patient system. It may be able to report the 18 weeks incomplete standard at the end of August 2015, but this is still an amber risk due to the sizeable task relating to validation of the non admitted Patient Tracking List. It is committed to resume reporting in September 2015. The Trust continues to report the Queen Elizabeth site pathways.
Quality Premium 14-15

The Quality Premium 14-15 forecast was presented to Delivery Committee. It is a forecast as three outcome indicators will not be available until the end of September 2015 with a final report to October Delivery Committee. As the Premium will be need to be spent within 15-16 a forecast was presented using current trends. The main forecast is £322k with a potential upside of £450k. For Learning and Action Group has been tasked by Delivery Committee to propose priorities for use of the Premium, so expenditure can be made in the year.

Finance

At Month 4 the CCG is forecasting to deliver its planned surplus at year end. Risk within the expenditure position is partly mitigated by the block and cap and collar contracts agreed with GSTT, Kings and LGT for 2015/16.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Plan / Target</th>
<th>Forecast Outturn</th>
<th>Forecast Variance</th>
<th>RAG YTD</th>
<th>RAG Forecast</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Surplus</td>
<td>£7.60m</td>
<td>£7.60m</td>
<td>£0.00m</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Acute Expenditure</td>
<td>£216.38m</td>
<td>£216.50m</td>
<td>£0.12m</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Total Expenditure</td>
<td>£398.24m</td>
<td>£398.24m</td>
<td></td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>QIPP Delivery</td>
<td>£7.42m</td>
<td>£7.42m</td>
<td>Nil</td>
<td>!</td>
<td>✔️</td>
</tr>
<tr>
<td>Risk Adjusted Surplus</td>
<td>£7.60m</td>
<td>£7.60m</td>
<td>£0.00m</td>
<td></td>
<td>✔️</td>
</tr>
<tr>
<td>Underlying Position (2%)</td>
<td>£8.12m</td>
<td>£8.85m</td>
<td>£0.73m</td>
<td></td>
<td>✔️</td>
</tr>
<tr>
<td>Better Practice Payments</td>
<td>95.0%</td>
<td>97.3%</td>
<td>2.3%</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Cash Drawdown</td>
<td>297</td>
<td>112</td>
<td>£0.00m</td>
<td>✔️</td>
<td>✔️</td>
</tr>
</tbody>
</table>

Activity and QIPP

Currently, there are issues in a rise in emergency admissions and first outpatients that is putting the targeted net benefit of QIPP schemes for emergency admissions and the Referral Support Service at risk. Exception Reports are being developed for the September Delivery Committee. A deep dive into emergency admissions was presented to August Contract Management Board for Lewisham and Greenwich Trust, which will form the basis of the report.

CORPORATE AND STRATEGIC OBJECTIVES

Delivery of the CCG’s standards for quality, outcomes, NHS constitutional commitments and expenditure plans will assist the Trust in meeting its operating plan, corporate objectives and
statutory duties. The corporate objectives specifically target recovery actions to improve the underperforming top performance measures

CONSULTATION HISTORY:
FLAG – Quality
Delivery Committee

PUBLIC ENGAGEMENT
Governing Body

HEALTH INEQUALITY DUTY
The failure to achieve access standards for, in particular, RTT, A&E 4 hour waits and some cancer treatments could potentially contribute to inequitable access to healthcare and poorer or differential outcomes. Significant additional resource has been targeted to improve performance against these targets in 2014/15 and 2015/16

PUBLIC SECTOR EQUALITY DUTY
This report does not specifically address the public sector equality duty. The CCG’s quality, outcome and financial objectives are designed to deliver the duty.

STAKEHOLDER INVOLVEMENT
To be communicated to the GP Membership

RESPONSIBLE LEAD CONTACT:
Name: Tony Read
E-Mail: tonyread@nhs.net
Telephone: 0203 049 3833

AUTHOR CONTACT:
Name: Mike Hellier
Email: Mike.Hellier@nhs.net
Telephone: 0207 206 3322

Name: Nick Brown
Email: Nick.brown1@nhs.net
Telephone: 0203 049 6101
### Integrated Performance Report
#### Overview Integrated Performance Heat Map

<table>
<thead>
<tr>
<th>Quality</th>
<th>Performance Acute</th>
<th>Recovery performance on track</th>
<th>Performance Other</th>
<th>Recovery Performance on Track</th>
<th>Finance</th>
<th>QIPP £</th>
<th>Activity, v. plan *</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Current</td>
<td>Forecast</td>
<td>Current</td>
<td>Forecast</td>
<td>Current</td>
<td>Current</td>
<td>Current</td>
</tr>
<tr>
<td>Patient safety</td>
<td>A&amp;E 4 hours</td>
<td>IAPT entering treatment</td>
<td>Planned surplus forecast</td>
<td>Emergency admissions</td>
<td>Emergency Admissions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient experience</td>
<td>18 weeks RTT</td>
<td>IAPT Recovery Rate</td>
<td>Acute expenditure forecast</td>
<td>RSS Outpatients</td>
<td>First Outpatients</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff engagement</td>
<td>Cancer waiting</td>
<td>IAPT 6 week from referral to treatment</td>
<td>Total expenditure forecast</td>
<td>Urgent Care Strategy</td>
<td>A&amp;E attendances</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CQC Registration &amp; Inspection</td>
<td>Cancer waiting times 62 days</td>
<td>Dementia Diagnosis Rate</td>
<td>QIPP Delivery forecast</td>
<td>KPIs</td>
<td>Elective Admissions</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>times 2 week waits</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Diagnostics 6 weeks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Trasforming Care Winterbourne</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mental Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cash Drawdown Balance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Quality Indicator Descriptions:**
- **Patient safety:** A&E 4 hours, IAPT entering treatment
- **Patient experience:** 18 weeks RTT incomplete, IAPT Recovery Rate
- **Staff engagement:** Cancer waiting times 2 week waits, IAPT 6 week from referral to treatment
- **CQC Registration & Inspection:** Cancer waiting times 62 days, Dementia Diagnosis Rate
- **Other:** Diagnostics 6 weeks, Trasforming Care Winterbourne

**Quality Indicators:**
- **A&E 4 hours:** IAPT entering treatment
- **18 weeks RTT incomplete:** IAPT Recovery Rate
- **Cancer waiting times 2 week waits:** IAPT 6 week from referral to treatment
- **Cancer waiting times 62 days:** Dementia Diagnosis Rate
- **Diagnostics 6 weeks:** Trasforming Care Winterbourne
- **LAS Red 1:** Better Practice Payments Code forecast
- **Cash Drawdown Balance:** Other
Governing Body  
10th September 2015 

Report from the Chair of the Strategy & Development Committee 
Date of Meeting(s) reported: 6th August 2015 
Author: Dr David Abraham 

Main Issues discussed 

The committee received update reports from key sub-groups: the CCG’s Public Engagement Group (PEG) and the Joint Public Engagement Group (JPEG). The Committee was asked to comment on the Draft Children and Young People’s Plan, Draft Annual Public Health Report and Draft Health and Wellbeing Strategy. Other items included an update on the Our Healthier South East London (OHSEL) programme, option development and appraisal process and an update on the process and timeline for the refresh of the Joint Commissioning Intentions for 2016/17. 

Key achievements 

The Committee noted and agreed the format and content of the draft Children and Young People’s Plan 2015-2018 which sets out the key strategic aims and outcomes across the Children and Young People’s Partnership in Lewisham. The plan will be finalised mid-October and published in an interactive on-line format. Four key areas to improve outcomes for children and young people have been identified: 

- Child and Family Resilience 
- Healthy and Active 
- Achievement and Attainment 
- Stay Safe 

Key challenges being addressed 

The Health and Wellbeing Board has recognised that the 10 year strategy needs to be refreshed to provide it with a greater strategic focus for the next three years. The nine priority outcomes identified through the JSNA process in the original ten year strategy will not change. The Committee gave detailed comments on the proposed three interdependent strategic priorities for 2015-18. 

It was noted that the timeline for consultation on the areas of the OHSEL Programme where option appraisal may be required has been moved back to June 2016. Four areas have been identified where option appraisal may be required, urgent and emergency care, maternity, elective care and children and young people. Aspects of the programme that can be implemented without consultation, CBC and Cancer, will continue to be implemented. It was agreed that the criteria for the option appraisal should be considered by the Governing Body at a future workshop. 

The Committee discussed the approach to Commissioning Intentions for 2016/17. It was agreed that it would be only a refresh of the second year of the previous years’ Joint
commissioning Intentions, with two separate parts - for Adults and for Children. The Adult Joint Strategic Commissioning Group will co-ordinate the work on behalf of adult commissioners and the Children’s and Young People’s Commissioning Group will co-ordinate the work on behalf of children’s commissioners. Public engagement will be embedded within the process as part of the on-going dialogue with the residents of Lewisham. The timeline to co-ordinate the Joint Commissioning Intentions was for final sign off by the CCG’s Governing Body on 12th November and the Health and Wellbeing Board on 24th November 2015.

**How did the meeting promote quality and safety?**

The Committee agreed the Quality Improvement Strategy. The Strategy is based on Lord Darzi’s seven steps to ensuring quality and outlines the strategic approach of the CCG in delivering its role as a commissioner in monitoring and supporting improvements in quality. It was agreed that the Quality Improvement Action Plan will be monitored by the Committee every 6 months.

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

The PEG, initially in January 2014, reviewed the findings of the GP patient survey, and noted in particular the differential outcomes between white British patients and BME patients in relation to feeling supported with their long term conditions. An independent research project was commissioned, which has identified some possible explanations for the differential outcomes. The findings cover seeing a GP, appointments, seeing a different GP, information giving, hospital experience, non-compliance, cultural understanding and self-management of long-term conditions. The Committee reviewed the report and requested the following actions be taken forward based on the findings:

- Primary Care Development Group to incorporate a module on cultural competence in the Year of Care training.
- Primary Care Development Group to review data and recording of ethnicity across primary care.
- Equality and Diversity Steering Group to include addressing cultural competence in this year’s objectives.
- Prescribing and Medicines Management Group to consider the report in the context of LIMOS and prescribing support to GPs.
- The Workforce Workstream of the Integrated Care Programme to consider cultural competence in workforce planning.
- Ensure the findings of the report are incorporated into the on-going work on self-management and reported to AICPB.

**How did the meeting promote and draw on public engagement?**

The committee noted that the engagement event on 4 July ‘Your Voice Counts’, which focused on the themes of ‘knowing the facts’ and ‘treated as people’ was well attended and that a full report will be provided via JPEG.

A personal reflection on the Lewisham OHSEL Issues Paper Deliberative Event on 16.07.2015 was given and the Committee requested that the write up of the event is circulated.
AUDIT COMMITTEE

Minutes of the meeting held 26 May 2015
Room 1 Cantilever House

PRESENT

Ray Warburton OBE  Lay Deputy Chair (Chair), LCCG
Prof Ami David MBE  Registered Nurse Member, LCCG
Dr Faruk Majid  Senior Clinical Director, LCCG
Diana Robbins  Lay Member, LCCG

IN ATTENDANCE

Lesley Aitken  Board Secretary (minutes), LCCG
Nick Brown  Head of Finance and Business, LCCG
Bill Bryant  Financial Controller SECSU
Paul Cuttle  Internal Audit Manager, KPMG
Matthew Dean  Assistant Manager, External Audit, Grant Thornton
Sue Exton  Director, External Audit, Grant Thornton
Graham Hewett  Head of Integrated Governance, LCCG
Tony Read  Chief Financial Officer, LCCG

APOLOGIES

Martin Wilkinson and Fleur Nieboer were unable to attend

AC15/58  Welcome

Mr Warburton welcomed all to the meeting and introductions were made.

AC15/59  Declarations of Interest

There were no interests declared which would knowingly affect the business of the meeting.

AC15/60  Minutes of the last meeting

The minutes of the meeting held on 21 April 2015 were agreed as a correct record.

AC15/61  Matters arising

61.1  Action Log

The action log was updated and revised.

61.2  Any matters not covered on the action log
61.2.1 Independent Member

Mr Warburton asked for an update on the recruitment of the independent member. Mr Read responded that this action was outstanding but that a draft person specification had been written, once finalised the position would be advertised through NHS Jobs, local media, accounting and audit organisations and local authority. A recruitment panel was in place comprising Jackie McLeod, Tony Read and Ray Warburton. Interview dates were to be diarised.

ACTION: Tony Read

61.3 Glossary of Terms

The glossary was received, any additions to be sent to Ms Aitken.

AC15/62 Draft Annual Report 2014/15

Mr Warburton explained that the Audit Committee was asked to receive and review the changes made since the last Audit Committee meeting the draft Annual Report 2014/15, along with the revised Remuneration Report and the draft Annual Governance Statement 2014/15.

Mr Read clarified that two sets of papers had been sent to members; the first set was the draft Annual Report and Accounts with changes made since the April meeting and the second was the full set of meeting papers including a revised Remuneration Report.

The updates had been made with comments from the Audit Committee, the Readers Panel and with the editorial team who worked on the Strategic Report. The report now included Financial Performance Indicators, a Sustainability Report with a more detailed Remuneration Report.

Mr Hewett added that the Annual Governance Statement had also been updated with the Finance and Investment Committee now mentioned, 360 degree appraisal information added and expanded sections on the Governing Body assessment. Following comments from NHSE the performance report and control mechanism work had been added.

62.1 Strategic Report

Mr Hewett reported that the Strategic Report had been changed following comments received from the Clinical Directors and Senior Management Team but that these had not majorly changed the content. He tabled the revised report.

The 24 page Strategic Report ‘Improving health and wellbeing in Lewisham’ still required minor changes.

Mr Warburton asked if it was felt that the Strategic and performance reports were in sync. Mr Read responded that the flow from the high level Strategic Report into the detail of the Annual report could flow better with the performance report in particular. However all required information is included. Lessons learned from this year would aid the production of the report next year. Mr Warburton acknowledged that it was a difficult task to pull all the comments received together. Mr Hewett confirmed that he was happy with the format of the designed summary version which would be used as an engagement tool.
Mr Warburton asked the Committee members for their comments:

Ms Robbins – was pleased that the summary document was to be used as an engagement tool but felt that the transition to the larger document should be more obvious.

Prof David – appreciated the difficulty in pulling together all the information required and comments and agreed that there needed to be a better follow through between the two documents.

Dr Majid – the documents should fulfil three objectives:

1. Fulfil statutory requirements.
2. Be used as an engagement document
3. Be used to engage primary care colleagues

He felt that some of the content was too complex.

Mr Warburton – the ambition of the Strategic Report was good, it reads well but there were problems with the interface with the performance report for example regarding cancer waiting times; the CCG’s achievements are not highlighted. It would be good to follow the example of the LIMOS page which was a good model. How we started the year, challenges and where we are now is a good format to follow for reports.

Mr Warburton and other members of the Committee made more detailed points regarding the report:

- The chart on ‘our expenditure on commissioned services in 2014/15’ was a good visual diagram.
- That the report relates to 2014/15 should be pointed out regularly in the report.
- Evidence from the performance report should be shown in areas such as ‘improving maternity care’.
- The designed version makes better sense than the full document.
- Regarding Strong Primary Care and GP Access the quote was from last year – what has happened this year?
- The ‘where you can find out more’ annex list to be updated and sync’d to websites where relevant. Regarding the list of annexes at the beginning of the Annual Report Mr Hewett said that some are links and others need to have documents downloaded from sites.
- Annex 2 – the performance report uses acronyms, also how the CCG managed in the year just gone which was not shown. Mr Read agreed that the performance report could benefit from review.
- Annex 3 – was fine and fits requirements.
- Acknowledged that the Sustainability Report has to be included in its entirety, though it was not helpful.
- The Members Report was good.
- Remuneration Report – Prof David said that the salary shown was for her employment with the three CCGs, rather than just for Lewisham CCG.
• The word *subordinate* to be changed in the Governance Statement regarding the Governing Body self-assessment.

• The font to be uniform on page 89 on the work of the Audit Committee. Areas such as; approved work plans of LCFS and received progress reports from IA etc., should also be included.

• Dr Majid noted that in last year’s report a statement was made explaining the reason for members not being present at a meeting could be due to other CCG commitments.

• On page 96, which related to risk assessment, text on how the risks were mitigated should be included.

• Page 100 – regarding Internal Audit reviews, to include that all recommendations bar one were accepted by management.

• The draft Head of Internal Audit Opinion to be updated.

Mr Read confirmed that the Committee would be asked later to approve the Annual Report and Accounts but that at this point in the agenda should indicate whether the presentation and content in the documents were good enough to be approved.

Prof David – With comments given incorporated the documents would be good enough.
Ms Robbins – The documents were good though she acknowledged that there were lessons to be learned for next year.
Dr Majid – Echoed Ms Robbins comments.
Mr Warburton – A good effort was made to ensure that the documents were easily readable for members of the public. For next year the documents should be more streamlined and integrated.

Mr Read said that subject to the External Audit findings, and some typos and minor changes being made (plus, if possible, an attempt at better integration between the Strategy and performance reports), the documents were good to be submitted on 28 May. Annex 2, the performance report would be reviewed. A session would be held to reflect on lessons learned from this year.

**ACTION: Tony Read/Lesley Aitken**

**The Committee received and reviewed changes made to the draft Annual Report 2014/15.**

**The Committee looked forward to a ‘lessons learnt’ paper in due course.**

**AC15/63 Draft Annual Accounts 2014/15**

Mr Read reported that there had been no adjustments made since the April meeting which affected the key financial statistics in terms of the financial position of the CCG. The adjustments were either presentational, misclassifications or disclosures. He highlighted the following:

• Two elements of Note 1 regarding the CCG as a lessor and valuation techniques have been deleted as not applicable.

• Note 1.5 has been expanded to include narrative on estimates

• Note 4 has improved disclosure narrative

• Note 17.1 now includes recovery of receivables past due date as at 31 March. There was £2k outstanding for invoices more than 6 months unpaid and there is an expectation of full payment.

• Notes 30 and 38 have been expanded

• Note 42 has a column added which states whether the financial duty was achieved or not.
Mr Read added that the developers of the Leegate Centre had submitted plans to redevelop the site including demolition of Cantilever House. There was a clause in the expired lease that the former PCT/NHSPS (NHS Property Services) had the responsibility to return the building in a state at least equal to when first leased in January 2005 or pay the landlord to bring it up to its evidenced state. He explained that no provision for potential costs arising from the future decant of Cantilever House have been included in the accounts. The circumstances do not satisfy the three requirements for a provision; as there was not a clear probability that the CCG will be liable for such costs. The expired lease was last held by NHSPS and the landlord has indicated that dilapidation clauses would not apply if decant is related to the redevelopment.

The Committee received and reviewed changes made to the draft Annual Accounts 2014/15 since the last meeting and reconfirmed and approved accounting policies.

AC15/64 Internal Audit Annual Report and Head of Internal Audit (HoIA) Opinion

Mr Cuttle confirmed that the draft can be removed from the report now that the Service Auditor Reports (SAR) reports had been received.

He described how the Annual Report detailed Internal Audit’s findings in relation to the planned internal audit coverage and output for 2014/15. During 2014/15 the seven reviews undertaken identified 27 accepted recommendations and one unaccepted. Mr Cuttle confirmed that there were no problems with outstanding recommendations which were all expected to be met.

In response to a question from Dr Majid on the QIPP review, Mr Cuttle said that internal audit were confident that robust processes were in place. Mr Read added that the review highlighted that the CCG was stronger with tracking and delivering the QIPP plan than setting and testing QIPP plans at the outset.

The Committee NOTED the content of the 2014/15 Annual Report and HoIA Opinion

AC15/65 External Audit Report

Ms Exton gave the audit findings report for the CCG for the year ending 31 March 2015 which primarily expressed their opinion on the financial value for money statements. It was reported that the accounts had been provided on time and were of a good standard.

The External Auditors had given:

- An unqualified opinion on the accounts,
- An unqualified regularity opinion – the CCG has met its financial targets
- There were no issues to report in relation to Value For Money (VFM)

Ms Exton confirmed that the work was substantially complete and anticipated that submission would be made by the Friday 29 May deadline. Minor enhancements were made to disclosure notes but these did not change the financial position. Dilapidation had been challenged and was mentioned in the letter of representation.
The Audit Committee congratulated all those concerned in the audit.

In response question raised by Mr Warburton on whether the financial resilience arrangements concerned with the acute overspend were good enough, Ms Exton said that it was found that there were arrangements in place to mitigate the risks. Mr Dean added that there were good arrangements in place for working across the wider SE London economy. It was acknowledged that External Audit draw on Internal Audit reviews in relation to the overall control environment and other reviews including QIPP and Information Governance.

The appendix ‘Audit Opinion’ would be updated to refer to the final Annual Report.

Mr Warburton and Mr Read signed the letter of representation from Grant Thornton the External Auditors.

The Committee received the letter of representation and draft audit findings.


The Committee reflected on their earlier discussion, and the amendments that were to be made.

The Audit Committee APPROVED the Annual Report 2014/15 and NOTED the Annual Governance Statement and reaffirmed and approved the account policies, reviewed adjustments to the draft accounts and APPROVED the final audited version of the Annual Accounts 2014/15.

AC15/67 Internal Audit Progress Report

67.1 Progress Report

Mr Cuttle gave the report which provided the Committee with an update on the internal audit’s work programme. The timetable in the report gave an indication of which Audit Committee meeting the reviews undertaken in 2015/16 would come to, though there could be flexibility for when the reviews were undertaken.

67.2 Conflict of Interest Report

Internal Audit had given an overall assessment of significant with minor improvement for the conflict of interest arrangements at the CCG. The focus of the review was on arrangements the CCG has in place to identify and manage actual and potential conflicts. There were three recommendations made which were all accepted by management:

- Training (medium risk) on conflicts of interest guidance – training had been provided for Governing Body members and staff for 21 May and future training for staff was due on 10 June.
- Commissioning for GPs (medium risk); NHSE guidance required to publish information on procurement exercises that would involve GPs – the CCG would implement this as part of the policy in new procurement decisions.
• Ensure that all Declaration of Interest forms were signed and dated – The CCG aimed to refresh the Register of Interests using the new forms by end of July.

The Committee welcomed the findings and management’s response to them. Mr Warburton noted that over the past year, the CCG had become much more aware of, and responsive to, conflicts of interests at its major Committee meetings.

The Committee NOTED the Internal Audit progress report, NOTED the progress against KPIs, NOTED the conflict of interest report and NOTED the timetable for the 2015/16 internal audit plan.

AC15/68 Service Auditors Reports

68.1 South East CSU Service Auditors Report 2014/15

Mr Read reported that there was nothing in the Service Auditors Reports (SAR) received which would change the HoIA opinion but that it was difficult to know if the exceptions mentioned were related to Lewisham. SECSU would produce an action plan and had already had produced an interim report which had been circulated to Committee members.

Referring to the comment that emails had been inadvertently deleted by the CSU Mr Read said that he shared Mr Warburton’s concerns. It was not clear if this was the mechanical process of archiving or human error. Mr Read would take forward.

ACTION: Tony Read

Mr Warburton expressed concerns that the expanding business of the CSU had affected their efficiency. Mr Read responded that the SAR would identify control weaknesses.

68.2 SBS – Business Process Outsourcing

It was noted that the Electronic Staff Record was not covered in this report.

68.3 SBS – NHS Procurement

Dr Majid said that Information Governance and ICT provision for primary care in Lewisham was poor and that other parts of London had better support. Mr Read reported that the report was regarding the control environment and that IG and ICT concerns are looked at locally through management processes, reports and KPIs. It was acknowledged that the GP ICT service does not have to be purchased through SECSU and that SEL CCGs are currently collaborating on the use of the national lead provider framework in relation to future IT services.

The Committee ACCEPTED the reports for information.

AC15/69 Local Counter Fraud Service update

Mr Read reported that there had been no changes to the work plan since the draft plan came to the meeting in March 2015. The fraud risk assessment undertaken annually which identified the
alerts and weaknesses in controls to prevent fraud and that may impact on the proposed plan would reported back to the Committee when relevant.

Mr Warburton said that Ms Alflatt had run a training session on Counter Fraud, Bribery Awareness and Conflicts of Interest for the Governing Body and CCG staff on 21 May. This was a useful session and it was agreed that further sessions would be arranged for those Governing Body members who were unable to attend.

**ACTION:** Lesley Aitken

The Committee **REAFFIRMED** approval of the LCFS work plan for 2015/16 and **NOTED** the progress of the counter fraud work to date against the counter fraud plan.

**AC15/70**  Local Security Management Service progress report

Mr Read confirmed that there were 10 days agreed for LSMS the work plan for 2015/16 and that there were no outstanding actions from the work plan. Work during 2015/16 would be focussed around the assurance required from providers which is reflected in the work plan. The Committee **NOTED** progress since 1 April regarding the new 2015/16 Security Standards for Commissioners.

**AC15/71**  Review of losses and special payments

Mr Read confirmed that there were no new losses or special payments made since the last meeting.

**AC15/72**  Waiver of SFIs

Mr Read reported that there were no waivers of SFIs since the last meeting.

**AC15/73**  Business of other committees and review inter-relationships

There was no business raised at this point of the meeting.

**AC15/74**  Any other business

There was no any other business reported at this meeting.

**AC15/75**  For information

75.1  Audit Fee Letter 2015/16

Mr Dean stated that there was a 20% fall in the 2015/16 audit fee which had been set for the CCG at £63,600, due to timing this had been accepted by the Chair on behalf of the Committee.

**AC15/76**  Summary of key messages to report to the Governing Body

The following was summarised by Mr Warburton:
• Approval of the Annual Report, Annual Governance Statement and Accounts 2014/15 and lessons learned. Thanks to be given to Mr Read and Mr Hewett and teams for their work.
• Conflict of Interest review
• Internal Audit Work Plan

AC 15/77  **Date of next meeting**

Tuesday 7 July 2015; 14:00 – 17:00 at Cantilever House
<table>
<thead>
<tr>
<th>Minute Ref</th>
<th>Action</th>
<th>Responsible Person</th>
<th>Timescale</th>
<th>Status/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>May</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15/61.2</td>
<td>Independent member – an update report to come back to the July meeting</td>
<td>Tony Read</td>
<td>July 2015</td>
<td>This is an agenda item for the July meeting.</td>
</tr>
<tr>
<td>62.1</td>
<td>A session to be held to reflect on lessons learned this year from the preparation of the Annual Report and Accounts</td>
<td>Tony Read/Lesley Aitken</td>
<td>To be arranged</td>
<td>Closed</td>
</tr>
<tr>
<td>68.1</td>
<td>To take forward the issues relating to the SECSU SAR and the deleted emails</td>
<td>Tony Read</td>
<td></td>
<td>Closed – this has been taken forward.</td>
</tr>
<tr>
<td>69</td>
<td>Further sessions on Counter Fraud, Bribery Awareness and CoI for the Governing Body to be arranged.</td>
<td>Lesley Aitken</td>
<td>To be arranged in July</td>
<td>Closed - Provisional date of 13 August booked.</td>
</tr>
<tr>
<td>April</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15/46.4</td>
<td>A glossary of terms used in the risk management process to be agreed at Risk Management Group and reported back to Audit Committee and Governing Body</td>
<td>Graham Hewett</td>
<td>July 2015</td>
<td>This is on the July agenda.</td>
</tr>
<tr>
<td>15/50.2</td>
<td>Clarification on planned work (see minute 50.2) to be given.</td>
<td>Inge Damiaens</td>
<td>May 2015</td>
<td>This is detailed on the work plan.</td>
</tr>
<tr>
<td>July 2014</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14/78.1</td>
<td>Information on ethical procurement for GPs and CCGs to come back to the Committee.</td>
<td>Martin Wilkinson</td>
<td>July FIC 2015</td>
<td>This has been deferred to the July FIC meeting.</td>
</tr>
</tbody>
</table>
Delivery Committee

Thursday 25 June 2015

Present
Martin Wilkinson (MW) Chief Officer (Chair)
Dr Hilary Entwistle (HE) Clinical Director
Dr Faruk Majid (FM) Senior Clinical Director
Dr Angelika Razzaque (AR) Clinical Director
Tony Read (TR) Chief Financial Officer
Marc Rowland (MR) Chair
Ray Warburton (RW) Lay Member

Attending
Dr David Abraham (DA) Senior Clinical Director
Mike Hellier (MH) Head of System Intelligence
Graham Hewett (GH) Head of Integrated Governance
Bobbie Scott (BS) Corporate Services Team Manager (Minutes)
Neil Stevenson (NS) Associate Partner (BGL), South East CSU
Richard Whittington (RWH) Deputy Director Commissioning

Apologies
Diana Braithwaite (DB) Commissioning Director
Alison Browne (AB) Nursing and Quality Director
Dee Carlin (DC) Head of Joint Commissioning

1. Welcome and Introductions

MW welcomed all to the meeting.

2. Apologies

Apologies were taken and noted.

3. Declaration of Interests (DoI)

There were no new interests declared.

4(a). Minutes of previous meeting

Minutes of the Delivery Committee meeting on Thursday 28 May were agreed.

4(b). Action Log

All outstanding actions had been addressed and the action log updated.

5. Matters Arising

There were no matters arising.
6. Report from sub-groups

Connect Care Programme Board
TR gave the report of the Connect Care Programme Board (CCPB) meeting held on 27.05.2015 and highlighted the following:
- There has been a delay to the go-live date
- There is increasing interest from Bexley CCG and Council regarding joining Connect Care
- Finances have been agreed and for the CCG they are significantly lower than those agreed in the Business Case
- A high level roll out timeline to GP practices over the summer of 2015 was included in the papers

MW gave a verbal report of the CCPB meeting held on 24.06.2015 and highlighted that the project status is currently red due to a two week outage caused by storage space issues. A root cause analysis has been requested for 10.07.2015 to ensure more robust arrangements are in place going forward.

HE stated that further membership engagement was needed, including an update from practices currently trialling Connect Care. MW responded that the Project Board was being re-established and will include a GP from the CCG’s Information Management & Technology Steering Group. It was agreed that a briefing would be scheduled for the July Membership Forum.

It was recognised that the report was hard to understand given the frequent use of acronyms.

In response to RW’s question regarding whether the recent outage will impact on the sign up rate of GP practices, MW responded that only two Lewisham GP practices are trialling Connect Care and it is understood that this is a testing phase to work out any issues prior to it going live.

In response to RW’s question regarding how many GP practices will go live, MW responded that it is hoped that all practices will sign up and use Connect Care.

Action: TR to produce a report on Connect Care for the July Membership Forum.

The Committee noted the report from the CCPB

FLAG
FM gave the report of the FLAG meeting held on 11.06.2015 which focused on the CCG’s Mental Health and Community service providers and highlighted the following:
- The SLaM dashboard was discussed. There are concerns regarding high staff vacancy rates, increase in complaints relating to treatment and care, increase in serious incidents regarding violence and harassment and deficiencies around data reporting for levels of safeguarding training.
- The SLaM Quality dashboard has been circulated for final comments before sign off at the next CQRG.
- FLAG has agreed with Healthwatch their attendance at FLAG meetings and a cycle of reporting.
- It was noted that a robust recovery plan was in place regarding LAS performance and that no further action was currently needed.
- FLAG has requested examples of completed RCA reports as well as the action plans from LGT to review implementation of learning.

- There are fewer GP raised quality alerts for district nursing however there are still alerts around poor communication. To assess progress it was agreed to re-audit district nursing in December 2015.

- Safeguarding concerns have been raised for Harcourt House. Following the completion of the investigations and interviews there will be a Quality Summit involving all parties.

- The management of leg ulcers is still a concern a report is due to FLAG in September.

In response to HE’s question regarding mental health quality alerts, GH responded that the process has been reviewed with SLaM, it was acknowledged that there has been a delay due to staff changes however this should now be resolved.

MW asked for the leg ulcer report at September’s Delivery Committee even if only available as an interim report. HE highlighted that neighbourhood 4 were working on proposals for practice nurses to work with district nurses to improve healing rates.

**Action:** Delivery Committee to receive the Leg Ulcer Report at its September Meeting, even if interim findings.

In response to RW’s question regarding the increase in complaints to SLaM relating to treatment and care, GH responded that overall complaints had fallen but the proportion relating to treatment and care being received is the largest and this is increasing. The CCG is reviewing with SLaM their reporting arrangements for complaints.

**The Committee noted the report from the FLAG**

**Information Management & Technology Steering Group**

TR gave the report of the first Information Management & Technology (IM&T) Steering Group meeting held on 09.06.2015 and highlighted the following:

- The CCG has established a new Group to provide strategic leadership on CCG and GP IT. The focus initially will be on GP IT given the current poor performance of the service provider.

- The draft terms of reference for the Group was included in the papers. Membership has been agreed and includes two representatives from each GP neighbourhood. It was proposed that the Group will report formally to the CCG Delivery Committee after each meeting but also to the Strategy and Development Committee as required.

Key issues for the Group to consider were highlighted and included inter-operability and patient access. It was agreed that a 6 month workplan for the Group would be produced to prioritise current issues and longer term plans.

It was agreed the quorum should include the Chair or Deputy Chair of the Group. MR stated that the terms of reference should include the purpose of supporting the strategic aims of the CCG. In response to RW’s question regarding the reporting arrangements for the Group TR responded that a formal annual report on the work of the Group would be produced but a report to the Delivery Committee will follow each meeting.

In response to HE’s question regarding the link between the CSU and EMIS, TR stated that the IM&T Steering Group will invite individuals to attend who are not members of the group including the CSU and other external organisations as required. The EMIS user group will also need to feed in to the IM&T Group.
In response to RW’s question regarding whether the terms of reference should include a direct reference to Connect Care, TR responded that Connect Care will be included in the workplan.

**Action:** IM&T Steering Group workplan to come back to the Delivery Committee.

The Committee AGREED the terms of reference for the IM&T Steering Group subject to the change to the quorum rules and purpose and NOTED the report of the June meeting.

**System Resilience Group**

MW gave the report of the System Resilience Group (SRG) meeting held on 01.06.2015 and highlighted the following:

- Alison Edgington has been appointed as Interim Delivery Director to work across Bexley Greenwich and Lewisham. The final phase of the McKinsey support concluded at the end of May 2015 and Alison will be ensuring that the plans are robust going forward.

- The 2015/16 Winter Resilience Planning is taking place over the summer and an update will be brought to the Delivery Committee.

- In response to the comments from the Delivery Committee at its May meeting a brief was provided on how the SRG fits in with the overall work of the CCG and includes an emphasis on community resilience.

DA stated that there is a gap in co-design between secondary and primary care clinicians and no forum to facilitate mutual discussion. MW acknowledged that the Surgical Assessment Unit was not co-designed and was developed in response to the A&E performance issues to support the flow of patients through A&E. Other initiatives such as the Ambulatory Care Unit will be co-designed through the BCF workstream. HE stated that the communication and infrastructure needed to co-ordinate long term condition pathways across secondary and primary care was not in place. MW responded that this should be driven through the Neighbourhood Community Teams.

**Actions:**

- Winter Planning to be discussed at the August Delivery Committee
- RWH and NS to draft communication to Membership on the SAU

The Committee noted the report from the SRG

7. **Integrated Performance Report**

**Quality**

The newly identified Quality Exceptions from FLAG were noted above.

Following the discussion regarding the timeliness of complaint responses at the May meeting an additional report on the performance of complaints management at LGT was included in the papers. The report does not include the additional actions LGT have taken following the allocation of Quality Premium funding to improve the timeliness of complaint responses.

DA highlighted the high number of complaints regarding nursing care at Lewisham compared to QE. MW responded that the figure for QE would include only acute nursing whereas Lewisham would include acute and community nursing. FM stated that FLAG has discussed issues around nursing inpatient care and these had been raised with the Director of Nursing.
RW thanked NS for the report and commended the deliberative approach being taken however highlighted the importance of ensuring that the complainant understands the timeframe in which their complaint will be handled as stated in the NHS constitution. MW responded that best practice included giving an expected timeframe for the investigation and response and keeping patients informed if it is expected the take longer than the timeframe initially given. NS stated that ‘complaints resolved within the locally agreed timescale’ is a performance measure.

In response to RW’s question regarding how the Committee can routinely get assurance against the measures that may require further or on-going explanation, TR stated that exception reports and deep dives should be scheduled where further explanation is required.

FM highlighted that KCH were also not meeting the responsiveness to complaints measure and that Southwark CCG has stated that they are not assured with the complaints process at KCH. A recovery plan on KCH’s complaint performance to be shared with the Delivery Committee.

**Action:** A recovery plan on KCH’s complaint performance to be shared with the Delivery Committee.

**Performance**

The following performance indicators were highlighted:

- **A&E 4 hour standard:** While performance is below the 95% standard LGT is on target to exceed the Q1 trajectory of 91.3%.

- **18 Week Referral to Treatment Times:** 18 week reporting requirements have been temporarily suspended by NHSE for KCH (April – September 2015) and LGT (June – August 2015). LGT have indicated that the 18 week standard for admitted patients cannot be delivered without mitigation. This has been escalated to the Contract Management Board and a full analysis has been requested from the Trust

- **Cancer waiting times:** The recovery trajectory for the 62 day GP referral to treatment is to meet the 85% standard by quarter 3. At April 2015 Lewisham CCG is marginally behind the recovery trajectory.

It was noted that barring RTT most recovery trajectories were on track.

In response to TR's question regarding what specifically has contributed to the improved A&E performance, MW stated that the combination of clinical and managerial leadership and improvement in the management of the flow of patients has improved performance. It was recognised that there was still work to do to close escalation beds, reduce delays around supported discharge and increase community initiatives such as Rapid Response and Enhanced Care to prevent admissions.

HE commended the work to improve the performance against the IAPT performance standards and suggested that the key to improvement, joint working between teams with the clear focus of the patient at the end, is taken into other areas.

**Finance**

TR gave the month 2 finance report and highlighted the following:

- The month 2 report is based on month 1 activity information which following the introduction of the dual tariffs for acute contracts has caused reporting issues and consequently the majority of expenditure reported is assumed to be at budgeted levels.

- Risk within the expenditure position is partly mitigated by the block contacts agreed with SLaM, GSTT and KCH and cap and collar contract agreed with LGT.

- The Better Practice Payments Code is above target.

- The position includes the 2014/15 carried forward surplus for which additional expenditure plans are needed.
In response to RW’s question regarding the definition of a cap and collar contract, TR responded that the CCG has agreed a minimum payment (collar) and maximum payment (cap) with LGT giving the Trust a guaranteed income and protecting the CCG against activity driven overspend.

In response to RW’s question regarding the CCG’s running cost allowance, TR responded that the CCG has a running cost allowance of £22.50 for 2015/16. The CCG’s forecast running cost expenditure for 2015/16 is £22.07 which has not been reduced from 2014/15.

Activity

NS gave the report of the month 1 assessment of performance for BGL commissioners against the contractual cap and highlighted the following:
- Lewisham CCG is £32k over the cap.
- Key pressure areas for Lewisham include emergencies, within which the main issue is respiratory, and outpatients.

In response to DA’s question regarding whether the block contract with KCH and GSTT will have implications on patients who need to be transferred to the specialist centres, NS responded that the pathway was secure and KCH have block contracts with most commissioners.

TR highlighted concerns that KCH will not meet their £80m cost improvement programme.

A fuller summary was requested at the beginning of future activity reports to highlight the key issues.

The report setting out activity and financial performance for adult critical care across LGT, KCH and GSTT was noted.

8. Key Items to be Reported to the Governing Body

The key items to be reported to the Governing Body include:
- The establishment of an IM&T Steering Group and the request for a prioritised workplan.
- Progress on performance against recovery trajectories including an update on RTT
- Report on LGT Complaints

9. Minutes from sub-groups

FLAG

The approved minutes of the FLAG meeting held on 14.05.2015 were taken for information.

System Resilience Group

The approved minutes of the System Resilience Group meeting held on 06.05.2015 were taken for information.


The Equality Impact Assessment of the South East London Treatment Access Policy 2015 was taken for information.

11. Any Other Business

Collaborative Agreement between CCGs: MW reported that the Collaborative Agreement between CCGs was being refreshed in light of the new governance arrangements for primary care and OHSEL.
The revised agreement will not be ready for the July Governing Body meeting and it will therefore be proposed that the Delivery Committee review the Collaborative Agreement prior to MR taking Chair’s action.

The Delivery Committee AGREED to the proposal that the Delivery Committee review the revised Collaborative Agreement on behalf of the Governing Body prior to MR taking Chair’s Action.

12. Date of Next Meeting

The next meeting would be held on Thursday 23 July 2015.
## Welcome and Introductions

MW welcomed all to the meeting.

## Apologies

Apologies were taken and noted.

## Declaration of Interests (DoI)

There were no new interests declared.

### Minutes of previous meeting

Minutes of the Delivery Committee meeting on Thursday 25 June were agreed.

### Action Log

**March 6:4:** The deep dive on continuing healthcare was deferred to September. The Ranyard Trust which provides nursing care at Dowe and Mulberry House went into liquidation in early July. The closure has resulted in the loss of 100 beds locally and permanent placements have been found for the 63 people currently in those homes. The final three placements are due to be made on 24.07.2015. The Committee recorded their thanks to Joint Commissioning Team for their hard work.
All additional outstanding actions had been addressed and the action log updated.

5. Matters Arising

Collaborative Agreement between CCGs
MW reported that the Collaborative Agreement had been revised but requires further editing to improve readability and will be brought back to the Delivery Committee in August.

Action: CCG Collaborative Agreement to be brought back to the Delivery Committee in August.

Complaints Management at KCH
The report on KCH’s complaints management process and the actions they have taken to improve their complaints performance was noted. It was requested that the graphs on page 1 of the report were revised to accurately reflect the percentage of complaints resolved within 25 days and the report re-circulated via email to the Committee.

RW stated that the approach taken by KCH which addresses simpler complaints quickly and informally allowing for a more detailed focus on complex and serious complaints seems sensible. MW responded that the CCG had invested additional quality premium money in the LGT PALS service to address concerns early.

It was agreed that there was learning from the actions taken by KCH should be shared with LGT through the CQRG.

Actions:
- Complaints report to be re-circulated with the correct graphs
- AB to share learning from the actions taken by KCH with LGT through the CQRG.

6. Report from sub-groups

Connect Care Programme Board
TR gave a verbal report of the Connect Care Programme Board (CCPB) meeting held on 22.07.2015 and highlighted the following:

- The previously reported outage caused by storage space issues has been resolved.
- An issue has been identified with the interface between LGT’s imaging system, which is due to be resolved by the end of July.
- The roll out timeline for GP practices, which was due over the summer of 2015, has been moved back to the autumn 2015. Currently 50% of Lewisham practices have signed the data sharing agreement. Additional communication is due to go out week beginning 27 July to practices. Further support with Caldicott Guardian training is being considered.
- Bexley CCG has confirmed their intention to sign up to Connect Care.
- The request for a Lewisham GP to sit on the Project Board has been followed up through the IM&T Steering Group.

In response to MR’s question as to whether the Caldicott Guardian training could be provided to the Federations rather than to each practice, TR stated that each individual practice has to have its own Caldicott Guardian however additional training could also be considered to address specific Information Governance issues relating to Federations.
AR gave the report of the FLAG meeting held on 11.06.2015 which focused on Primary Care and other private providers and highlighted the following:

- Reports were received on the BMI Hospital at Blackheath. A number of concerns were raised, including poor patient experience scores, a CQC rating of “requires improvement” and no commissioner engagement in the quality account. Further information has been requested on the commissioning and contract monitoring processes in place for BMI Blackheath Hospital.

- A report on the liquidation of Ranyard Trust was requested for the August meeting.

- Concerns were raised regarding the lack of discharge summaries from LGT. It was confirmed that this had been escalated through the contracts lead. RWH confirmed that the list of addresses being used by LGT had been requested and these will be mapped against the addresses that should be used.

- To address the decline in the number of GP quality alerts it was agreed that a quarterly report would be prepared and presented at the neighbourhood meetings.

- An analysis of key themes identified within the Root Cause Analyses (RCA) investigations into Serious Incidents was received. Two of the themes identified included that there was no engagement with GPs during the RCA investigations even in cases where recommendations for primary care are made and that there was a recurring problem of GPs not receiving copies of test results carried out on / for pregnant women. A meeting with LGT has been arranged on 29 July to discuss this with LGT. HE stated that the clinician who initiates the test is responsible for following up the outcome and cautioned against causing confusion by sending GPs copies of test results without also including the copy of the outcome of the decision.

MW stated that the fuller report on primary care finance, quality and performance is required now the CCG had taken forward joint commissioning responsibility with NHS England. MR cautioned against taking a PCT approach to performance management of practices and membership perception. MW responded that the CCG is not taking on a contract management role however information does need to flow through the CCG’s formal governance structures to enable the CCG to take on an increased role in the commissioning of GP services and for the CCG to be able to take a decision on whether to take forward full delegated responsibility for commissioning the majority of GP services.

**Action:** DB/TR to ensure primary care finance, quality and performance data flows through relevant local CCG Governance Committees.

The Committee noted the report from the FLAG

Information Governance Steering Group

TR reported that the Information Governance Steering Group (IGSG) had not met since the June Delivery Committee and highlighted the following work being undertaken:

- A new approach to training is being developed which will be rolled out in quarter 3 2015/16 to provide more intensive training to those regularly dealing with personal identifiable data and a lighter touch to those who do not.

- A new framework and workplan is being developed to reflect the highest risk on the risk register.

In response to RW’s question regarding who is a member of the IGSG, TR responded that he chaired the group as the CCG’s SIRO, members also include Alison Browne as the CCG’s Caldicott Guardian, the CSU IG Manager and members from the CCG’s Medicines Management and Joint Commissioning Teams.
In response to RW’s question regarding the timetable for Internal Audit, TR responded that this has been scheduled for November after the mid-year tool kit submission.

Information Management & Technology Steering Group

TR gave a verbal report of the Information Management & Technology (IM&T) Steering Group meeting held on 21.07.2015 and highlighted the following:

- The focus of the meeting was the windows 7 refresh project. A formal complaint was made by the Southwark, Lambeth, Lewisham and Greenwich CCGs to the SE CSU about the poor performance of the GP IT service with particular regard to the implementation of the Windows 7 Upgrade project. A response has been received however there has been no improvement in the performance of the service and a new project plan for the roll out of Windows 7 has yet to be received.
- The neighbourhood representatives agreed to discuss a common solution for an SMS service within their neighbourhoods.

Prescribing & Medicines Management Group

The Committee noted the report of the Prescribing and Medicines Management Group meeting on 15.07.2015. TR reported that the Lewisham Integrated Medicines Optimisation Service (LIMOS) business case extension was approved at the Finance and Investment Committee.

Information on the key findings from of the following reports was requested:
- Medicines Optimisation Education and Training (MOETs)
- LIMOS
- NPSA anticoagulation report

Action: Key findings from the MOETs, LIMOS and NPSA anticoagulation report to be circulated to the Committee.

System Resilience Group

MW gave the report of the System Resilience Group (SRG) meeting held on 15.07.2015 and highlighted the following:

- Five key priorities have been identified for the Winter Resilience Plan for 2015/16 which include:
  - Improving the NHS Funded Continuing Care process to reduce delayed transfers of care
  - Improving patient access to the admission avoidance team and rapid response
  - Improving non-acute bed efficiency and utilisation within Brymore, Sapphire and recuperative beds within UHL, including the role of ‘discharge to assess’ to reduce the unnecessary acute bed stays
  - Increasing support to residential care/nursing homes to reduce avoidable and inappropriate use of acute care services
  - Improving ‘hospital at home’ care
- Despite performance above trajectory in June, performance fell below the recovery trajectory in the first two weeks of July, albeit there has been strong performance at the UHL site.

TR clarified that the total resource allocation to the BGL system for winter resilience funding is £8.7m of which £7.1m is included in the LGT contract and £1.6m is available to the wider system.
In response to FM’s question regarding the definition of diversion, MW stated that in the context of the paper it was used to describe how to pick up people earlier in the emergency care pathway rather than diversion at the front of A&E or UCC.

The Committee noted the report from the SRG

7. Integrated Performance Report

TR introduced the month 3 integrated performance report highlighting the new structure which moves away from a largely narrative based report to a dashboard approach.

The following comments were made regarding the new format:

- Primary care co-commissioning indicators to be included
- Quality scorecard to include primary care via neighbourhoods
- An explanation of the report to be included on the first page
- Standardise the format of the first page, current and forecast, for Quality, Finance and QIPP
- New exception reports to include more detail on the risk and progress against milestones

In response to RW’s question regarding the meaning of the activity v plan column, TR stated that the activity relates to high level groupings of acute activity and is red as there is a significant variance against the planned activity.

Quality

In response to RW’s concern that 13 of the quality indicators were red, MW stated that the CCG is aware of and working with the Trust to improve performance on main red themes, responsiveness to complaints and safeguarding adults training compliance. GH highlighted that the indicators were chosen by FLAG based on areas of concern.

Performance

The exception report for cancer waiting times, 62 days from GP referral to treatment, was noted. Key areas for improvement to meet the standard are lower gastrointestinal and urological. The following comments were made on the format of the exception report:

- More information on the site(s) concerned
- Graph axes to be labelled
- Include performance against trajectory as well as performance against standard
- Include information on whether there is a capacity issue or there is an issue with the interface between the specialist and local providers

MW reported on the Mental Health Stocktake meeting on 21.07.2015 between SLaM, NHS England and four CCG commissioners and requested that the new intervention targets are included in the performance report.

Actions: Slide pack for the mental health stocktake meeting to be circulated to the committee.

Finance

In response to RW’s question regarding why the forecast variance for acute expenditure is £0.08m when the CCG has ‘block’ and ‘cap and collar’ contracts in place, TR stated that this expenditure is related to activity outside of KCH, GSTT and LGT. TR highlighted that the finance position is on plan and at month 3 the CCG is forecasting to deliver its planned surplus at year end, however there are early indications that acute activity is above plan. Due to the ‘block’ and ‘cap and collar’ contracts this information does not flow through into the finance position as the CCG pays a fixed amount regardless
of activity. The CCG included in the 2015/16 contract 4% more emergency activity than 2014/15 to take account of population and system growth; however the current activity levels are 13% above plan. The activity figures are based on 2 months data, which has not yet been fully validated. A higher level of activity was seen at the end of 2014/15 however it has not been proven that this level of activity has been sustained and LGT has reported that they may be over reporting activity levels due to the implementation of CERNER. However the Trust has improved the flow of patients as a result of McKinsey work and if there is a higher level of activity there is a risk that the cap will not hold going into 2016/17.

The importance of winter resilience plans, particularly admission avoidance and rapid response, was highlighted to reduce unnecessary activity.

Action: The Integrated Performance Report to be amended to reflect the Committee’s comments.

The Committee NOTED the new Integrated Performance Report and NOTED the exception report for Cancer Waiting Times.

8. Emergency Preparedness, Resilience and Response (EPRR) Update

GH gave the report providing an update on the progress against the CCG’s EPRR action plan and requested comments on the draft EPRR policy and the Major Incident Plans for Pandemic Influenza, Severe Weather, Fuel Disruption and Infectious Disease. The Major Incident Plans will also be sent to the Borough Resilience Forum and NHS England for comment prior to being signed off by MW.

RW gave the following comments during the meeting and stated more detailed comments would follow in an email to GH:
- A sharper distinction between inward and outward looking preparation and action was needed throughout the policy and plans.
- The vulnerable groups that are considered in the policy and plans should extend to major ‘inclusion health’ groups such as homeless or isolated people.
- The staff cascade should include Clinical Directors and independent members being clear that their roles would be different to staff and be for information / alert.

In response to RW’s question regarding the definition of a loggist, GH stated that a loggist was someone formally trained in recording decisions and rationale during an emergency.

The Committee NOTED that good progress had been made to close the assurance gaps identified in the 2014/15 Assurance Process.

9. Key Items to be Reported to the Governing Body

The key items to be reported to the Governing Body include:
- Update on delivery against local and constitutional performance standards
- Commented on the new style of the integrated performance report
- Requested learning from Medicines Management initiatives
- Good progress made to close assurance gaps identified in the CCG’s EPRR 2014/15 assurance review.

10. Minutes from sub-groups

FLAG

The approved minutes of the FLAG meeting held on 11.06.2015 were taken for information.
Prescribing and Medicines Management Group

The approved minutes of the PPMG meeting held on 15.04.2015 were taken for information.

11. Lewisham Neighbourhood Primary Care Improvement Scheme 2014/15

NI joined the meeting.

The End of Scheme summary of Lewisham Neighbourhood Primary Care Improvement Scheme 2014/15 was taken for information.

In response to RW’s question on what the key learning taken from the schemes success, NI highlighted the following successes:

- Flu vaccination uptake for over 65s and under 65s at risk has increased and the CCG improved its position amongst the London CCGs and the percentage of Lewisham patients aged over 65 who had received the pneumococcal vaccine also increased.
- 84 local GP Practices clinicians were trained in the year of care approach to collaborative care and there are year of care trained clinicians in each Lewisham practice.
- Four patient engagement events took place across each neighbourhood discussing PPGs, access and collaboration between practices. Feedback will be used to inform future work.

In response to RW’s question regarding the evaluation of the surveys for those who declined the referral or failed to complete DESMOND; NI stated that this was being considered by commissioners to inform future arrangements.

In response to RW’s question whether patients were involved in the neighbourhood wide meetings, NI stated that these meetings were separate from the patient engagement events; one GP per practice was required to attend.

HE stated that the scheme was developed and implemented with the best of intentions and encouraged people to work together, however the administration required has prevented people from thinking initiatively and more clinical input is needed into future schemes. MW responded that the scheme will evolve for 2016/17 into a 1 contract delivered by the 4 neighbourhoods and early discussions are needed to start this planning.

12. NHS 111 Briefing

An update on the NHS 111 re-procurement was taken for information. NHS England has asked all CCGs nationwide to put on hold any plans to re-procure NHS 111 or out of hours services until the end of September 2015.

MW stated that the hold on re-procurement will allow time to link plans to the OHSEL Strategy and the Keith Willett review and to work with partners on a collaborative solution.

In response to RW’s question regarding whether patients and the public need to be informed, MW stated that this is not necessary as 111 is still available to public and there has been no change to the service.

13. Any Other Business

HE will be stepping down as a Clinical Director at the end of August. The Committee recorded its thanks to HE for the contribution, insights and wisdom she had provided.
14. Date of Next Meeting

The next meeting would be held on Thursday 27 August 2015.
Members:

Dr David Abraham (DA) Senior Clinical Director (Chair)
Dr Hilary Entwistle (HE) Clinical Director
Charles Malcolm-Smith (CM-S) Deputy Director (Strategy & Organisational Development)
Susanna Masters (SM) Corporate Director
Tony Read (TR) Chief Financial Officer
Diana Robbins (DR) Lay Member

In Attendance:

Trish Duffy (TD) Health & Wellbeing Population Intelligence Manager
Caroline Hirst (CH) Joint Commissioner, Children and Young People’s Services
Dr Faruk Majid (FM) Senior Clinical Director
Jane Miller (JMI) Deputy Director of Public Health
Ashley O’Shaughnessy (AO) Associate Director Commissioning
Dr Angelika Razzaque (AR) Clinical Director
Bobbie Scott (BS) Corporate Services Team Manager (Minutes)

Apologies

Dr Jacky McLeod (JM) Clinical Director
Dr Marc Rowland (MR) Chair
Martin Wilkinson (MW) Chief Officer

1. Welcome and Introductions

DA welcomed all to the meeting.

2. Apologies for Absence

Apologies for absence were taken and recorded.

3. Declarations of Interests

There were no new interests declared.

4(a) Minutes of the previous meeting

The minutes of the meeting on 2 April 2015 were agreed as an accurate record.

4(b) Review of Action Log/Tracker

02.04.2015/6c: The Healthwatch Director, Folake Segun, provided an overview to PEG on 30.04.2015 of its approach to workplan development and working with the CCG, and confirmed Healthwatch will continue to be a member of PEG and ensure representation and input to other CCG groups such as FLAG. The workplan is still to be agreed and further assurance is required on the capacity to deliver the workplan, which will be taken forward by PEG.
02.04.2015/11: CCG representation on the LSL Sexual Health Commissioning Board is to be discussed at the System Management meeting on 09.06.2015. The business case for the outreach nurse has been discussed at the Adult Joint Strategic Commissioning Group. TR pick up with Joint Commissioners.

All other outstanding actions had been addressed and the action log updated.

5. **Matters Arising**

There were no matters arising.

6. **Report from PEG**

DR gave the report of the PEG meeting on 30.04.2015 and highlighted the following:

- A proposal to amend the PEG terms of reference to enable PEG to focus on developing public engagement activities within the CCG was supported. The Strategy and Development Committee was asked to approve the updated terms of reference for PEG which amends the committee membership to include members from the CCG and Healthwatch only. Oversight and co-ordination of engagement activity by health and social care partners in Lewisham will continue to be provided by the JPEG and the membership of JPEG would continue to include representatives from all partner organisations.

The committee APPROVED the revised terms of reference for the PEG subject to the addition that public health will be invited to attend meetings as appropriate.

7. **Report from JPEG**

DR gave the report of the JPEG meeting on 30.04.2015 and highlighted the following:

- The engagement activity on the Joint Commissioning Intentions was commended. A report that summarised the feedback and outlined how the results of the consultation exercise will inform future plans was received. The five areas that commissioners will have a greater focus on as a result of the consultation exercise are:
  - Prevention and early intervention – commissioners will have a particular focus on proactively sharing health and wellbeing information with local people - ‘knowing the facts’.
  - GP Practices and primary care - commissioners will have a particular focus on improving the patient experience and outcomes.
  - Neighbourhood Care Networks and Enhanced Care and Support - commissioners will have a particular focus on ensuring individuals are- ‘treated as people’, supporting workforce development and training and supporting information sharing.
  - Children and Young People - commissioners will have a particular focus on providing the right support at the right time and improving successful transition to adulthood.
  - Making this happen – commissioners will have a specific focus on supporting collaborative working with all providers, working towards ensuring that mental health has the same importance as physical health and reducing inequalities.

- It was noted that the proposed approach to engagement activity in support of the Adult Integrated Care Programme outlined at the January JPEG meeting had not progressed. DR requested assurance that the commitment to the public is taken into account during the work to refresh the commissioner narrative on integration and that the public is involved from the very beginning in the programme of work.
- The process for engaging stakeholders and the wider community in the selection and production of needs assessment topics for the JSNA was discussed. It was recognised that a pragmatic solution may be needed for 2015/16 to inform the 2016/17 commissioning intentions.

- The engagement event to be hosted on 4 July 2015 has been renamed ‘Your Voice Counts’ and will focus on two key themes ‘knowing the facts’ and ‘treated as people.’ This is a joint event with partners and Sue Richie will be facilitating. Clinical Directors were invited to attend.

**Actions:**
- The CCG’s ‘integration’ narrative to be circulated
- SM to ensure that the commitment to engage the public is included in the commissioning narrative

**The Committee NOTED the report from the JPEG.**

8. **Report from the Primary Care Development Group**

AO joined the meeting

AO gave the update from the Primary Care Development Group (PCDG)

- The PCDG has been involved in discussions on primary care collaboration. Two protected learning time events (PLT) on collaboration have been held. Legal support at the event on 04.06.2015 has been arranged to ensure practices are able to have productive discussion about forming new provider entities by quarter 3 2015/16.

- The primary care access programme has been discussed; an access subgroup is being setup to implement the Access PID which looks to improve access to core (in-hours) GP services.

- The 2015/16 Lewisham Neighbourhood Primary Care Improvement Scheme (LNPCIS), worth £1.5m, has commenced and focuses on self-management of long term conditions, risk stratification and care planning, cancer, end of life care, flu and pneumococcal vaccinations, patient participation and reducing emergency admissions. The 2015/16 Engagement LIS includes an element requiring neighbourhoods to produce their own commissioning proposals to be submitted to the CCG in Q3.

- The PCDG is reviewing its role in the co-commissioning of primary care and looking to support maximising the benefits.

In response to FM’s question regarding the input of Clinical Directors in the PLT AO stated that neighbourhood provider leads are attending and Clinical Directors if attending should be clear whether they are attending in a Clinical Director or provider role.

In response to DA’s question regarding the need for a workplan including timescales, AO stated that the primary care strategy had been signed off and agreed a more detailed implementation plan was needed for 2015/16.

DA requested that primary care quality and work on variation in primary care was included in the next update from the PCDG.

It was recognised that the Strategy and Development Committee needs to hold its sub committees to account for delivering against the CCG’s developmental objectives, to be more directive on the vision for Local Care Networks and how the component parts of primary care collaboration, primary care co-commissioning and the work of the Adult Integrated Care Programme Board fits together. This would allow the Committee to give more robust assurance to the Governing Body on progress and escalate outstanding issues. It was agreed to discuss this further under the item on the Governing Body self-assessment.
AO left the meeting.

The Committee NOTED the report from the PCDG.

9. **Report from the Maternity Commissioning Steering Group**

CM-S gave the report from the Maternity Commissioning Steering Group and highlighted the following:

- The Joint Commissioning team at LB of Lewisham will take over Maternity Commissioning from 1 June 2015.

In response to DR’s question regarding the engagement of the Maternity Services Liaison Committee (MSLC) with the Steering Group JMi responded that the MSLC was a very effective group and are engaged with the work.

DA highlighted the need to review where the effectiveness of the strategy is scrutinised.

**Action:** SM to review where in future maternity commissioning is reported in the CCG.

The Committee NOTED the report from the Maternity Commissioning Steering Group.

10. **Governing Body Assessment: Strategy & Development Committee Findings**

CM-S gave the report summarising the outcomes of the assessment undertaken by the Governing Body. The scores for the Strategy and Development Committee were good with an overall average of 4. The identified improvements areas included sufficient time for proper evaluation of agenda items, openness, clarity and decision-making, relationships and communication with stakeholders, and access and availability of information.

Chair’s reports were discussed. The current restrictive format of the reports is recognised and the format will be reviewed to allow local authors flexibility within the template. TR suggested that the lead for the Committee supports the Chair during the meeting to record the key items that need to be reported to the Governing Body to be agreed by the Committee at the end of the meeting.

The quality of agenda items was discussed. SM stated that the papers received are sometimes those that are ‘ready’ rather than those that the Committee requested. The Committee’s agenda should be driven by the CCG’s strategic objectives and cover the areas included in the Committee’s terms of reference. The Committee has responsibility for monitoring the CCG’s two developmental objectives and regular, clear reports on progress against these objectives should be received. It was agreed that the Committee needed to be more directive regarding the reports it receives.

The links with the Primary Care Joint Committee, Adult Integrated Care Board and South East London Committee in Common were discussed. It was noted that there is not capacity to duplicate the assurance process, but that there may be gaps in the system particularly where work relates to the CCG’s two developmental objectives where the Strategy & Development Committee needs to hold the appropriate board/group to account. It was noted that the Strategy and Development Committee has a key role in horizon scanning regarding relevant new developments.

**Action:** SM/DA to develop the forward plan for the Strategy and Development Committee

11. **Adult Integrated Care Programme Board Update**
SM tabled a report providing an update on Lewisham’s Adult Integrated Care Programme, the Better Care Fund and the Joint Commissioning Intentions for Integrated Care. The following was highlighted:

- The Adult Integrated Care Programme refresh is underway and includes a review of the programme structure to improve decision-making and accountability. In addition to the Board a more operational group will be established.
- The draft section 75 agreement for the BCF had been approved by the Mayor and Cabinet on 3 June and will be presented for approval to the CCG’s Governing Body on 9 July.

12. Neighbourhood Profiles

TD joined the meeting.

The Strategy and Development Committee at its April meeting requested further information on the health needs of the four neighbourhoods to inform strategy development and future commissioning.

TD gave the report and highlighted the following:
- Lewisham has a diverse, young, dynamic, growing and deprived population.
- Neighbourhood 3 and 4 see similar populations sizes however the age profile of these areas differ with neighbourhood 4 seeing a much older bias. The age profiles of neighbourhoods 2 and 3 are similar with strong biases towards those aged 20-39.
- Neighbourhood 1 and 3 share similar ethnic diversity proportions, yet neighbourhood 1 sees much higher proportions of its residents born overseas.
- Neighbourhood 1 sees the lowest life expectancy for both men and women.
- For long-term conditions neighbourhood 3 currently experiences the worst outcomes, this is despite not having the oldest population.

The detailed information for each neighbourhood was noted but there was not sufficient time to review it at the meeting.

In response to HE’s question regarding the GP registered population of neighbourhood 2 which is nearly twice the total population of neighbourhood 2; TD responded that there are a number of practices in neighbourhood 2 that boarder other neighbourhoods and whose registered list includes patients who live in other neighbourhoods. It was recognised that this is important to note when planning services and for neighbourhood care networks.

In response to FM’s question regarding whether the CCG is funded on total population or GP registered population, TR stated that CCGs are funded on an adjusted historical basis. NHSE has adopted a funding formula that predicts need according to predicted population factors such as number, age, sex, deprivation. For 2015/16 NHSE agreed variable growth uplifts for CCGs within a floor and ceiling to assist movement towards the targeted allocation. Lewisham CCG is 0.52% below target.

The outcomes for neighbourhood 3 were discussed and whether commissioning efforts need to be more focused to address the inequalities. JMi clarified that while neighbourhood 3 has the worst outcomes for long term conditions neighbourhood 1 has the worst outcomes in terms of mortality indicators. Neighbourhood 3 is more deprived and there is a direct correlation between deprivation and health outcomes however the quality of primary care in neighbourhood 3 is most likely also a factor. The Marmot Review stated that actions must be universal but with a scale and intensity that is proportionate to the level of disadvantage.

TR highlighted that this information also needs to inform the discussions on estates and configuration of services.
It was agreed that the information should go to the Membership to support commissioning plans for neighbourhood care networks and that further work with public health was required to draw out the key messages and conclusions.  

**Actions**

- Further work with Public Health to draw out the key messages and conclusions
- Report to be considered by the Neighbourhood Leads before being taken to the Membership Forum

TD left the meeting.

13. **An Overview of Child and Adolescent Mental Health (CAMHS) Provision**

CH joined the meeting.

CH gave the report providing an overview of current service configuration, an analysis of the gaps, highlighted measures being taken to manage need and provided details of planned developments.

Additional resources secured through the Big Lottery Fulfilling Lives: HeadStart programme and the proposed £1.25 billion investment into CAMHS through central government were highlighted. The HeadStart Funding is to be used as a vehicle for change to prevent early signs of mental health issues escalating to higher need. Over the next 12 months, the ‘test and learn’ phase, different models will be reviewed to understand how different approaches can help build resilience and wellbeing amongst 10-14 year olds, their families and their communities.

CH stated that currently reports are being provided to the Children and Young Peoples Partnership Board and Mental Health Executive and asked for clarification on the role of the Strategy and Development Committee in devising plans for the spending of the additional resources.

HE welcomed the increased focus on resilience and the link between CAMHS and Adult Mental Health services.

In response to TR’s question regarding whether the additional resources are sustainable, CH responded that the HeadStart and Government funding will be provided over 5 years however funding is focussed on system change and sustainability is a key consideration.

In response to TR’s question regarding whether the distinct funding streams for CAMHS and AMH hampers the transition for the patient between services, CH responded that a member of staff from AMH team has been seconded to the CAMHS team to put plans in place for patients 6 months prior to their 18th birthday. The team will also review the new model in Birmingham which provides a community mental health service for children and young adults aged up to 25.

In response to TR’s question regarding the availability of CAMHS beds in London and whether out of London residents were using London beds, CH responded that this is a national issue.

---

1 Following the meeting JM made the following comments on the Neighbourhood Profiles item
- Given the age profile of neighbourhoods 2 and 3 the CCG should promote more online access, telephone consultations, self-help.
- Neighbourhoods 1 and 3 would benefit from strategic use / work with clinical champions and community groups and neighbourhood 1 might need strategic work around language and navigation system.
- A deep dive should be considered into the low life expectancy in Neighbourhood 1.
- A partnership with social services / CAB to understand the ‘deprivation’ in Neighbourhood 3 and how it can best be improved.
In response to CH’s question regarding the role of the Strategy and Development Committee SM stated that the CCG will need to have oversight of key developments.

The Committee NOTED the update on CAMHS provision.

14. **CCG Stakeholder Survey**

CM-S gave the report on the outcomes of the 2015 CCG Stakeholder survey and highlighted the following:

- The overall response rate was 63% which was higher than in 2014.
- Lewisham CCG compares favourably in benchmarking with a group of 20 other similar CCGs. However the results for the CCG across all domains are generally not as good as the 2014 survey.
- Strong communication and engagement with stakeholders is a positive theme across all domains.
- Other strong areas are the effectiveness of monitoring the quality of services, support for the CCG’s plans and priorities, the blend of skills and experience of the CCG’s leadership and confidence in the CCG’s clinical leadership.
- The area that is highlighted as a development requirement for the CCG is concerned with member practice familiarity and understanding of the CCG’s finances.

In response to DR’s question regarding the lack of response to the statement that ‘patients and the public have the opportunity to input into the CCG’s commissioning decisions’, CM-S stated that only 4 patient group stakeholders including Healthwatch could be asked the questions and none responded to that statement.

TR stated that to address the development requirement an executive summary of the finance report will be included for information in the papers for the Membership Forum. Members should also be encouraged to read the public documents available on the CCG’s website.

CM-S highlighted that a communications survey will be going out to members shortly to review the best methods of communication. A summary of the highlights of the outcomes to the stakeholder survey will be included in the Chief Officers report to the Governing Body and full report circulated to Governing Body Members.

**Actions:**

- A finance report to be included for information in the papers for the Membership Forum
- Outcomes of the stakeholder survey to be included in the Chief Officers and the full report circulated to Governing Body Members

The Committee NOTED the outcomes of the 2015 CCG Stakeholder survey

15. **SEL Clinical Leadership Groups Feedback**

There was no feedback from the SEL Clinical Leadership Groups.

**King’s College Hospital NHS Foundation Trust – Orpington Strategic Options**

TR tabled the feedback from the SEL CCG Commissioners on the Trust’s proposals. The response highlights the following issues:

- Commissioners’ concerns that the scale of service portfolio and investment in the Orpington site could make it a fixed site in the future.
Specific concern that a consolidated Trust orthopaedic centre at Orpington would establish a significant fixed point in the consideration of future orthopaedic and elective centre site options, which would impact on the considerations of the planned care options for the Our Healthier South East London (OHSEL) Strategy.

- No impact assessment for patients has been received on the proposal to move the neuro rehabilitation service from the Lewisham site to Orpington and Commissioners have requested further information on the discussions that have taken place with LGT in relation to the proposal.

The Committee expressed concerns that the proposals potentially undermine the objectives of Lewisham CCG and the OHSEL Strategy by increasing hospital bed capacity rather than increasing community based care. TR stated that the tabled response highlights that commissioners view the response as the start of the engagement process and not the definitive commissioner response.

**Action**

- TR to discuss a further response on the KCH Orpington proposals in consultation with MW and circulate a draft to the Strategy and Development Committee for comment.

**16. Minutes from sub-groups**

PEG: The approved minutes of the meeting held on 05.03.2015 were taken for information.

**Children and Young People’s Joint Commissioning Group:** The approved minutes of the meeting held on 26.01.2015 were taken for information.

**17. Key Messages from the Joint Strategic Needs Assessment and Engagement Process for Selection of Topics for 2015-16**

The report describing the process for engaging stakeholders and the wider community in the selection and production of needs assessment topics for the JSNA was noted.

**18. Any Other Business**

There was no other business.

**19. Date of Next Meeting**

Thursday 6th August 2015
MINUTES OF THE
HEALTH AND WELLBEING BOARD
Tuesday, 19 May 2015 at 3.00 pm

ATTENDANCE

PRESENT: Dr Marc Rowland (Chair of Lewisham Clinical Commissioning Group, Vice-Chair of the Health and Wellbeing Board, and Acting Chair for the meeting), Cllr Chris Best (Cabinet Member for Community Services), Aileen Buckton (Executive Director for Community Services, LBL), Elizabeth Butler (Chair, Lewisham and Greenwich NHS Trust), Jane Clegg (Director of Nursing, South London, NHS England), Dr Simon Parton (Chair of Lewisham Local Medical Committee), Rosemarie Ramsay (Healthwatch Lewisham), Dr Danny Ruta (Director of Public Health, LBL), Tony Nickson (Director, Voluntary Action Lewisham), Peter Ramrayka (Voluntary and Community Sector representative).

IN ATTENDANCE: Carmel Langstaff (Service Manager, Strategy and Policy, Community Services, LBL), Catherine Bunten (Policy Manager, Commissioning, Performance & Strategy, Children and Young People, LBL), Warwick Tomsett (Head of Commissioning, Performance & Strategy Resources, Children and Young People), Sarah Wainer (Head of Service, Strategy, Improvement and Partnerships, Community Services, LBL), Martin Wilkinson (Chief Officer, CCG), and Kalyan DasGupta (Clerk to the Board, LBL).

APOLOGIES: Apologies were received from Mayor Sir Steve Bullock (Chair), Brendan Sarsfield (Family Mosaic), and Frankie Sulke (Executive Director for Children and Young People, LBL).

Welcome and Introductions

The Acting Chair, Dr Marc Rowland, welcomed everyone and conveyed the Chair’s apologies for being unable to attend because of a prior engagement.

1. Minutes of the last meeting and matters arising

1.1 The minutes of the last meeting (24 March 2015) were agreed as an accurate record.

1.2 There were no matters arising.

1.3 Action Tracker

The following actions were agreed:

- No 6 (Primary Care Development Strategy): Martin Wilkinson will discuss with Marc Rowland about the proposed model for Primary Care and feed back at 7 July HWB.

- No 7 (Board’s vision/blueprint for whole health and care system): Closed.
• No 9 (HWB Work Programme – JSNA priorities): Closed.

• Nos 10 and 11 (technical actions for Kalyan DasGupta--draft agenda circulation and links into PDFs): Closed.

2. Declarations of Interest

There were no declarations of interest.

3. Adult Integrated Care Programme, Better Care Fund and Draft Joint Commissioning Intentions (Sarah Wainer)

3.1 Sarah Wainer (Head of Service, Strategy, Improvement and Partnerships, Community Services, LBL) provided members with an update on Lewisham’s Adult Integrated Care Programme, the Better Care Fund and the Joint Commissioning Intentions for Integrated Care.

3.2 With respect to “Patient Experience” (Sections 6.2-6.4 of the submitted report), Dr Simon Parton stressed the importance of encouraging the public to regard GPs as a valuable asset and resort rather than as a default option.

3.3 The Board:

• Noted the update provided on the Adult Integration Care Programme;

• Approved the process for approving the Better Care Fund quarterly return and noted the progress on the establishment of pooled budget arrangements (Section 75) for the Better Care Fund plan;

• Noted the findings of the joint public engagement exercise and the draft Commissioners response on the impact on the joint commissioning plans for integrated care.

• Agreed that the draft template should be circulated to the full Board concurrently with the Chair and Vice-Chair, for possible comments from members.

• Agreed that the final version should be signed by the Chair and Vice-Chair and circulated to the Board later.

• Agreed that Martin Wilkinson should feed back to the 7 July 2015 HWB a progress report, focusing on some key messages from the planned engagement exercise. (The Board also noted that the co-ordination of data is already underway under the direction of the AICPB and that CYP’s work is progressing via Customer Services.)

• Agreed that the HWB should publish the data in the interests of transparency.
• Agreed to consider the CCG Operating Plan as an Information item. Charles Malcolm-Smith to confirm whether the item will feature in July or in September 2015.

4. **Key Messages from the Joint Strategic Needs Assessment and Engagement Process for Selection of Topics for 2015-16** (Dr Danny Ruta)

4.1 Dr Danny Ruta (Director of Public Health, LBL) provided an overview of the health of the population of Lewisham and key challenges to inform the Health and Wellbeing Board and the Strategy. Additionally, he described the process for engaging stakeholders and the wider community in the selection and production of needs assessment topics for the JSNA.

4.2 The following points were highlighted:

- Lewisham continues to face notable health challenges. With a fast-growing population, these issues need to continue to be addressed through the Health and Wellbeing Board and its Strategy.

- The proposed process for engaging stakeholders and the wider community in selecting and prioritising JSNA topics for future needs assessments will ensure that the process is systematic and improved and overseen by the Health And Wellbeing Implementation Group, which is accountable to the Health and Wellbeing Board.

4.3 The following issues were raised or highlighted in the discussion:

- Radical action may be needed to address the inequality and needs, linked to poverty, of Lewisham’s Black and Minority Ethnic (BAME) population, especially regarding their mental health needs.

- Communication, through community engagement at neighbourhood level (e.g. through the Neighbourhood Care Network), is key to addressing the community's health and wellbeing needs.

- In key areas of risk, preventive measures should be implemented, especially targeted at children vulnerable to toxic stress, smoking, etc. Low birthweight among BAME babies is also an important area to address.

- Tony Nickson raised the issue of addressing the potential impact of impending service cuts on patients with long-term conditions.

4.4 The Board:

- Agreed the proposed process for engaging stakeholders and the wider community in the selection and production of needs assessment topics for the JSNA.
• Agreed to refer the data on the impact of impending cuts to patients with Long-Term Conditions to the Advice Consortium, which has already started to collect data.

• Thanked the writer and presenter for the report.

5. **Children and Young People’s Plan 2015-18: Engagement Process Progress Update** (Warwick Tomsett/Catherine Bunten)

5.1 Warwick Tomsett (Head of Commissioning, Performance & Strategy Resources, Children and Young People) and Catherine Bunten (Policy Manager, Commissioning, Performance & Strategy, Children and Young People, LBL) provided the Board with an update on the development of the Children and Young People’s Plan 2015-2018 (CYPP) and informed the Board of the timetable for publication.

5.2 The following points were highlighted:

- Children’s carers should be encouraged to take responsibility for the health of the children and to access GPs in a correspondingly responsible way.
- Pre-birth early intervention should be used for babies at risk of low birth-weight.
- Child and Adolescent Mental Health Services (CAMHS) should also be used as an early intervention tool. Headstart is designed for such interventions.

5.3 The Board noted the contents of the report.

6. **Health and Wellbeing Board Work Programme** (Carmel Langstaff)

6.1 Carmel Langstaff (Service Manager, Strategy and Policy, Community Services, LBL) presented the draft work programme for discussion and approval.

6.2 The following issues were raised or highlighted in the discussion:

- Elizabeth Butler proposed that the Greenwich and Lewisham NHS Trust should feed into the planned collaborative reports rather than producing separate ones of its own.
- There was a request to defer the CCG operating plan to September.

6.4 The Board:
- Agreed that the frequency of exception reporting on the HWB Strategy performance dashboard should be considered when the HWB Strategy is refreshed.
- Agreed to a CCG update on plans developed in response to the engagement activity re: the joint commissioning intentions.
- Agreed that the AICP update in September should focus on the neighbourhood community care model.
- Agreed to consider a paper on approaches to tackling FGM as an information item.
- Agreed that the Action Plan following the dementia event should be presented to the Board.
- Agreed that the following items could be included in the work programme:
  - The South East London Strategy
  - Healthwatch update (this could be an information item)
  - Feedback from the second Quality Summit.

7. Information items

7.1 The items were noted.

8. Any Other Business

8.1 There was no other business.

The meeting ended at 16:00 hrs.
Primary Care Joint Committees (PCJC)

11 June 2015

Meeting held at:
Coin Street Community Builders Coin Street 108 Stamford Street South Bank London SE1 9NH

Minutes

Meeting Chair  Diane French
Executive Support  Gilbert George

Bexley Primary Care Joint Committee

Attendees:

- Sandra Wakeford (SW)  Member  Committee Chair (Lay Patient Public Involvement)
- Keith Wood (KW)  Member  Committee Vice-Chair (Lay Governance)
- Mary Currie (MCV)  Member  CCG Governing Body Nurse
- Sarah Blow (SB)  Member  CCG Chief Officer
- Dr Howard Stoate (HW)  Member  CCG Chair
- Dr Sid Deshmukh (SD)  Member  CCG Governing Body GP
- David Sturgeon (DS)  Member  NHS England - Director of Primary Care
- Lotta Hackett (LH)  Observer  Healthwatch (Deputising for Anne Hinds Murray)
- Dr Richard P Money (RM)  Observer  Local Medical Committee
- Sue Robinson (SR)  Observer  Health and Wellbeing Board (Deputising for - Teresa O'Neill)

Apologies:

- Anne Hinds Murray  Healthwatch
- Teresa O'Neill  Health and Wellbeing
- Dr Jane Fryer  NHS England (Medical Director for South London)
- Matthew Trainer  NHS England (Director of Commissioning Operations)

Bromley Primary Care Joint Committee

Attendees:

- Martin Lee (ML)  Member  Committee Chair (Lay Patient Public Involvement)
- Harvey Guntrip (HG)  Member  Committee Vice-Chair (Lay Governance)
- Sara Nelson (SN)  Member  CCG Governing Body Nurse
- Dr Angela Bhan (Dr AB)  Member  CCG Chief Officer
- Dr Andrew Parson (AP)  Member  CCG Chair
- Dr Mark Essop (ME)  Member  CCG Governing Body GP (Deputising for - Dr Ruchira Paranjape)
- David Sturgeon (DS)  Member  NHS England - Director of Primary Care
Linda Gabriel (LG) Observer Healthwatch
Dr Mukesh Sahi (MS) Observer Local Medical Committee
Cllr David Jefferys (DJ) Observer Health and Wellbeing Board

Apologies:

Dr Ruchira Paranjape CCG Governing Body GP
Dr Jane Fryer NHS England (Medical Director for South London)
Matthew Trainer NHS England (Director of Commissioning Operations)

Greenwich Primary Care Joint Committee

Attendees:

Dr Greg Ussher (GU) Member Committee Chair (Lay Patient Public Involvement)
Jim Wintour (JW) Member Committee Vice-Chair (Lay Governance)
Dr Iyngaran Vanniasegaram (IV) Member CCG Governing Body - Secondary care clinician
Annabel Burn (ABu) Member CCG Chief Officer
Dr Ellen Wright (EW) Member CCG Chair
Dr Rebecca Rosen (RR) Member CCG Governing Body GP
David Sturgeon (DS) Member NHS England - Director of Primary Care
Leceia Gordon-Mackenzie (LG) Observer Healthwatch
Dr Dermot Kenny (DK) Observer Local Medical Committee
Cllr David Gardner (DG) Observer Health and Wellbeing Board

Apologies:

Dr Jane Fryer NHS England (Medical Director for South London)
Matthew Trainer NHS England (Director of Commissioning Operations)

Lambeth Primary Care Joint Committee

Attendees:

Graham Laylee (GLK) Member Committee Vice-Chair (Lay Governance)
Professor Ami David (AD) Member CCG Governing Body GB Nurse
Andrew Eyres (AE) Member CCG Chief Officer
Dr Adrian McLachlan (AM) Member CCG Chair
Dr Hasnain Abbasi (HA) Member CCG Governing Body GP
David Sturgeon (DS) Member NHS England - Director of Primary Care
Catherine Pearson (CP) Observer Healthwatch
Jenny Laws Observer Local Medical Committee

Apologies:

Sue Gallagher Committee Chair (Lay Patient Public Involvement)
Cllr Jim Dixon Health and Wellbeing Board
Dr Jane Fryer NHS England (Medical Director for South London)
Matthew Trainer NHS England (Director of Commissioning Operations)

Lewisham Primary Care Joint Committee

Attendees:
Ray Warburton OBE (RW)  Member  Committee Vice-Chair (Lay Governance)
Ami David (AD)  Member  CCG Governing Body Nurse
Martin Wilkinson (MW)  Member  CCG Chief Officer
Dr Jacky McLeod (JM)  Member  CCG Governing Body GP
David Sturgeon (DS)  Member  NHS England - Director of Primary Care
Rosemarie Ramsay (RR)  Observer  Healthwatch
Dr Simon Parton (SP)  Observer  Local Medical Committee
Carmel Langstaff (CL)  Observer  Health and Wellbeing Board

Apologies:
Diana Robbins  Committee Chair (Lay Patient Public Involvement)
Dr Marc Rowland  CCG Chair
Dr Jane Fryer  NHS England (Medical Director for South London)
Matthew Trainer  NHS England (Director of Commissioning Operations)

Southwark Primary Care Joint Committee

Attendees:
Diane French (DF)  Member  Committee Chair (Lay Patient Public Involvement)
Ami David (AD)  Member  CCG Governing Body Nurse
Andrew Bland (AB)  Member  CCG Chief Officer
Dr Jonty Heaversedge (JH)  Member  CCG Chair
Dr Sian Howell (SH)  Member  CCG Governing Body GP
David Sturgeon (DS)  Member  NHS England - Director of Primary Care
David Cooper (DC)  Observer  Healthwatch
Dr Kathy McAdam Freud (KMF)  Observer  Local Medical Committee
Rachel Flagg (RF)  Observer  Health and Wellbeing Board

Apologies:
Arti Gandesha  Healthwatch
Dr Claire Lloyd  Local Medical Committee
Dr Jane Fryer  NHS England (Medical Director for South London)
Matthew Trainer  NHS England (Director of Commissioning Operations)

Seminar – All six Joint Committees

<table>
<thead>
<tr>
<th>Item</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Meet and Greet</td>
</tr>
</tbody>
</table>

AB welcomed members, observers and members of the public to the inaugural meeting of the Primary Care Joint Committees (PCJCs) consisting of:

- NHS Bexley CCG and NHS England
- NHS Bromley CCG and NHS England
- NHS Greenwich CCG and NHS England
- NHS Lambeth CCG and NHS England
- NHS Lewisham CCG and NHS England
- NHS Southwark CCG and NHS England
AB explained that all six PCJCs had agreed to work collaboratively and in doing so they would meet at the same time and in the same place. He went on to explain that all of the committees had some degree of shared membership and that NHS England members were members of all six committees.

AB explained that in advance of the main agenda item the committee would receive a seminar style session outlining some background to the committees’ formation, under Primary Care co-commissioning arrangements now agreed for each borough as of 1 April 2015, collective working and the strategic context that was common to the six boroughs in south east London.

### 2 Introductory Seminar

AB introduced the seminar session of the Primary Care Joint Committees and invited SB to present the background to Primary Care Co-commissioning.

SB reminded Joint Committees that all six CCG Governing Bodies, acting with a mandate from their members had applied for and received approval as Level 2 co-commissioners of primary care or Joint commissioning with NHS England.

SB outlined how NHS England and the six CCGs will work together for primary care co-commissioning, giving focus to the NHS Five Year Forward View (FYFV) and specifically New Models of care. This would involve joining up the commissioning systems through co-commissioning to help unlock barriers to integrated care and the models described in the FYFV such as Multispecialty Community Providers (MCPs).

SB continued with a focus on how joint commissioning arrangements would allow for local flexibility alongside national requirements and the designing of locally focussed schemes.

SB spoke about ‘Our Healthier South East London and transformation of Community Based Care (CBC), which would be supported by Local Care Networks (LCNs) with federations or ‘At Scale’ delivery of general practice with collective responsibility for the population; developing the workforce; patient centred coordinated care and continuity of care.

AB then directed Joint Committees to the ‘Our Healthy South East London’ Strategy Programme including its ‘Whole system’ model. Emphasis was placed on the importance of LCNs, being the foundation of the whole system model providing person centred care to both individuals and to local populations. AB drew Joint Committees attention to the slide ‘Whole System Model’ – the model consisted of six models of care focused on by the programme:

- Community Based Care
- Maternity
- Children and Young People
- Cancer
- Planned care
- Unscheduled and emergency care

RW (Lewisham CCG) informed Joint Committees that he welcomed the ‘whole system model’ slide, but impressed on Joint Committees the importance of engaging with those who are marginalised and disenfranchised in our communities. There should be
clear pathways on how we are going to reduce inequalities in our communities. He also emphasised that we must find ways to reach out to those in our communities who are seldom heard so that we can make a difference to all sections of our communities.

ABu made Joint Committees aware that the ‘whole system model’ was developed with local authorities and she was confident that working together will deliver the outcomes desired by all. She also informed Members and Observers that south east London CCGs had good working relationship with the voluntary sector and that these were being strengthened.

JH commented that he understood the Primary Care Joint Committees governance structures, the commissioning intent but wanted to be informed on how having Primary Care Joint Committees specifically with NHS England could best strengthen our approach.

DS responded by outlining the advantage of NHS England working jointly with the six CCGs in making joint commissioning decisions that allowed the entire locally available NHS budget to be considered would underpin the implementation of the strategy.

### Meeting in Common of the Primary Care Joint Committees in South East London

#### 3 Welcome and Introductions

AB informed Joint Committees that to facilitate an effective meeting DF was asked to be the interim Chair of the meeting (as opposed to any one committee and this was acceptable to the members of all six committees.

DF asked members and observers to introduce themselves by name, position and organisation representing.

#### 4 Election of Chair for the meetings

AB requested nominations from amongst Chairs of the six Primary Care Joint Committees for the Chair and Vice-Chair for the Primary Care Joint Committees meetings.

GU was nominated to be Chair of the meetings of the Primary Care Joint Committees; there were no objections and GU was duly elected by chairs of all Committees to be the Chair of the Primary Care Joint Committee meetings.

ML was nominated as the Vice-Chair; there were no objections and ML was duly elected by all chairs to be Vice Chair of the Primary Care Joint Committees meetings.

Joint Committees agreed that the elected roles (Chair and Vice-Chair) would be for duration of 12 months with a review after six months.

#### 5 Terms of Reference

The Joint Committees noted the Terms of Reference for their respective committees which had previously been approved by the six CCGs Governing Bodies and Membership and with NHS England at the point of application for joint commissioning and subsequent approval.
Members of the Lewisham committee noted that the version of the Terms of Reference included in the Committee papers was an incorrect version and would need to be replaced with a correct version.

DS informed the Joint Committees that any fundamental changes to the approved Terms of Reference will require a further approval by NHS England.

A member requested clarification on how the Joint Committees would be able to manage budgets as outlined in the section ‘remit of Joint Committees’ in the Terms of Reference.

DS informed the Joint Committees that NHS England will be providing reports on budget and performance of the CCGs on a routine basis for discussion at the Joint Committees meetings and that under Level Two co-commissioning they remained responsible for doing so.

An observer noted that Terms of Reference gives no voting rights to those designated as ‘observers’ of the Primary Care Joint Committees and that this should be reviewed. DS confirmed that the terms of reference provided and approved compiled with national guidance. AB confirmed that the Terms of Reference and the wider application for co-commissioning had been the subject of a significant engagement process in each borough with the stakeholders including those groups from which ‘observers’ were drawn.

Members and Observers requested that the Bexley Terms of Reference be corrected for an error on page 6, 2nd paragraph.

6 Register of Interests

Members and observers of:

- NHS Bexley CCG and NHS England
- NHS Bromley CCG and NHS England
- NHS Greenwich CCG and NHS England
- NHS Lambeth CCG and NHS England
- NHS Lewisham CCG and NHS England
- NHS Southwark CCG and NHS England

Made their declarations of interests with reference to the register of interests that had been compiled in advance of the meeting (and was available at the meeting) and updated declarations where required.

The register of interest was agreed to be circulated to all members following the meeting and that it would be made available at the next meeting and all subsequent meetings.

7 Operating Model of Joint commissioning in south east London’s boroughs

AB introduced this section of the meeting and informed Joint Committees that it would consists of three elements:

- Primary Care Co-commissioning Memorandum of Understanding (MoU): Core principles (NHS England)
### Memorandum of Understanding (MoU)

DS informed Joint Committees that whilst the MoU had been approved by NHS England for use it was subject to change pending comments from CCGs and if changes were required then they would be brought to the Joint Committees before being enacted.

DS outlined the purpose and contents of the MoU. He also informed the committees that the resourcing in his team was subject to change and that individuals would have split roles between commissioning and performance / contracting.

### Draft Operating Model

DS drew the attention of the Joint committees to the Draft Operating Model, he reminded Joint Committees that all six south east London CCGs had opted for Level Two, which meant that NHS England and CCGs would be involved in decision making and as a result any decisions required by NHS England will be brought to the Joint Committees; unless they were being made under a clear National policy or an existing Standing Operating Procedure (SOP). All NHS England national policies or SOPs will be brought to the Joint Committees next meeting.

DS commented on the planned Service Level Agreement (SLA) for co-commissioning, he stated this was for those CCGs who had opted for level 3 or full delegation.

RW enquired how quickly financial reports would be published and made available in view of the remit of the Joint Committees to make decisions based on financial reports and recommendations from CCGs. DS replied that reports will be made available as per the normal cycle of reporting currently being used by CCGs (Monthly).

Joint Committees requested the following change and inclusion to the operating model:

- Guiding principles
- Themes and examples to add clarity
- An appeals process to be drafted into model
- Managing complaints – explicit statement
- Review process of the operating model
- Definition and examples of urgent decisions which cannot wait until the next committee
- Examples of other decisions the Joint Committees may make

AB (Southwark CCG) concluded that although the operating model was still work in progress, it was a document that the Joint Committees could work with until it was completed and ready for approval of the Committees. All parties agreed to operate in the spirit of the framework until that point.
AB introduced this paper emphasising the need to set up sub groups of the Joint Committees and to establish how these committees would report to and support the Committees. He also acknowledged an interdependency between this arrangement and the previous items in this agenda item as they need to reflect one another.

A LMC observer queried on who will be invited to join the sub groups referred to in the documentation. AB responded that this would be for local determination and may differ in each borough. It would be driven by the actions required of that group.

It was noted that the reference to the role of Local Medical Committee Page 5 of 13, bullet point would be replaced as follows:

The PCJC will include a representative from the relevant Local Medical Committee who [Delete - and will] represents the interests of GP providers who may be impacted by decisions taken at the PCJC. [Delete - The LMC representative will promote a greater understanding of commissioning and associated commissioner responsibilities amongst the primary care workforce they represent].

<table>
<thead>
<tr>
<th>8</th>
<th>Recommendations for amendment to the terms of reference for the Joint Committees</th>
</tr>
</thead>
<tbody>
<tr>
<td>The committees considered whether their review of the items outlined in the previous agenda items would require amendment to the committee Terms of Reference, beyond the changes required under item 5 of the meeting.</td>
<td></td>
</tr>
<tr>
<td>The committee members sought assurance that the Terms of Reference allowed for the establishment of working groups in support of the committee and determined that this was allowed for; noting that the outcome of the NHS England Operating Model work may require a future amendment.</td>
<td></td>
</tr>
<tr>
<td>The committee members also sought assurance that the Terms of Reference allowed for any appropriate matters to be considered in a ‘Part Two’ on private part of the committee business and again this was confirmed to be possible.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>9</th>
<th>Questions from members of the public</th>
</tr>
</thead>
<tbody>
<tr>
<td>A member of the public concurred with the desired outcomes outlined in the ‘whole system model’ and focus on health inequalities. He asked if funding would be made available for patients with mental health issues and why more innovative ways to treat patients with mental health issues had not been introduced by clinicians.</td>
<td></td>
</tr>
<tr>
<td>In addition, he asked about support for people with emotional distress and using models that have worked well in other countries to support people diagnosed with psychosis. He added that this approach has proven successful and would reduce dependence on the welfare state.</td>
<td></td>
</tr>
<tr>
<td>A member of the public stated that mental health staff should all be trained in the open dialogue approach. He went on to ask what percentage of South London and Maudsley NHS Foundation Trust (SLAM) funding is from CCGs and why SLAM recovery rates are low?</td>
<td></td>
</tr>
<tr>
<td>DF thanked members of the public for raising these issues and clarified that the Primary Care Joint Committees meeting was not the forum for decisions on care</td>
<td></td>
</tr>
</tbody>
</table>
pathways for mental health patients specifically but that these issues had been heard and requested that CCG commissioners take account of them when assessing their commissioning intentions for mental health services.

A member of the public asked for a glossary to be provided with the Primary Care Joint Committees papers.

DF responded by saying this was normal for other public committees of the CCGs. She added that circulation of papers for the next Joint Committees meeting will contain a glossary and apologised for not having one circulated at this meeting.

A member of the public asked whether there is Patient Participation Group (PPG) presence/influence on this committee. A number of committee members noted that their engagement with PPGs was undertaken through their governance structures that supported their Governing Body in its work and that as co-commissioners of care they welcomed the opportunity to receive and act upon that representation within those processes.

A member of the public brought the committees attention to his experience and that of people he had spoken with that waiting times for a GP appointment were ten days. DS invited further and specific details to be brought to his attention with regards this particular example.

| 10 | Meeting close |
**Primary Care Joint Committees**

11 June 2015

**Signed Attendance Sheet (Public and other observers)**

<table>
<thead>
<tr>
<th>Name</th>
<th>Affiliation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gary Beard</td>
<td>NHS England</td>
</tr>
<tr>
<td>Angela Buckingham</td>
<td>Melbourne Parkside</td>
</tr>
<tr>
<td>Rebecca Burns</td>
<td>Kings College Hospital NHS FT</td>
</tr>
<tr>
<td>Diana Braithwaite</td>
<td>NHS Lewisham CCG</td>
</tr>
<tr>
<td>Lesley Chandler</td>
<td>Public</td>
</tr>
<tr>
<td>Helen Chourn</td>
<td>DMC Patient Participation Group</td>
</tr>
<tr>
<td>Sharon Fernandez</td>
<td>NHS England</td>
</tr>
<tr>
<td>Malcolm Hines</td>
<td>NHS Southwark CCG</td>
</tr>
<tr>
<td>Liam Link</td>
<td>Public</td>
</tr>
<tr>
<td>Dolly Mace</td>
<td>Public</td>
</tr>
<tr>
<td>Susanna Masters</td>
<td>NHS Lewisham CCG</td>
</tr>
<tr>
<td>Andrew Parker</td>
<td>NHS Lambeth CCG</td>
</tr>
<tr>
<td>Barry Silverman</td>
<td>OHSEL Patient Public Advisory Group</td>
</tr>
<tr>
<td>Jill Webb</td>
<td>NHS England</td>
</tr>
</tbody>
</table>