AGENDA
A meeting of the Governing Body Part I

Date: 9 March 2017
Time: 10.00 am - 12.30 pm
Venue: Cantilever House, Eltham Road, London SE12 8RN
Chair: Dr Marc Rowland

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

Voting Members

Dr Marc Rowland (Chair)  
Martin Wilkinson  
Dr Faruk Majid  
Dr Angelika Razzaque  
Tony Read  
Dr David Abraham  
Dr Sebastian Kalwij  
Dr Jacqueline McLeod  
Ray Warburton OBE (Vice-Chair)  
Dr Charles Gostling

Chair
Chief Officer
Senior Clinical Director
Clinical Director
Chief Financial Officer
Senior Clinical Director
Clinican Director
Clinical Director
Lay Member
Clinical Director

Non-Voting Members

Aileen Buckton  
Dr Danny Ruta  
Dr Simon Parton  
Dr Magna Aidoo

Executive Director, Community Services, Lewisham Council
Public Health Director, Lewisham Council
Local Medical Committee Chair
Healthwatch Lewisham Representative

Quorum

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

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

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

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<tr>
<th>Time</th>
<th>Item</th>
<th>Papers</th>
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<td>1. 10:00</td>
<td>Welcome and introductions</td>
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<td>Chair</td>
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<td>2.</td>
<td>Apologies for absence</td>
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<td>3.</td>
<td>Declarations of Interest</td>
<td>1 - 2</td>
<td>Chair</td>
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<td>Members should discuss any potential conflicts of interest with the Chair prior to the meeting.</td>
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<td>4.</td>
<td>To agree minutes of the previous meeting</td>
<td>3 - 18</td>
<td>Chair</td>
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<td>To review the action log</td>
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<td>5. 10:05</td>
<td>Matters Arising</td>
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<td>6. 10:15</td>
<td>Chairs Report</td>
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<td>To receive and note for information</td>
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<td>To note Chair’s action for Annual Equalities Report</td>
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<td>Chief Officer’s Report</td>
<td>19 - 22</td>
<td>Martin Wilkinson</td>
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<td>Audit Committee Chair’s Report</td>
<td>23 - 24</td>
<td>Ray Warburton</td>
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<td>To receive and note for information from the meeting held on 24 January 2017</td>
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<td>9.</td>
<td>Finance and Investment Committee Chair’s Report</td>
<td>25 - 26</td>
<td>Tony Read</td>
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<td>To receive and note for information from the meeting held on 24 January 2017</td>
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<td>10.</td>
<td>Primary Care Joint Committee Chair’s Report</td>
<td>27 - 28</td>
<td>Ray Warburton</td>
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<td>To receive and note for information from the meeting held on 8 February 2017</td>
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<td><strong>Public Engagement and Equalities Chair's Report</strong></td>
<td>29 - 30</td>
<td>Dr Angelika Razzaque</td>
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<td><em>To receive and note for information from the meeting held on 28 February 2017</em></td>
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<td><strong>Questions in relation to agenda items from members of the public</strong></td>
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<td>13.</td>
<td><strong>Integrated Governance Committee</strong></td>
<td>31 - 48</td>
<td>Tony Read</td>
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<td><em>Chair’s report from the meetings held in January and February 2017</em></td>
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<td><em>To receive and note for information</em></td>
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<td>- <strong>Integrated Performance Report</strong> including Quality, Finance, QIPP and Performance</td>
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<td><em>To receive and endorse the report</em></td>
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<td>14.</td>
<td><strong>Board Assurance Framework (BAF)</strong></td>
<td>49 - 72</td>
<td>Martin Wilkinson</td>
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<td><em>To receive and agree the risks on the BAF</em></td>
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<td><strong>Equality Delivery System (EDS) 2 Summary Report for 2016</strong></td>
<td>73 - 84</td>
<td>Dr David Abraham</td>
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<td><em>To note the report and approve the publication of the EDS2 Summary</em></td>
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<td>16.</td>
<td><strong>Strategy and Development Workshop Chair's Report</strong></td>
<td>85 - 86</td>
<td>Dr David Abraham</td>
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<td><em>To receive and note for information from the meeting held on 2 February 2017</em></td>
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<td>17.</td>
<td><strong>Corporate Objectives 2017/18</strong></td>
<td>87 - 94</td>
<td>Martin Wilkinson</td>
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<td><em>To agree the Corporate Objectives high level summary and for IGC to be responsible for monitoring in year delivery of Corporate Objectives 2017/18 and for management of risks 2017/18 on behalf of the Governing Body</em></td>
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<td>18.</td>
<td><strong>2017/18 Draft Revenue Budget</strong></td>
<td>95 - 106</td>
<td>Tony Read</td>
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<td><em>To approve the start revenue budget 2017/18</em></td>
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<td>19.</td>
<td><strong>Treatment Access Policy (TAP)</strong></td>
<td>107 - 134</td>
<td>Dr David Abraham</td>
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<td><strong>To approve the 2017 South East London Treatment Access Policy</strong></td>
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<td>20.</td>
<td>12:05 <strong>Committee Terms of Reference</strong></td>
<td>135 - 166</td>
<td>Martin Wilkinson</td>
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<td>To review and approve the Terms of Reference for Governing Body Committees, reflecting the changes to the composition of the Governing Body from 1 April 2017</td>
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<td>21.</td>
<td>12:15 <strong>Delegated Commissioning - General Practice</strong></td>
<td>167 - 210</td>
<td>Martin Wilkinson</td>
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<td>To approve the Terms of Reference for the Primary Care Commissioning Committee and note Chair’s action</td>
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<td>22.</td>
<td><strong>Potential Audit and Risk Management Issues</strong></td>
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<td>To identify any issues which the Governing Body consider would benefit further scrutiny by the Audit Committee</td>
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<td>23.</td>
<td><strong>Any Other Business</strong></td>
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<td>24.</td>
<td>12:25 <strong>Questions from the members of the public</strong></td>
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<td>25.</td>
<td><strong>Approved committee minutes for information only</strong></td>
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<td>• Audit Committee (18 October 2016)</td>
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<td>• Strategy and Development Workshop (December 2016)</td>
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<td>• Public Engagement and Equalities Committee (December 2016)</td>
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<td>• Committee in Common (June 2016)</td>
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<td>• Primary Care Joint Committee (October and December 2016)</td>
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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.

Date of next meeting: Thursday, 11 May 2017, 10.00 am
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<th>Time</th>
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Chair: Dr Marc Rowland

Chief Officer Martin Wilkinson
Managing Conflicts of Interest: Governing Body, committees, sub-committees and working groups

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

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

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

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

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

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

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

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

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

9. These arrangements will be recorded in the minutes.
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Minutes of the meeting of the Lewisham Clinical Commissioning Group (LCCG) Governing Body held on Thursday, 12 January 2017 at Cantilever House, London SE12 8RN

Dr Marc Rowland Chair, LCCG (Chair)
Dr David Abraham Senior Clinical Director, LCCG
Dr Magna Aidoo Representative, Healthwatch Lewisham
Ms Aileen Buckton Executive Director Community Services, LB Lewisham
Dr Charles Gostling Clinical Director, LCCG
Dr Mark Hamilton Secondary Care Doctor, LCCG
Dr Jacqueline McLeod Clinical Director, LCCG
Dr Faruk Majid Senior Clinical Director, LCCG
Dr Angelika Razzaque Clinical Director, LCCG
Mr Tony Read Chief Financial Officer, LCCG
Dr Danny Ruta Public Health Director, LB Lewisham
Mr Ray Warburton OBE Lay Deputy Chair, LCCG
Mr Martin Wilkinson Chief Officer, LCCG

In Attendance

From Lewisham CCG, South East CSU, NHS England or London Borough of Lewisham:

Ms Lesley Aitken Board Secretary (notes), LCCG
Ms Alison Browne Director of Nursing and Quality, LCCG
Mr Russell Cartwright Head of Communications and Engagement, LCCG
Mr Mike Hellier Head of System Intelligence, LCCG
Mr Graham Hewett Associate Director of Quality and Designated Adult Safeguarding Manager, LCCG
Mr Charles Malcolm-Smith Associate Director, Strategy and Organisational Development
Ms Susanna Masters Corporate Director, LCCG
Ms Victoria Medhurst Associate Director, Integrated Governance, LCCG
Ms Jodie Moore Senior Associate, Communications, SECSU
Ms Hannah Reeves Corporate Services Administration Manager, LCCG

There were 11 members of the public present for the meeting.

Apologies

Dr Sebastian Kalwij Clinical Director, LCCG
Dr Simon Parton LMC Chair

LEW 17/01 Welcome and Announcements

Dr Rowland welcomed all to the Governing Body meeting. Dr Rowland explained that Ms Rosemarie Ramsay, Lay Member with responsibility for Public and Patient Involvement, had resigned from her post with the CCG for personal reasons. He expressed his regret and wished to thank Ms Ramsay for her work and wished her well for the future. Ms Ramsay joined the CCG as Lay Member in 2015 having previously been the Healthwatch representative on the Governing Body and had made a positive difference in the time she was with the organisation particularly regarding public engagement.
LEW 17/02  Declarations of Interest

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

LEW 17/03  Previous Minutes

The minutes of the Governing Body meeting held on 10 November 2016 were taken as a true record.

17/03.1  Minutes of September 2016 Annual General Meeting

Dr Rowland presented the minutes for the September 2016 Annual General meeting for approval. Mr Warburton felt that the meeting had been successful but was disappointed at the low number of members of public who had attended and asked how the CCG could ensure a higher attendance. Dr Rowland asked that if Governing Body members had any ideas on how to improve public involvement to discuss with Mr Russell Cartwright outside of the meeting.

Mr Read also highlighted that only three representatives of the Membership had attended the meeting, this was disappointing and a way to increase their involvement was also needed.

The Governing Body APPROVED the minutes as a true record of the meeting.

LEW 17/04  Action Log and Matters Arising

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

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

Mr Wilkinson pointed out that an action from the November 2016 meeting had not been added to the log;

16/118 – regarding the CAMHS Transformation Refresh overview; the full refresh document would be circulated to the Governing Body with an executive summary covering how it supported the CCG’s Public Sector Equality Duty. Mr Wilkinson said that Joint Commissioners had provided a case study which would be circulated to the Governing Body outside of the meeting.

ACTION: Martin Wilkinson

16/132  Mr Warburton clarified that he would be discussing the Conflict of Interest (CoI) process for the Lewisham Primary Care Strategy prior to the Primary Care Programme Board meeting.

There were no further items of matters arising items not already on the agenda.

LEW 17/05  Chair’s Report

Dr Rowland stated that last year had been an interesting year and that there were many challenges this year, though he felt positive as there were processes in place already to meet some of these challenges.

The Governing Body NOTED the report

LEW 17/06  Chief Officer’s Report

Mr Wilkinson reported that work had been undertaken to ease the pressures on A&E services since Christmas including investment of non-recurrent funding and work on discharge lists. The following was highlighted:

- Both Lewisham (UHL) and Queen Elizabeth hospitals had been full, with one 12 hour wait breach at UHL which was being investigated.
• There had been increased ambulance delays.
• Work was being undertaken on issues around A&E attendances and admission avoidance which included the new Ambulatory Centre and the opportunities of ‘hot’ clinics.
• There had been increased support for Care Homes
• There was pressure for other services to be used including Integrated Urgent Care (formerly NHS 111)

It was noted that there had, to date, been no confirmation back on the CCG’s proposal for Level 3 co-commissioning.

The Governing Body NOTED the report

LEW 17/07 Finance and Investment Committee’s Chairs Report

Dr Hamilton reported that he had been Chair of the Finance and Investment Committee since December 2016 but would also be giving the report from the meeting held in September 2016. For the September meeting it was highlighted:

• End of Life Care; the Committee had agreed to the consolidation to a single specialist palliative care service provider and approved, in principle, the development of a new Coordination Centre.
• Primary Care Extended Access Pilot; the Committee reviewed and endorsed the procurement approach which supported a single tender procurement approach as a pilot initially which was due to the framework of the service being explicitly linked to the GP registered lists.
• Primary Care Assessment Pilot; the Committee reviewed and endorsed the procurement approach to adopt the UCC Primary Care Assessment Pilot. The Senior Clinical Directors were not present for this and the Primary Care Extended Access Pilot items in order to manage any potential conflicts of interest.

For the December 2016 meeting:

• Integrated Urgent Care (IUC); The Committee agreed with the direction of travel but expressed concerns over the financial implications. The Senior Clinical Directors were absent from this meeting due to the potential conflict of interest.

The Governing Body NOTED the report

LEW 17/08 Primary Care Joint Committee (PCJC) Chair’s Report

Mr Warburton, as Vice Chair of the PCJC, gave the report from the meeting held on 15 December 2016. The following was highlighted:

• CQC Requires Improvement Potential Breach and Remedial Notices; Lewisham PCJC considered for approval the recommended actions proposed by NHSE for GP practices that had received a Requires Improvement’ rating following a CQC visit. It had been agreed to defer any decisions on these matters at this stage.
• Woodlands Health Centre; the recommendation that a single handed GP with a PMS contract took on an additional non-clinical partner was agreed.
• Proposed Partnership Merger for Lewisham; St. John’s Medical Centre, Hilly Fields Medical Centre, Brockley Road Medical Centre, Morden Hill Surgery and Honor Oak Group practice had agreed to pursue a merger of their individual practices into one partnership. This would result in the second largest registered size partnership in London. The practices proposed, from 1 April 2017, to work under a super partnership model, initially retaining each of the current PMS contracts held by the practices. The Lewisham Primary Care Programme Board had welcomed the proposal and requested that the PCJC noted the proposal and that both NHSE and the CCG would work with the practices to submit a business case in January 2017.

The Governing Body NOTED the report
LEW 17/09        Public Engagement and Equalities Forum (PEEF) Chair's Report

Dr Razzaque, as Acting Chair of the PEEF, gave the report from the Public Engagement and Equalities Forum held on 13 December 2016. Ms Rosemarie Ramsay, as Chair of PEEF, was thanked on behalf of PEEF for her work on driving forward public engagement and equalities issues on behalf of the residents of Lewisham.

The following was highlighted from the meeting:

- Musculoskeletal Assessment Treatment and Triage Service (MCATTS); patient engagement was reviewed which included the methodology used, the key outcomes and equalities analysis. No trends had been identified. The learning would feed into future commissioning.
- Public Engagement & Equalities; a forward plan was agreed which would align with the commissioning priorities and annual planning cycle with regular reporting back from the PRG.
- Public Reference Group (PRG); the monitoring and evaluation framework was being developed further to provide a process through which PEEF ensures that the PRGs activities meet the needs to the CCG.
- Annual General Meeting Table discussions; a draft of the summaries of the table discussions at the AGM were reviewed, these would be considered in the development of the urgent and emergency care services and preventative work undertaken by Public Health.

Mr Warburton added his praise for Ms Ramsay and her involvement in public engagement. Regarding the table discussions at the AGM he asked if it would be useful to know who said what, for example if an older person, in order to guide the CCG for future planning. Dr Razzaque agreed taking into account confidentiality issues, and explained that feedback forms were provided. In response to Dr Abraham on the desire to improve the interface between mental health and urgent and emergency care, Dr Razzaque said that this was indeed important as part of the active commissioning and engagement in integrating health and social care provision.

The feedback from the table discussions would be published on the CCG website and discussed at the PRGs and the commissioning workstreams. There was the possibility of a follow on event.

The Governing Body NOTED the report

LEW 17/10        Committee in Common Report

Mr Wilkinson presented the report from the Committee in Common meeting held on 29 November 2016 for information.

It was noted that under the section ‘key achievements’ the text should read ‘clarity on the objectives (rather than objections) and weighting from the financial assessment.’

The Governing Body NOTED the report

LEW 17/11        Questions for Members of the Public

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

Q. Asked whether the session held before the Governing Body meeting in public was minuted? Also regarding the sign off by Chair’s action of the consultative document for the Elective Orthopaedic Centre, should the Lewisham CCG position be subject to general consultation by the CCG membership as a whole?

A. Mr Wilkinson responded that the informal session was noted and published on the CCG website. He acknowledged potential difficulty with some accessing the website, he stated that hard copies would be brought to the following meeting. Other ways to disseminate information was currently being explored.
Dr Rowland responded to the second part of the question, that the consultative document would be discussed internally. Mr Warburton added that it originally looked like a two site option which excluded Lewisham Hospital was being proposed. Lewisham CCG’s views were raised at the CiC and the consultative document should reflect these comments.

**LEW 17/12 Board Assurance Framework (BAF) 2016/17**

Mr Wilkinson presented the updated on the BAF since the last Governing Body meeting in November 2016. He reported that the comments made at that meeting had been taken on board and adjustments made. The following was highlighted that for Risk 75; acute hospital activity was more focus on medium term planning with the right processes in place and a flow into A&E and the hospital. There were plans in place to reduce demand for emergency care.

Mr Warburton said that the BAF was a good focussed piece of work which related to the Integrated Governance Committee (IGC) report. He asked that:

- For R8, cancer waiting times and R78, acute providers delivering quality, A&E 4 hour standard, the target scores were not good as they remain a high risk, are these therefore optimistic.
- R41, safeguarding and healthcare providers in Lewisham do not have adequate arrangements for adult and or child safeguarding – the action that to invite all the small providers to the health safeguarding sub group, should be made stronger.
- There should be timescales on all actions included within the BAF

Mr Wilkinson agreed that there should be timescales on actions and the Risk Management Group would look into actioning this.

**ACTION: Susanna Masters**

Regarding R41, Dr Majid said that the CCGs had encouraged attendance of small providers acknowledging that it does not have a responsibility to make them attend all meetings. There was now an open style of safeguarding meetings with the opportunity for providers to learn from their peers. There was continuing scrutiny. Ms Browne added that the CCG worked closely with the Local Authority, in particular if a high number of alerts regarding a provider were received.

Ms Buckton commented that the Adult Safeguarding Board had a new Chair. The Board now had statutory powers with a framework to hold providers to account. The details of the new Chair would be circulated to Governing Body members outside of the meeting.

**ACTION: Aileen Buckton**

Responding to Dr Hamilton on the gaps in controls for R75, plans for reducing the demand of acute services in an emergency/urgent situation do not achieve the impact anticipated, Mr Wilkinson responded that there was a shared understanding of the flow of information through the system including data sets and daily information. There had been work across the three CCGs and Lewisham and Greenwich Trust (LGT) on the capture of activity. There was an issue with Quality Innovation Productivity and Prevention (QIPP) and how to get agreement, including enhanced care and support programmes.

Responding to Mr Warburton on the risks on cost of prescribing, delayed transfer to care and the London Ambulance Service (LAS) performance, Mr Wilkinson responded that the LAS were working across London on the issue of releasing ambulances to respond to 999 calls and to improve staffing levels. Regarding delayed transfer to care A&E, further work with the Local Authority was required. It was recognised that the overspend on prescribing had an impact on the overall budget.

Mr Read explained that these issues were covered by the IGC, though the objective to which the risk applied and credible actions plans was not apparent enough. He felt that some actions in the BAF were not sufficient to meet the objective or justified the target scores. He was concerned that the CCG was in danger of under stating the difficulties in achieving the target score.
Mr Wilkinson agreed that some actions could be more strongly articulated in the BAF. The BAF was continuously being refined but there was a need to decide how in future to best present it to the Governing Body. Feedback from the Governing Body was invited.

Mr Read pointed out that the third recommendation on endorsing that the CCG had adequate controls in place to mitigate the risks to the Corporate Objectives and where there are gaps in controls there are credible action plans to mitigate them could not be agreed as some of the objectives in the BAF do not have sufficient actions in place to mitigate the risk. It was agreed that the IGC would formally look into this area.

**ACTION: Martin Wilkinson/Susanna Masters**

The Governing Body:
- NOTED the changes to the CCG’s Corporate Risk Register which included the amendment to Risk 75 to ‘plans for reducing the demand for acute services (for both physical and mental health) in an emergency/urgent situation do achieve the impact anticipated’
- NOTED the Current and Target risk scores as shown within the BAF

**LEW 17/13 Integrated Governance Committee (IGC) Chair’s Report**

Mr Wilkinson gave the Chair’s report which summarised the main areas discussed at the IGC at the meetings of 24 November and 23 December 2016. Mr Read explained that the format of the report had changed for this meeting as it had been agreed at the IGC that there was a need to link the BAF more fully with the Integrated Performance Report to aid the flow of reports.

**Performance**

Mr Read highlighted the following exceptions where standards were not being met:
- There was a 12 hour from decision to admit breach at Lewisham Hospital in January 2017
- The key exceptions in terms of achievement of the NHS Performance Indicators:
  - The A&E 4 hour standard; performance at LGT was below the planned trajectory of 90%. There had been a marked improvement in the reduction in numbers of “ready for discharge” patients.
  - Cancer waiting times were behind plan with a cumulative performance 66.7%
  - Referral to Treatment (RTT) was behind plan. In October 2016 less than 92% (87.9%) were on an 18 weeks Incomplete Referral to Treatment plan.
  - Improving Access to Psychological Therapies (IAPT); and mental health standards were being met except the service users reaching recovery at the end of their therapy; which is meeting our agreed improvement trajectory.

**Finance at Month 8**

- The CCG was on target to deliver the planned surplus
- There had been an increase to allocation for overseas visitors relating mainly to mental health services
- There were low levels of reserves, all of which have to be fully utilised to deliver the year end planned surplus
- Some budgets were experiencing overspend pressures which were being compensated for partly by underspends in other budgets and by the utilisation of reserves, notably:
  - Occupied bed days for adult mental health services
  - Continuing Health Care
  - Acute hospital services
- The QIPP savings forecast for 2016/17 was on plan

**Quality**

- The IGC had been monitoring the reported excess deaths from pneumonia at LGT; a subsequent audit identified some coding issues that could have presented an overestimation of pneumonia deaths.
The CQC Inspection of the Emergency Department at QEH; the urgent and emergency services and medical care services at QEH had both been rated as ‘requires improvement’. Work was ongoing to take forward the provider action plan.

Mr Read added that there had been an overspend of £400k for Prescribing at Month 8 which was decreasing in recent months. The Head of Prescribing came to the last IGC meeting and gave an overview of the work being undertaken with GP practices to address the overspend.

The Governing Body NOTED the IGC Chair’s report from 24 November and 23 December 2016 and NOTED the Integrated Performance Report


Mr Read gave the report which introduced the December 2016 submission of the Lewisham CCG Operating Plan which summarised the financial plan, NHS Constitutional targets plan, activity and data assurance and contract status. This year’s submission of the Operating Plan was earlier than previous years on 24 November (draft) and 23 December (final draft). It had been difficult to adjust the business cycle to conform to the new timetable but there had been good work with partners to meet the deadlines.

The contracts with our main providers had been agreed. A draft budget 2017/18 would come to the March 2017 Governing Body.

The headlines were:

- The uplifts of 2.5% for both years were the lowest experienced in the 5 year planning period of the STP.
- The CCG financial plans had minimal reserves and required £14m and £13m of QIPP efficiencies to be delivered in 2017/18 and 2018/19 respectively (3.3% of recurrent revenue resource limit (RRL)). For 2017/18 unidentified QIPP plans were currently £1.278m.
- There had been two RRL adjustment reductions: one relating to a transfer of responsibility for some specialised services. This is expected to be cost neutral to the CCG and the other relating to the introduction of the new HRG4+ tariff for 2017/18. Nationally the expectation is that this change is cost neutral to the CCG, however current estimates indicate a significant cost pressure to the CCG.
- There was a balanced financial plan but this is only achieved with significant risk
- The activity baselines and the forecast for 2017/18 had been agreed with providers with additional adjustments for increases in population, non-demographic reasons and the demand management plan.
- Constitutional Standards; the CCG was forecasting to meet all standards with the exception of:
  - A&E; which would not achieve the national 95% target. The draft improvement trajectory was 89% for Lewisham and Greenwich Trust.
  - RTT; it is anticipated that this target will not be met at King’s. There are challenges to delivery at LGT and an action plan is in development.

Dr Rowland said it was a good report especially recognising the tight deadlines. The team was thanked for their efforts.

Dr Hamilton asked whether there was confidence that the required QIPP efficiencies would be delivered, Mr Read responded that the Governing Body should be scrutinising the QIPP plans and QIPP delivery in particular. There was £1.278m still unidentified for 2017/18. That position is worse for 2018/19. The 2017/18 target is double the amount required for 2016/17 and the risks to delivery are considerably higher. There was a high risk profile across all budget headings. There was to be a discussion at the Clinical Directors meeting on 19 January to look at the QIPP opportunities and challenges. The discussion from this meeting would be shared with Governing Body members.

**ACTION: Tony Read**

In response to Dr Hamilton, Mr Wilkinson said that QIPP progress would be tracked through IGC meetings and QIPP workstream meetings which followed a programme management approach.
Mr Read confirmed that the full detail on the contracts went to IGC and would come back to the Governing Body through the next IGC Chair’s report.

The Governing Body NOTED the current position of the operating plan and contracts; AGREED the approach being taken to achieve our commissioning and financial targets for the next two years and NOTED the activity data quality

LEW 17/15 Annual Reports and Accounts 2016/17

Mr Read summarised the report which requested that the Governing Body agreed for authority to be delegated to the Audit Committee for approval and submission of the audited Annual Report and Accounts 2016/17 to NHS England.

Mr Warburton stated that the Audit Committee accepted the delegated responsibility and requested that a final as possible draft Annual Report was received by the Audit Committee at its meeting on 28 March 2017.

The Governing Body NOTED the timeline for preparing and approving the 2016/17 Annual Report and Accounts, delegated authority to approve the 2016/17 Annual Report and Accounts to the Audit Committee and NOTED the management arrangements in place prepare the content of the annual report and accounts.

LEW 17/16 Strategy and Development Workshop Chair’s Report

Dr Abraham gave the report from the Strategy and Development Workshop held on 1 December 2016 which discussed embedding equalities in the CCG. Dr Abraham was not at the meeting but acknowledged the challenges the CCG face and the need to have access to more detailed data about disease prevalence for the population, for example against age and ethnicity.

Mr Wilkinson added that the workshop had been useful with the outputs of the meeting being fed into CCG work and the draft Annual Equalities Report. Mr Warburton stated that regarding EDS Goal 4 – inclusive leadership, he knew that the CCG was committed to fairness and equity but that the Governing Body needed to be more demonstrative on these issues.

Responding to Dr McLeod on whether data could be provided from Public Health on disease prevalence for the population especially in relation to the protective characteristics, Dr Ruta stated that this was a JNSA (Joint Needs Strategic Assessment) area with groups looking into required topics including ethnicity and health. Ms Buckton added that there was a potential to look at other areas including those patients who had both District Nursing and Domiciliary visits. She agreed that specific data was required.

The Governing Body NOTED the report

LEW 17/18 Annual Equalities Report

Mr Wilkinson presented, and asked for any comments on the draft Annual Equality report. Chair’s action would then be required to approve the final report before publication by 31 January 2017. The following aspects of the Equality Delivery System (EDS) were highlighted:

- Goal 1; Better Health Outcomes and Goal 2; Improved Patient Access and Experience – work had been undertaken with the Public Reference Group which along with local people were invited to join the External Stakeholders panel. The areas they chose to focus on were; maternity services, Home Treatment Team for Adults Mental Health – working age adults and Community Anti-coagulation monitoring service
- Goal 3; A Representative and Supported Workforce; the outcomes of the staff survey would inform four of the Goal 3 outcomes.
- Goal 4; Inclusive Leadership; the Governing Body members were asked to provide examples of how they had demonstrated their commitment to Equality and Diversity since November 2015. An independent third party had been invited to assess and grade the evidence.
Since 2016-16 all CCGs were required to demonstrate that they were giving due regard to using the Workforce Race Equality Standard (WRES) indicators and that they were assured that their providers were implementing the WRES.

Dr Rowland said that it was an excellent report.

Dr McLeod, on the CCG’s main providers being stated as only LGT and SLaM, asked whether other neighbouring CCG’s have the same equality process, Mr Wilkinson responded that this was the case, however the CCG was not involved in the quality meetings for GSTT and King’s which Lambeth CCG and Southwark CCG covered respectively, but agreed that the CCG’s main provider should be added to the report.

**ACTION: Charles Malcolm-Smith to inform Ms Valerie Richards**

Mr Warburton welcomed the comprehensive report and congratulated Ms Richards on being invited to the Equality Delivery System (EDS) Council where the EDS approach in Lewisham report was taken as a good practice example.

Mr Warburton commented that the report could be strengthened with some changes:

- The commissioning cycle section to mention more on equalities.
- The case study for the SEL Integrated Urgent Care Service Procurement was good but that the Reducing Harm from Community Acquired Pressure Ulcers needed to be expanded and a mention of what was being achieved for the BMI community to be included.
- Equalities objectives to be linked with the STP and Corporate Objectives

Dr Hamilton said that the direction of travel was good and that there should be the same rigour for all monitoring data collection to include protected characteristics.

**The Governing Body considered the Lewisham CCG’s draft Annual Equality report and AGREED to Chair’s action to approved the Annual Equality Report to be published by 31 January 2017**

**LEW 17/19 Sustainability and Transformation Plan (STP) Submission**

Dr Abraham presented the report which introduced the final submission of the south east London STP. The Governing Body was asked to endorse the direction of travel recognising the need to be locally focussed. The STP was a south east London collaborative document including engagement with the public and clinicians. There had been a focus, with a clinical perspective on outcomes, quality, equity, patient experience and sustainability. The challenges had been recognised including the scale and impact on savings.

Mr Wilkinson added that providers were working together for mutual benefit around areas including ordering, procurement, equipment and back office support. There were some issues raised as a Governing Body which would be referenced in the CCG endorsement.

Mr Warburton asked the following:

- How the leadership team, ‘the quartet’, would feedback to the CCG. Mr Wilkinson responded that the governance of the quartet is through the sovereign bodies. The Strategic Planning Group would feed into the new boards for clinical redesign and provider production. The quartet was a coordination body.
- Is the STP the successor to Our Healthier South East London (OHSEL)? Mr Wilkinson said that was correct and was now system led rather commissioning led collaborative work, but was still called OHSEL, the case for change had not changed.
• Was the statement ‘from 2018, all practices will offer online as well as telephone booking, and will also allow every single patient to manage their prescription and medical records online’ correct. Mr Wilkinson responded that work was ongoing with Primary Care to offer the facility to allow every patient to view their medical records. This was still to be rolled out.

• Was ‘we are planning to consult on proposals to develop two new specialist orthopaedic centres’ correct. Mr Wilkinson responded that the report was written before Christmas and would need to be changed in line with the new proposals to consider the three site option. The Committee in Common preference was the consolidated model. The consultation was planned to commence in the Spring.

Ms Buckton added that the six Local Authorities were all involved in pulling the proposals together and had a scrutiny function rather than decision making role. Conversations were being held regarding Local Authority involvement in a supportive role.

Dr Rowland agreed with Dr McLeod in that there was no detailed narrative on the transformation and development of a resilient workforce. Mr Wilkinson explained that behind the STP document there was an implementation plan, this would be reviewed at the Strategy and Development Workshop to give assurance on how the work was being taken forward.

**ACTION: Strategy and Development Forward Planner**

Mr Wilkinson updated that at the last Committee in Common meeting it had been agreed that the elective orthopaedic consultation would now be in the spring due to further work on; provider collaboration, the three site option, workforce implications and medical director sign off. The Governing Body would be kept up to date over the coming months.

**The Governing Body ENDORSED the STP as the right strategic direction for the NHS in south east London and NOTED developments on the elective orthopaedic proposals**

**LEW 17/20 Potential Audit and Risk Management Issues**

To look at the BAF and flow of reports through the Governing Body papers.

**ACTION: Dr Marc Rowland/Martin Wilkinson/Susanna Masters**

**LEW 17/21 Any Other Business**

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

**LEW 17/22 Questions from Members of the Public**

Questions were taken from members of the public.

Q. When assessing the risk around Health Visiting with the Council please could account be taken be taken of other cuts that are coming through including those around child safeguarding assessment and school nursing?

Regarding the risks to the STP model the viability of the vision regarding community based care has silo assessment of savings with the risk of treble counting including the QIPP challenge and savings on consolidation. OHSEL have said that there was a risk of double counting of £242m. What kind of quality of staff will be available, there is a financial risk on the viability of the plan.

A. Ms Buckton responded that there were no proposals for further cuts to School Nursing or Health Visiting, though it was known that there were further cuts expected from central government to the Public Health budget with no identification on how to achieve them yet. There is recognition of the importance of the financial impact on 2018/19.

Dr Ruta added that there were changes to the threshold of risk in regard to safeguarding; there was recognition of the gaps in the Child Protection plan. The service would be redesigned to
address the gaps. He stressed that safeguarding was a priority and any issues would be monitored.

Q. Clarification was requested about the statement around online prescriptions. Not all GP surgeries have this in place but there was a plan for all patients to have the opportunity to access their medical records online.

A. Mr Wilkinson agreed that it is planned all patients would have the choice to have online access to prescriptions. Mr Warburton said that the statement in the STP read as too definite there may need to be support to access online prescriptions, also to bear in mind there are numerous other routes to get prescriptions.

Q. I am pleased the Governing Body accepted the direction of travel of the STP and not the specifics. Lewisham’s response to the STP and the two-year Operating Plan should be made explicit in the public domain and to NHSE.

Regarding the Equality Review and the STP – Currently sickle cell patients are sent to GSTT but could get immediate treatment from LGT A&E. There would be better treatment at Lewisham Hospital, orthopaedics are a part of the sickle cell symptoms.

A. This was noted.

Q. In the spirit of working together should there be a member of the Trust attending the Governing Body meeting.

A. Mr Wilkinson responded that there were other more effective ways of facilitating collaborative working and that a Board to Board meeting had been arranged with LGT and that the CCG met with providers in other meetings.

**LEW 17/23 Reports Taken for Information**

The approved minutes from the following meetings were taken for information:

- Integrated Governance Committee (October and November 2016)
- Strategy and Development Committee (October 2016)
- Public Engagement and Equalities Committee (October 2016)
- Health and Wellbeing Board (July 2016)

**LEW 17/24 Date of Next Meeting**

The next meeting of the Governing Body would be held on Thursday 9 March 2017 at Cantilever House, Eltham Road, London SE12 8RN
<table>
<thead>
<tr>
<th>Minute Ref</th>
<th>Action</th>
<th>Owner</th>
<th>Agreed at meeting</th>
<th>Due Date</th>
<th>Status</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>16/118</td>
<td>CAMHS Transformation Refresh overview: the full refresh document with an executive summary to be circulated to Governing Body members. A case study from Joint Commissioners as relates to Equalities Duty would be circulated outside of the meeting.</td>
<td>Martin Wilkinson</td>
<td>January 2017</td>
<td>March 2017</td>
<td>To be closed</td>
<td>Completed – Circulated to Governing Body members on 3 March 2017</td>
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<tr>
<td>17/12</td>
<td>BAF: Timescales on actions would be included, to be actioned by the Risk Management Group</td>
<td>Martin Wilkinson/ Susanna Masters</td>
<td>January 2017</td>
<td>March 2017</td>
<td>To be closed</td>
<td>Updated BAF now includes timescales for actions where agreed.</td>
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<tr>
<td>17/12(i)</td>
<td>Details of the new Adult Safeguarding Board Chair to be circulated outside of the meeting</td>
<td>Aileen Buckton</td>
<td>January 2017</td>
<td>March 2017</td>
<td>To be closed</td>
<td>Details received and to be circulated by the March Governing Body meeting</td>
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<tr>
<td>17/12(ii)</td>
<td>The IGC to formally look into the issue that some of the objectives in the BAF do not have sufficient actions in place to mitigate the risks.</td>
<td>Martin Wilkinson/ Susanna Masters</td>
<td>January 2017</td>
<td>March 2017</td>
<td>To be closed</td>
<td>Updated BAF has been reviewed by the IGC on 23 February to ensure sufficient actions in place to mitigate the key risks</td>
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<tr>
<td>17/14</td>
<td>Discussion from the Clinical Directors meeting on 19 January regarding QIPP opportunities and challenges would be shared with Governing Body members</td>
<td>Tony Read</td>
<td>January 2017</td>
<td>March 2017</td>
<td>To be closed</td>
<td>Slide pack from the meeting and subsequent minute was circulated to the members on 3 March 2017</td>
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<tr>
<td>17/18</td>
<td>The CCG’s main providers to be included in the Annual Equalities Report</td>
<td>Charles Malcolm-Smith</td>
<td>January 2017</td>
<td>January 2017</td>
<td>To be closed</td>
<td>This had now been included in the Annual Equalities Report</td>
</tr>
<tr>
<td>17/19</td>
<td>The implementation plan of the STP would be reviewed at the Strategy and Development Workshop to give assurance on how the work was being taken forward</td>
<td>Martin Wilkinson</td>
<td>January 2017</td>
<td>January 2017</td>
<td>To be closed</td>
<td>To be scheduled into the S&amp;D forward planner 2017/18</td>
</tr>
<tr>
<td>17/20</td>
<td>To look at the BAF and flow of reports</td>
<td>Martin Wilkinson/</td>
<td>January</td>
<td>To be</td>
<td></td>
<td>Piloting for the March</td>
</tr>
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through the Governing Body papers.

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<tr>
<th>Minute Ref</th>
<th>Action</th>
<th>Owner</th>
<th>Agreed at meeting</th>
<th>Due Date</th>
<th>Status</th>
<th>Comments</th>
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<tbody>
<tr>
<td>16/116</td>
<td>Primary Care Engagement Plan - A formal plan with an action plan to be</td>
<td>Diana Braithwaite</td>
<td>November 2016</td>
<td>January 2017</td>
<td>Closed</td>
<td>This is a part of the development of Integrated Urgent &amp; Primary Care and will be monitored on a monthly basis by the appropriate working group</td>
</tr>
<tr>
<td>16/124</td>
<td>The wording of Risk 65, Quality of Primary Care, to be changed to reflect</td>
<td>Susanna Masters</td>
<td>November 2016</td>
<td>Risk Management Group – December 2016</td>
<td>Closed</td>
<td>Risk 65 has been amended and will be reported at the January 2017 Governing Body meeting</td>
</tr>
<tr>
<td>16/124.1</td>
<td>Further detail on Risk 66, Quality Assurance of Private Providers, would be circulated to Governing Body members outside of the meeting to provide assurances of the process to accept the risk by the Chief Officer was appropriate.</td>
<td>Susanna Masters</td>
<td>November 2016</td>
<td>January 2017</td>
<td>Closed</td>
<td>Further information on Risk 66 was circulated outside to the meeting on 8 December</td>
</tr>
<tr>
<td>16/132</td>
<td>Discussion to be held with Mr Warburton as CoI Guardian on managing the CoI process for the Lewisham Primary Care Strategy</td>
<td>Ashley O'Shaughnessy</td>
<td>November 2016</td>
<td>January 2017</td>
<td>Closed</td>
<td>This will be picked up at the January 2017 Primary Care Programme Board</td>
</tr>
</tbody>
</table>
1. **Primary Care Co-commissioning Update**

Following the application to take on delegated commissioning of primary medical services, NHS England has confirmed that NHS Lewisham CCG has been approved to take forward these new arrangements from 1 April 2017.

Delegated commissioning offers further opportunities to develop more integrated out-of-hospital services and improve the quality of primary care GP services.

2. **Operating Plan**

Since reporting on the operating plan to the January meeting of the Governing Body, we have submitted a further iteration of the plan to NHS England on 27th February. There is no change to the overall financial plan previously reported. The unidentified QIPP target has reduced from £1.2m to £0.6m and we are committed to identify the remaining £0.6m by 17th March. We have undertaken a further review of risk associated with the QIPP and activity plans, in particular those aspects that are not embedded in our signed contracts. We have reviewed our A&E 4 hour wait improvement plans and have increased our expected improvement from 89% to 90% for the year 2017/18. We have also worked through the implications of the reduction in the Kings College Hospital improvement trajectory for the Referral to Treatment standard which means that the standard will not be achievable 2017/18 to 2018/19 for Lewisham patients.

We have signed contracts for 2017/18 with all of our major NHS providers.

3. **Better Care Fund**

It was reported in the January Chief Officer’s report that the publication date for the 2017-19 Better Care Fund Policy Framework and Planning Guidance had slipped. The Policy Framework and Planning Guidance are in the process of being finalised and publication is now expected in March 2017. The BCF Plan 2017-19 will be an evolution of the 2016/17 Plan and, subject to the policy framework and planning guidance, is expected to continue to fund activity in the following areas:

- Prevention and Early Intervention
- Primary Care including supporting extended access to GP services.
• Community based care and the development of neighbourhood care networks
• Enhanced Care and Support to reduce avoidable admissions to hospital and to facilitate timely discharge from hospital.
• Estates and IMT

As in previous years, the Better Care Fund Plan will be signed off by the Health and Wellbeing Board.

3. **Changes to the Constitution following Conflicts of Interest Approval**

NHS England has a responsibility to assure that the changes requested to CCG Constitutions comply with the requirements of the NHS Act 2006 as amended by the Health and Social Care Act 2012 and are otherwise appropriate.

Lewisham CCG applied for amendments to the constitution reflecting strengthened Conflict of Interest arrangements as set out in the new Policy and the composition of the Governing Body, as approved by the Governing Body in November 2016; the change from NHS Commissioning Board to NHS England (trading name) and the amendment of the composition of the Clinical Directors Committee (Executive Committee) to include “The Chair of the CCG is an ex-officio member of all committees and sub groups except for the Audit Committee. A CCG Chair cannot be member of the CCG Audit Committee.” NHS England have reviewed these changes and are assured that the constitution complies with the requirements as set out above.

4. **SEL Collaborative Arrangements**

In order to ensure that we remain fit for purpose in meeting the needs of our local population, we are going to review current arrangements across the six clinical commissioning groups (CCGs) in south east London. The review is expected to make recommendations for how the CCGs can work together more closely to improve performance and benefit our local population. We are not merging the six CCGs. The review is likely to recommend an increase in collaboration across CCGs.

We are all well aware of the many challenges facing the NHS both nationally and locally. The NHS Five Year Forward View articulated these key challenges as gaps in: health and wellbeing; care and quality; and funding and efficiency. To effectively respond to these challenges requires us to review our existing collaborative arrangements. The six CCGs will continue to work together to help ensure that what needs to be done locally happens locally, and what it makes sense to do together, we collaborate on.

5. **Centralised Place of Safety**

The Centralised Place of Safety (CPoS) opened at the Maudsley Hospital to Lewisham residents/patients on the 7th February 2017 and is one of the first multi-borough dedicated 24 hour services for individuals that have been sectioned by the
police under 136/135 of the Mental Health Act in London. The CPoS is fully staffed and has four dedicated beds with two step down beds. The CPoS covers the boroughs of Lewisham, Croydon, Lambeth and Southwark and will also be supported by Adult Social Service Approved Mental Health Social Teams from each borough. A strategic steering group comprised of Social Care and Commissioning leads is currently being developed to provide oversight and will consider regular reports on its activity.

6. **Risk Management Workshop**

On the 23 February a workshop for the Governing Body and Officers of the CCG was held on Risk Management. The workshop was very helpful in further developing our understanding of the subject and was well attended by a good mix of Governing Body members and officers. Whilst it is acknowledged that the processes and grasp of this subject has improved during this financial year, we recognise that we could still improve further integrating risk into our management and monitoring of the achievement of our Corporate Objectives.

**Martin Wilkinson**  
2 March 2017
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Main issues discussed

As its deep dive, the Committee discussed the CCG’s approach to identifying and dealing with Conflicts of Interest.

The Committee received a progress report from its Internal Auditors, KPMG, and discussed the report from its review into Risk Management.

KPMG also explained their Risk Benchmarking Report, which reviewed the Board Assurance Frameworks of 28 CCGs.

The Service Auditor Report (SAR) for the South East Commissioning Support Unit for March to August 2016 was presented.

The CCG’s External Auditors, Grant Thornton, shared the planned timeframes for the 2016/17 External Audit.

The CCG’s Local Counter Fraud Specialists, TIAA, reported on recent work including results from the Fraud Awareness Survey Report.

The CCG’s Local Security Management Service, also TIAA, reported on recent work, and provided an overview of the work to be completed before the end of the financial year.

The Chief Finance Officer reported on two waivers to the Standing Financial Instructions since the last meeting of the Committee.

The Chief Finance Officer also explained the Month 9 accounts for the CCG, which had been submitted to NHS England.

Key achievements

The Committee was satisfied that Conflicts of Interest were being handled well, and that the 2016 guidance from NHS England had been well understood and incorporated into the CCG’s evolving policies and practice. Suzanne Masters and Victoria Medhurst were thanked for their good work on this policy.

KPMG reported that the CCG’s Risk Management arrangements had achieved an overall assessment of ‘significant assurance with minor improvement opportunities’ (amber-green). Actions to address these opportunities would be completed by end of March 2017 and had been agreed by management.
The results of the Fraud Awareness Survey were very positive, with most CCG staff being aware of what fraud amounted to and how to go about reporting it.

The Month 9 accounts exercise had gone well, and provided a useful dry run for the actual closing and reporting of the accounts for the year in April and May.

**Key challenges addressed**

During the discussion of risk management, ideas for the better description of risks were aired together with ways to improve the interface between the Performance Report and the Board Assurance Framework. A further workshop on Risk Management, scheduled for 23 February 2017, will pick up these and other themes.

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

Based on the benchmarking report shared by KPMG, the CCG might consider how to more fully represent its own workforce issues, and those of its main providers, in the Board Assurance Framework.

While the results from the Fraud Awareness Survey were positive, more could be done to ensure that CCG staff know how, and are encouraged, to raise concerns.

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

On this occasion there were no agenda items of direct relevance to inequalities and fairness.

23 February 2017
Report of the Chair of the Finance and Investment (FIC) Committee

The FIC met on 24 January 2017. There were no new investment proposals for consideration.

The Committee reviewed its Terms of Reference to strengthen arrangements for managing Conflicts of Interest and including a second lay member to the membership.

The Committee considered the risks inherent in the CCG’s financial plans and QIPP plans for 2017/18 to 2018/19 and concluded that there is a case to strengthen our PMO and delivery plans for QIPP in 2017 – 2019 due to the significant challenge posed.

Chair: Dr Mark Hamilton
1st March 2017
Governing Body meeting on 9th March 2017

Report from Ray Warburton OBE, CCG Lay Member and Vice Chair of the Primary Care Joint Committee (PCJC)

Date of Meeting reported: 8th February 2017

Author: Ashley O'Shaughnessy, Deputy Director of Primary Care

The Lewisham Primary Care Joint Committee with NHS England was held in common with the other South East London Primary Care Joint Committee’s on the 8th February 2017.

1. Overview from Director of Primary Care, NHS England (London Region)

The Director of Primary Care, NHS England (London Region) gave a progress update on key elements of the GP Forward View including the General Practice Resilience Programme and implementation of extended GP access.

2. Update on GP Premises developments in South East London

An update was given on the Estates and Technology Transformation Fund and the London Improvement Grant Programme.

3. Quality, performance and finance update

Quality and performance

The GP Commissioning and Contracting Quality and Performance Report for January 2017 was presented which includes summary information regarding:

- GP Patient Survey
- Friends and Family returns
- Quality & Outcomes Framework
- CQC reports

Month 9 Finance report

Nine months results to 31st December 2016 are showing an underspend of £180k (0.6%) due to underspends on premises cost and enhanced services offset by QIPP under achievement after a non-recurrent benefit from 2015/16 accruals (£150k). Refunds in relation to prior year business rates are expected to contribute towards the QIPP savings target.

The forecast year end outturn variance based on month 9 is an underspend of £244k after a non-recurrent benefit on prior year accruals (£200k).

Lewisham’s weighted population has increased by 2.5% year on year from April 2015 to April 2016. There has been a year to date growth of 1% (3,166 weighted population) for the three quarters to 1st October 2016.
4. **Business case for proposed Partnership Merger in Lewisham**

The Primary Care Joint Committee approved the merger between St John’s Medical Centre, Hilly Fields Medical Centre, Brockley Road Medical Centre, Morden Hill Surgery and Honor Oak Group Practice subject to the stated conditions.

The practices propose, with effect from 1st April 2017, to work under a ‘super partnership model’, initially retaining each of the current PMS contracts held by the 5 existing practices, which the new entity will hold in trust; and at a later stage moving on to one PMS contract, or consider the new voluntary Multispecialty Community Provider contract. This would involve the 5 current PMS contracts remaining initially as separate contracts but benefiting from the integration of clinical and access services and systems.

The proposal fits strategically with local priorities as set out in the CCG’s Primary Care Strategy for General Practice, Community Based Care as part of the Our Healthier South East London – Community Based Care, Sustainability & Transformation Plan; delivering core general practice ‘at scale’. This is also supported nationally, as articulated in the General Practice Forward View, specifically with regard to the sustainability of General Practice.

5. **Further information**

Full meeting papers for the Primary Care Joint Committee held on the 8th February 2017 are available at: [http://www.lewishamccg.nhs.uk/about-us/how-we-work/Pages/Primary-Care-Joint-Committee.aspx](http://www.lewishamccg.nhs.uk/about-us/how-we-work/Pages/Primary-Care-Joint-Committee.aspx)

6. **Date of next meeting**

The next Primary Care Joint Committee in public will be held on the 30th March 2017.

This will be the last meeting of the Committee as new governance arrangements to support fully delegated GP commissioning will come into effect as of the 1st April 2017.
Governing Body Meeting 9th March 2017

Report from the Chair of the Public Engagement & Equalities Forum
Date of Meeting(s) reported: 28th February 2017
Author: Dr Angelika Razzaque, Clinical Director

Main Issues discussed

- **Equalities Analysis of Partnership Commissioning Intentions**

  The main item of discussion was the emerging findings from the equalities analysis of the Lewisham Partnership Commissioning Intentions that is being undertaken by the South East Commissioning Support Unit. The Forum reviewed the approach being undertaken, the most significant impacts and highest level equality-related risks that have been identified in the analysis so far. Further work is being undertaken so that the findings can be used in the development of implementation plans and to inform engagement around each of the priority areas.

- **NHS England Feedback of Annual Engagement Report**

  The CCG has received additional feedback from NHS England on its annual engagement report. The assessment received was ‘good’ for both the collective duty and for the individual duty. A follow-up discussion with the NHS England team has identified areas for further development, such as ensuring the impact of engagement is clear and that it is part of everyday business. Strong areas were the CCG’s vision for participation, and understanding of local population.

- **Public Reference Group**

  The Forum received the final report from the facilitator who was engaged to support the development of the Public Reference Group (PRG) in its first year. The report included recommendations for promoting the work of the group and running its meetings, as well as making sure it can provide meaningful input to the work of the CCG.

- **Healthwatch Reports**

  Healthwatch Lewisham is a member of the Forum, and their in-depth reviews provide valuable insight into our local population’s experience of local services. The Forum workplan will incorporate an overarching review of these reports to identify and feedback any themes across the CCG as well as to look at the responses that may be made by service providers.

- **Public Engagement & Equalities Forum Workplan**

  The Forum discussed the outline workplan for 2017. All Governing Body members and senior management team will be invited to attend the June meeting which will reflect on engagement during 2016-17 to inform the annual engagement report, and to consider the
public engagement requirements to support the key areas of the 2017-18 corporate objectives.

**Challenges**

The Forum identified at a number of points the importance of demonstrating that public engagement has an impact on commissioning decisions and that this requires early planning which will be strengthened with the involvement of key partners such as the PRG and Healthwatch.

**Quality & Safety**

The Partnership Commissioning intentions are underpinned by quality and safety objectives and considerations. The equalities analysis will ensure that service change and improvement will have a positive impact on those affected groups.

**Inequality & Fairness**

The equalities analysis on the Lewisham Partnership Commissioning Intentions is assessing the impact of the proposals on groups with protected characteristics as well as on carers and taking account of social deprivation. This meeting looked at the emerging findings and a further report is due on 10th March 2017.
A meeting of the Governing Body
9 March 2017

Integrated Governance Committee Chairs Report & Integrated Performance Report

RESPONSIBLE LEAD: Tony Read, Chief Financial Officer

AUTHOR: Tony Read, Chief Financial Officer
         Mike Hellier, Head of System Intelligence
         Paul McAuliffe, Head of Financial Management and Planning
         Graham Hewett, Associate Director of Quality

RECOMMENDATIONS:
The Governing Body is asked:

- To note the Integrated Governance Committee Chair’s Report which summarises the main areas discussed at the Integrated Governance Committee meetings held on 26 January and 23 February 2017
- To note the Integrated Performance Report Dashboard at Appendix 1 and the Month 10 Finance Report, period to 30 November 2016 at Appendix 2

SUMMARY:

New issues

A new issue has emerged regarding a Peer Review on adult critical care services at Queen Elizabeth’s Hospital site of Lewisham and Greenwich Trust (LGT) in February 2017. Although no formal report has been received, the CCG, as co-ordinating commissioner, is reviewing key findings with the Trust to make the required rapid improvements.

NHS Performance Indicators – underachieving standards

- Cancer Waiting Times relating to GP Referral to Treatment within 62 days.
- Referral to Treatment 18 week incomplete satandard

NHS Performance Indicators – achieving standards/improvement trajectories

- Access to Psychological Therapies
- Cancer Waiting Time two week waits
- Early Intervention in Psychosis
Finance - forecast out-turn is £1.75m worse than plan related to the LGT run rate support payment.

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<thead>
<tr>
<th>Measure</th>
<th>Plan / Target</th>
<th>Forecast Outturn</th>
<th>Forecast Variance</th>
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<tr>
<td>Planned Surplus</td>
<td>£7.64m</td>
<td>£5.89m</td>
<td>£(1.75)m</td>
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<tr>
<td>Acute Expenditure</td>
<td>£229.92m</td>
<td>£231.22m</td>
<td>£(1.30)m</td>
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<tr>
<td>Total Expenditure</td>
<td>£418.54m</td>
<td>£420.29m</td>
<td>£(1.75)m</td>
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<tr>
<td>QIPP Delivery</td>
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<td>£6.94m</td>
<td>£0.12m</td>
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<tr>
<td>Risk Adjusted Surplus</td>
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<td>£5.89m</td>
<td>£(1.75)m</td>
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<td>Underlying Position</td>
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<td>£6.74m</td>
<td>£(1.78)m</td>
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<td>Better Practice Payments Code</td>
<td>95.0%</td>
<td>98.2%</td>
<td>3.2%</td>
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<tr>
<td>Cash Drawdown</td>
<td>£417.75m</td>
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The Committee reviewed the Governing Body self assessment and is developing an improvement plan. Terms of Reference have been amended to strengthen management of conflicts of interest and increase lay membership.

2017/18 Planning - The Committee received the 2017/18 QIPP plan. Full assurance could not be given due to the significant risks associated with delivering the QIPP target.

CORPORATE AND STRATEGIC OBJECTIVES:

*High Quality Care and Best Value: Management of the contract*

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:
- Integrated Governance Meeting
- System Resilience
- QIPP Clinic Review Meeting

PUBLIC ENGAGEMENT

Summary detail from integrated performance report is routinely reported in summary to the Governing Body in public.

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, 2015/16 and 2016/17.

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 support the delivery of the duty.
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<th>STAKEHOLDER INVOLVEMENT:</th>
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<th>RESPONSIBLE LEAD CONTACT:</th>
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<tbody>
<tr>
<td>Name: Tony Read</td>
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<table>
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<th>AUTHOR/S CONTACT:</th>
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<tr>
<td>Name: Mike Hellier</td>
</tr>
<tr>
<td>Name: Paul McAuliffe</td>
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Governing Body meeting on 9 March 2017

Report from the Chair of the Integrated Governance Committee
Date of Meeting Reported: 26 January and 23 February 2017

Author: Martin Wilkinson

Quality

The Committee received an escalation report highlighting the quality assurance concerns. A new issue has emerged regarding a Peer Review on adult critical care services at Queen Elizabeth’s Hospital site of Lewisham and Greenwich Trust (LGT) in February 2017. Although no formal report has been received, the CCG, as co-ordinating commissioner, is reviewing key findings with the Trust to make the required rapid improvements.

The CQC Inspection Emergency Department LGT – Queen Elizabeth site. Bexley, Greenwich and Lewisham CCGs reviewed the action plan following the recommendations of this inspection and this will be monitored by the CCG.

It was noted that there has been a CQC inspection at South London and Maudsley at the end of January 2017 relating to inpatient services. The Inspection report is awaited. The CQRG for South London and Maudsley is reviewing services and workforce. The Committee was informed that a Quality Priority Setting meeting had taken place. It was noted that the Trust has not met its training plan for relevant staff on the Mental Health Act.

The Committee reviewed the 6 month update on infection control. It was agreed to invite the report’s author to attend the meeting for the next update and to identify any key messages for the Committee

NHS Constitutional Standards

In terms of achievement of NHS Performance Indicators, the key exceptions are:


- Cancer Waiting Times relating to GP Referral to Treatment within 62 days. While the CCG met the standard in December 2016 at 88.2%, the year to date figure is still below standard at 77%. Inter-provider transfers between Lewisham and Greenwich Trust and the tertiary centre by day 38 was improved above the 85% standard in December 16. The effect of this on Lewisham patients will be dependent on the total number of referrals to Guys and St Thomas’, which delivers over half of all treatments, and the performance of the Trust for these externally referred patients. There is a risk that sustainable improvement will not be met in 16-17. The
Committee raised increased concerns regarding the significant risk of not delivering the 62 day target.

Regarding GP referrals, the Committee considered comments regarding the proposed system change being implemented without appropriate education.

- **Referral to Treatment** - In December 2016 less than 92% (86.9%) of Lewisham patients were on an 18 weeks Incomplete Referral to Treatment path. The Committee was informed of the level of challenge at Kings College Hospitals, as they are not signing up to improvement trajectories they believe they cannot hit. It was noted that CCGs would like a higher level of ambition. It was agreed to conduct further work to identify any clinical assistance to Lewisham patients waiting a long time for treatment.

- For Improving **Access to Psychological Therapies**, the CCG is meeting all standards apart from service users reaching recovery at the end of their therapy. Finalised official data confirms that the Recovery Rate improvement plan was met in Q2. Locally sourced data indicates that we are above our plan for Q3 and into January 2017 when the plan rises to the 50% standard.

**Quality Premium** - Due to the high risk of not recovering performance to the Sustainability and Transformation Fund (STF) trajectory in Q4 for A&E 4 Hour, London Ambulance Service (Red1), Cancer Waiting Times 62 Days and Referral to Treatment Times, it is likely that NHS Lewisham CCG will receive no Quality Premium for 2016-17 – no matter what the achievement of outcomes.

**Positive achievements:**

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

**Early Intervention in Psychosis** – the CCG has met the standard for Q3 at 56.5%. Of the 10 breaches, 7 were treated between 2 and 3 weeks.

**Finance (achieving)**

- The Finance Report for Month 10 is attached at Appendix 1.

- At Month 10 the CCG is forecasting a year end surplus of £5.89m. This will under deliver against the planned cumulative surplus of £7.64m for the year by £1.75m. This position reflects the payment by the CCG as contribution to the NHS’s financial commitments relating to the takeover of Queen Elisabeth Hospital by Lewisham Healthcare Trust.

- The forecast assumes that the non-recurrent 1% reserve is fully committed although, in accordance with NHS England planning requirements, there are no commitments against this in 2016/17. It is possible that the forecast year end position could therefore be significantly better than currently forecast.

- The QIPP savings target for 2016/17 is £6,824k. Performance is projected to deliver the planned in-year savings level.
Activity Report

A summary trend and actual against plan report for hospital activity at Month 9 was considered. Trends remain as before with emergency and elective admissions under plan and first outpatients over plan and A&E attendances marginally over plan.

The Committee was informed that the run rate graphs provided in the activity report highlight that for A&E the run rate trend is upwards, with notable increases in volumes at GSTT and KCH. The Director of Commissioning added that this is despite the positive response to the GP front door streaming at Lewisham and Greenwich Trust.

The Committee was informed that though emergencies at LGT are under previous years, the increase at KCH and GSTT as well as other providers continues, to such an extent that cumulatively 16/17 volumes are now ahead of previous years, bar 15/16.

The Committee learnt that the increase continues in Out Patient First Attendances, reflected contractually at LGT and GSTT.

The Committee heard that elective activity had dipped in December, as is expected.

CCG Improvement and Assurance Framework

The National Diabetes Audit for 15-16 has been published in late January. All Lewisham practices took part, so the CCG numbers relate to all patients.

Referrals to structured education and take up continue to be high. However, percentage of people with Diabetes meeting the three treatment targets has reduced and there remains a gap to the national and peer CCGs.

The Committee was informed that the report demonstrates that the right actions are being taken, however, the pace of these actions may not be good enough.

The Committee was informed that the Diabetes Champion role has not been active, due to the cuts in the Public Health budget, however, work is underway to reinstate this role at a Neighbourhood Care Network (NCN) level.

Corporate Objectives and Board Assurance Framework (BAF):

The Committee heard from the Corporate Director regarding the Corporate Objectives and BAF. The Committee noted that Lewisham CCG sits over a high to medium risk environment and that both the Corporate Objectives and BAF reflect the conversations held and frustrations felt by the Committee.

Planning / QIPP

The Committee received the QIPP Programme report for 2017/18, which provides an overview of the CCG’s entire QIPP programme for all providers. For 2017/18 the minimum gross QIPP required is £14m.

The Committee heard that a QIPP and provider efficiency (CIP) Board has been jointly established by Bexley, Greenwich and Lewisham CCGs and Lewisham & Greenwich NHS
Trust. This will look at joint working, as well as the continuation from Lewisham CCG to review the Right Care recommendations to try and identify additional schemes.

The Committee was informed that assurance could not be given as there are significant risks associated with reaching the QIPP target. However, the Committee recognise this does not negate the hard work by the team, which should be appreciated.

The Committee agreed that it is imperative there is a more radical approach to identifying QIPP schemes going forward, especially when considering the QIPP and stretch for the next 2 years.

The Committee suggested the possibility of rationalising / integrating some of the current QIPP schemes in order to make them easier to manage, rather than having lots of small programmes to manage.

**Governing Body Self-Assessment**

The Committee received the report regarding the self-assessment. The Committee was informed that despite the changes put in place, the score for IGC is lower than previously and lower than expected. Following the self-assessment being discussed at the Strategy and Development workshop there were suggestions received to improve the IGC meetings:

- That the exception reports received by the Committee be reviewed, to ensure the correct information is highlighted, and that the Quality Escalation Report is written afresh every month, rather than the current process of adding in updated information to the previous months report.

- To make optimum use of the meeting time available, priority items to be highlighted to the Committee, with information on how this links to the contract management / delivery and wider transformation agenda.
2016/17
Month 9: Integrated Performance Report-Dashboard
Governing Body – 5th March 2017

Appendix 1
**Performance Summary**

<table>
<thead>
<tr>
<th>Health Outcomes Framework / Every one Counts</th>
<th>Target</th>
<th>Performance YTD</th>
<th>Performance Month</th>
<th>Breaches</th>
<th>Recovery Plan RAG</th>
<th>Latest Data</th>
<th>12M Trend</th>
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<tbody>
<tr>
<td>Safe environment and protecting from avoidable harm</td>
<td>M. MRSA - Incidence of HCAI YTD</td>
<td>0</td>
<td>7</td>
<td>0 (YTD)</td>
<td>Dec-16</td>
<td>▼</td>
<td></td>
</tr>
<tr>
<td></td>
<td>C. difficile - Incidence of HCAI YTD</td>
<td>40</td>
<td>26</td>
<td>1 (YTD)</td>
<td>Dec-16</td>
<td>▼</td>
<td></td>
</tr>
<tr>
<td>NHS Constitution</td>
<td>RTT admitted</td>
<td>90%</td>
<td>72.1%</td>
<td>74.9%</td>
<td>308</td>
<td>Dec-16</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td>RTT non-admitted</td>
<td>95%</td>
<td>86.6%</td>
<td>85.9%</td>
<td>796</td>
<td>Dec-16</td>
<td>▼</td>
</tr>
<tr>
<td></td>
<td>RTT incomplete</td>
<td>92%</td>
<td>100%</td>
<td>110%</td>
<td>3645</td>
<td>Dec-16</td>
<td>▼</td>
</tr>
<tr>
<td></td>
<td>RTT 52+ week waiters</td>
<td>0</td>
<td>140</td>
<td>14</td>
<td>14</td>
<td>Dec-16</td>
<td>▼</td>
</tr>
<tr>
<td></td>
<td>RTT Admitted Backlog</td>
<td>1416</td>
<td>1416</td>
<td>1416</td>
<td>Dec-16</td>
<td>▲</td>
<td></td>
</tr>
<tr>
<td>Diagnostics</td>
<td>Diagnostics - 6 weeks +</td>
<td>99%</td>
<td>97.5%</td>
<td>96.3%</td>
<td>77</td>
<td>Dec-16</td>
<td>▲</td>
</tr>
<tr>
<td>Cancer - 2 weeks</td>
<td>2 week wait</td>
<td>93%</td>
<td>92.0%</td>
<td>94.3%</td>
<td>52</td>
<td>Dec-16</td>
<td>▲</td>
</tr>
<tr>
<td>Cancer - 31 days</td>
<td>31 day first definitive treatment</td>
<td>96%</td>
<td>97.3%</td>
<td>98.4%</td>
<td>1</td>
<td>Dec-16</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td>31 day subsequent treatment surgery</td>
<td>94%</td>
<td>88.3%</td>
<td>84.6%</td>
<td>2</td>
<td>Dec-16</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td>31 day subsequent treatment drug</td>
<td>98%</td>
<td>99.3%</td>
<td>100.0%</td>
<td>0</td>
<td>Dec-16</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td>31 day subsequent treatment radiotherapy</td>
<td>94%</td>
<td>94.6%</td>
<td>89.7%</td>
<td>3</td>
<td>Dec-16</td>
<td>▲</td>
</tr>
<tr>
<td>Cancer - 62 days</td>
<td>62 day standard</td>
<td>85%</td>
<td>77.3%</td>
<td>88.2%</td>
<td>4</td>
<td>Dec-16</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td>62 day screening</td>
<td>90%</td>
<td>95.8%</td>
<td>100.0%</td>
<td>0</td>
<td>Dec-16</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td>62 day upgrade</td>
<td>90%</td>
<td>82.6%</td>
<td>100.0%</td>
<td>0</td>
<td>Dec-16</td>
<td>▲</td>
</tr>
<tr>
<td>Trust Measures</td>
<td>Mixed-sex accommodation breaches</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>Dec-16</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td>Total number of Delayed Transfers of Care</td>
<td>0</td>
<td>592</td>
<td>47</td>
<td>47</td>
<td>Dec-16</td>
<td>▲</td>
</tr>
<tr>
<td>Mental Health</td>
<td>CPA follow up within 7 days</td>
<td>95%</td>
<td>97.5%</td>
<td>95.5%</td>
<td>5</td>
<td>Dec-16</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td>IAPT 6 week target</td>
<td>75%</td>
<td>81.7%</td>
<td>85.4%</td>
<td>70</td>
<td>Oct-16</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td>IAPT 18 week target</td>
<td>95%</td>
<td>99.3%</td>
<td>99.0%</td>
<td>5</td>
<td>Oct-16</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td>IAPT in recovery</td>
<td>50%</td>
<td>45.7%</td>
<td>46.3%</td>
<td>110</td>
<td>Oct-16</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td>Early Intervention Psychosis 2 week target</td>
<td>50%</td>
<td>56.7%</td>
<td>53.8%</td>
<td>6</td>
<td>Dec-16</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td>Dementia</td>
<td>67%</td>
<td>73.1%</td>
<td>74.5%</td>
<td>459</td>
<td>Dec-16</td>
<td>▲</td>
</tr>
<tr>
<td>A&amp;E 4 Hour Waits</td>
<td>% within 4 hours LEWISHAM AND GREENWICH NHS TRUST</td>
<td>95%</td>
<td>88.4%</td>
<td>81.2%</td>
<td>4543</td>
<td>Dec-16</td>
<td>▼</td>
</tr>
<tr>
<td></td>
<td>% within 4 hours LEWISHAM UNIVERSITY HOSPITAL</td>
<td>95%</td>
<td>93.1%</td>
<td>96.4%</td>
<td>2019</td>
<td>Dec-16</td>
<td>▲</td>
</tr>
<tr>
<td>Ambulance</td>
<td>LAS Red 1</td>
<td>75%</td>
<td>68.4%</td>
<td>68.7%</td>
<td>570</td>
<td>Dec-16</td>
<td>▲</td>
</tr>
<tr>
<td></td>
<td>Cat A19</td>
<td>95%</td>
<td>99.5%</td>
<td>99.9%</td>
<td>4161</td>
<td>Dec-16</td>
<td>▲</td>
</tr>
</tbody>
</table>

This month there has been an improvement in Cancer Waits - 62 days GP referred. Diagnostics, however has decreased below 99% within 6 weeks.
Performance 2016/17 – Exception Report - Metrics
- Cancer Waiting Times – 62 Days

Cancer 62 day standard
NHS Lewisham CCG (Performance)

Inter Provider Transfers LGT
% within 38 days

Provider Performance 62 Days

Cancer waits
Breach Analysis YTD

NB Interprovider transfers data is from the LGT Board pack.
Discharge data is Lewisham and Greenwich Trust Board pack.

18 weeks incomplete - Lewisham CCG Performance

Provider Performance 18 weeks

18 weeks Incomplete Long waiting patients Lewisham CCG
Data from NHS Digital (HSCIC) apart from last 2 months which is local data to support NHS England collection.
Finance Report
Month 10, period to 31st January 2017.

1. Summary

At Month 10 the CCG is forecast to deliver a surplus of £5.89m for the year. As reported last month, this is £1.75m worse than plan due to the Lewisham and Greenwich NHS Trust run rate contribution payment. The CCG headline financial position is provided in the table below.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Plan / Target</th>
<th>Forecast Outturn</th>
<th>Forecast Variance</th>
<th>Relevant Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Surplus</td>
<td>£7.64m</td>
<td>£5.89m</td>
<td>£(1.75)m</td>
<td>3</td>
</tr>
<tr>
<td>Acute Expenditure</td>
<td>£229.92m</td>
<td>£231.22m</td>
<td>£(1.30)m</td>
<td>3.1</td>
</tr>
<tr>
<td>Total Expenditure</td>
<td>£418.54m</td>
<td>£420.29m</td>
<td>£(1.75)m</td>
<td>3</td>
</tr>
<tr>
<td>QIPP Delivery</td>
<td>£6.82m</td>
<td>£6.94m</td>
<td>£0.12m</td>
<td>3</td>
</tr>
<tr>
<td>Risk Adjusted Surplus</td>
<td>£7.64m</td>
<td>£5.89m</td>
<td>£(1.75)m</td>
<td>4</td>
</tr>
<tr>
<td>Underlying Position</td>
<td>£8.52m</td>
<td>£6.74m</td>
<td>£(1.78)m</td>
<td>5</td>
</tr>
<tr>
<td>Better Practice Payments Code</td>
<td>95.0%</td>
<td>98.2%</td>
<td>3.2%</td>
<td>6</td>
</tr>
<tr>
<td>Cash Drawdown</td>
<td>£417.75m</td>
<td>£417.75m</td>
<td>£0.00m</td>
<td>6</td>
</tr>
</tbody>
</table>

2. Revenue Resource Limit and Start Budget

2.1. At Month 10 the CCG’s combined Revenue Resource Limits totals £426.18m. This includes £6.61m for the running cost allowance as included in the budget.

2.2. Table 1 shows the confirmed allocations categorised by Running and Programme Costs. Further details of allocation adjustments are provided in Appendix 1.

Table 1: Revenue Resource Limits

<table>
<thead>
<tr>
<th>Notified Allocation at Month 9</th>
<th>Programme £’m</th>
<th>Running Cost £’m</th>
<th>Total £’m</th>
</tr>
</thead>
<tbody>
<tr>
<td>M10 Allocations:</td>
<td>417.31</td>
<td>6.61</td>
<td>423.92</td>
</tr>
<tr>
<td>Quality Premium Awards 2015/16</td>
<td>0.17</td>
<td></td>
<td>0.17</td>
</tr>
<tr>
<td>Healthy London Partnership Underspend</td>
<td>1.04</td>
<td></td>
<td>1.04</td>
</tr>
<tr>
<td>Health in Justice Funding - CYP</td>
<td>0.35</td>
<td></td>
<td>0.35</td>
</tr>
<tr>
<td>Office of CCGs admin levy</td>
<td>.07</td>
<td></td>
<td>.07</td>
</tr>
<tr>
<td>SEL GPFV &amp; Access monies</td>
<td>.43</td>
<td></td>
<td>.43</td>
</tr>
<tr>
<td>TB strategy for Q3 and Q4</td>
<td>.02</td>
<td></td>
<td>.02</td>
</tr>
<tr>
<td>GP WIFI early adopters</td>
<td>.11</td>
<td></td>
<td>.11</td>
</tr>
<tr>
<td>CYP WL &amp; WT Reduction: 2nd tranche</td>
<td>.07</td>
<td></td>
<td>.07</td>
</tr>
<tr>
<td>Notified Allocation at Month 10</td>
<td>419.57</td>
<td>6.61</td>
<td>426.18</td>
</tr>
</tbody>
</table>

3. Month 10 Financial Performance

3.1. At Month 10 the CCG forecasts to deliver a surplus of £5.89m for the year. This is £1.75m less than plan. The CCG is delivering a cumulative surplus of £4.91m at Month 10 which is £1.46m less than plan. Programme budgets were under-spent by £4.74m and Running Cost budgets were under-spent by £0.17m.
This is summarised in Table 2 below:

**Table 2: Headline Financial Performance**

<table>
<thead>
<tr>
<th>Overall CCG Budget</th>
<th>Budget £m</th>
<th>Year to Date</th>
<th>Variance £m</th>
<th>Annual Budget £m</th>
<th>Actual £m</th>
<th>Variance £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Contracts</td>
<td>191.60</td>
<td>192.76</td>
<td>(1.15)</td>
<td>229.92</td>
<td>231.22</td>
<td>(1.30)</td>
</tr>
<tr>
<td>Community Services</td>
<td>25.57</td>
<td>24.89</td>
<td>0.68</td>
<td>30.68</td>
<td>29.89</td>
<td>0.79</td>
</tr>
<tr>
<td>Joint Commissioning Adults</td>
<td>70.03</td>
<td>71.73</td>
<td>(1.70)</td>
<td>84.04</td>
<td>86.15</td>
<td>(2.12)</td>
</tr>
<tr>
<td>Joint Commissioning Children</td>
<td>2.06</td>
<td>2.06</td>
<td>0.00</td>
<td>2.47</td>
<td>2.47</td>
<td>0.00</td>
</tr>
<tr>
<td>Primary Care Budgets</td>
<td>33.60</td>
<td>33.77</td>
<td>(0.17)</td>
<td>40.32</td>
<td>40.52</td>
<td>(0.20)</td>
</tr>
<tr>
<td>Corporate Budgets</td>
<td>7.19</td>
<td>7.00</td>
<td>0.20</td>
<td>8.63</td>
<td>8.44</td>
<td>0.19</td>
</tr>
<tr>
<td>Other, Reserves and Financing</td>
<td>15.36</td>
<td>14.66</td>
<td>0.70</td>
<td>22.48</td>
<td>21.59</td>
<td>0.89</td>
</tr>
<tr>
<td>Planned Surplus</td>
<td>6.37</td>
<td>0.00</td>
<td>6.37</td>
<td>7.64</td>
<td>0.00</td>
<td>7.64</td>
</tr>
<tr>
<td><strong>Total CCG Budget</strong></td>
<td><strong>351.77</strong></td>
<td><strong>346.86</strong></td>
<td><strong>4.91</strong></td>
<td><strong>426.18</strong></td>
<td><strong>420.29</strong></td>
<td><strong>5.89</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Programme/ Running Costs Split</th>
</tr>
</thead>
<tbody>
<tr>
<td>Programme Budgets</td>
</tr>
<tr>
<td>Running Costs</td>
</tr>
<tr>
<td><strong>Total CCG Budgets</strong></td>
</tr>
</tbody>
</table>

3.2 The acute budget forecast overspend has decreased by £0.04m to £1.30m in month.

3.2.1 Lewisham and Greenwich Trust (LGT) – the underperformance against plan increased within the month due to pricing adjustments and elective activity levels. The position assumes elective activity will continue above monthly planned rates to address the Referral to treatment (RTT) underperformance. The forecast is that elective activity will not fully recover the RTT backlog by end of March 2017. The forecast overspend is reduced from £460k at Month 9 to £270k.

3.2.2 There are block contracts for Guy’s and St. Thomas’ NHS FT and Kings Hospitals NHS FT. YTD activity in elective is £1.3m (9%) below plan in aggregate across both trusts. Non Elective activity is above plan at both.

3.2.3 External Service Agreements are forecast to overspend by £0.5m.

3.2.4 Non Contractual Activity (NCA) is forecast to overspend by £0.33m.

3.3 The community budgets are forecasted to underspend by an aggregate £0.79m.

3.4 Adult Joint Commissioning Budgets – the overall position at Month 10 shows a year to date increase in overspend from £1.3m last month to £1.7m and a similar £0.4m increase in the forecast overspend to £2.1m. Adult mental health overspend on occupied bed days increased by £200k and Continuing Health Care costs increased by £200k (this constitutes the majority of the forecast overspend).

3.5 Other, Reserves and Financing - The CCG’s opening budget included reserves in line with NHS England national business rules, Better Care Fund transfers and budget equal to the
CCG’s planned surplus. Reserves have been necessarily fully released against their specific purposes or applied to manage cost pressures within the CCG’s forecasted financial position. The 1% non-recurrent reserve has been accrued to breakeven. The CCG is unable to commit expenditure in 2016/17 from this reserve and it is being treated as part of a national risk reserve pool. The CFO is anticipating that the treatment of this will become clear in late March. It could potentially create a significantly higher year end surplus than currently forecast.

4. **Quality, Innovation, Productivity and Prevention (QIPP)** - The CCG is achieving £5.24m against the YTD plan of £5.20m. The current forecast is a likely case delivery of £6.94m that would meet the plan.

5. **Risks and Mitigation (In Year)** - The CCG’s general reserves and contingencies are less than 2015/16. In addition the CCG is not permitted to make expenditure commitments against its £4m non recurrent set-aside reserve. Consequently the CCG’s capacity to mitigate financial risk through utilisation of reserves is lower than in previous years. Reserves are fully released to deliver the current year end forecast.

6. **Underlying Position**

6.1. The CCG’s underlying financial position is 1.64% surplus against RRL; indicating that the CCG has recurring expenditure commitments that are less than it’s notified and estimated recurring income.

<table>
<thead>
<tr>
<th>Underlying Position – Surplus/ (Deficit) Cumulative</th>
<th>2016/17 Plan</th>
<th>2016/17 FOT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Underlying Position – Surplus/ (Deficit) Cumulative %</td>
<td>1.82%</td>
<td>1.64%</td>
</tr>
</tbody>
</table>

6.2. Current planning estimates for 2016/17 to 2020/21 indicate that there will be further and accelerated deterioration in the underlying position unless the CCG increases its delivery of recurrent QIPP to more than 3.3% of RRL per annum from 2017/18.

7. **Cash and Maximum Cash Drawdown**

7.1. The CCG’s advised maximum cash drawdown is £417.75m for the year. As at Month 10 the CCG has drawn down £334.97m (80%). This is in line with the CCG’s cash forecasts.

7.2. At the end of the month the CCG expects to hold a cash balance that is not in excess of 1.25% of its monthly drawdown. The CCG’s cash balance at the end of November was £371k compared to a maximum position of £378k.

7.3. The CCG expects to spend its annual maximum cash drawdown in total by 31st March 2017.

8. **Better Payments Practice Code** - The CCG is complying with the Better practice Payments Code.

Tony Read  
Chief Financial Officer  
2nd March 2017
### Appendix 1: Revenue Resource Limit

<table>
<thead>
<tr>
<th></th>
<th>Admin £'m</th>
<th>Programme £'m</th>
<th>Total £'m</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016-17 Opening Baseline</td>
<td>6.61</td>
<td>405.17</td>
<td>411.78</td>
</tr>
<tr>
<td>2015-16 Surplus Carry Forward</td>
<td></td>
<td>7.65</td>
<td>7.65</td>
</tr>
<tr>
<td><strong>Board Approved Budget</strong></td>
<td>6.61</td>
<td><strong>412.82</strong></td>
<td><strong>419.43</strong></td>
</tr>
<tr>
<td>TB Funding Q1</td>
<td>0.02</td>
<td>0.02</td>
<td>0.02</td>
</tr>
<tr>
<td>Eating Disorder Service Q1</td>
<td>0.18</td>
<td>0.18</td>
<td>0.18</td>
</tr>
<tr>
<td>TSA</td>
<td>1.57</td>
<td>1.57</td>
<td>1.57</td>
</tr>
<tr>
<td>HLP Transfer</td>
<td>(0.61)</td>
<td>(0.61)</td>
<td></td>
</tr>
<tr>
<td>Levy Transfer</td>
<td>(0.20)</td>
<td>(0.20)</td>
<td></td>
</tr>
<tr>
<td>GP Development Programme - reception and clerical training</td>
<td>0.03</td>
<td>0.03</td>
<td></td>
</tr>
<tr>
<td>Safeguarding children named GPs</td>
<td>0.03</td>
<td>0.03</td>
<td></td>
</tr>
<tr>
<td>Latent TB Funding Q2</td>
<td>0.02</td>
<td>0.02</td>
<td>0.02</td>
</tr>
<tr>
<td>CYP Local Transformation Mental Health</td>
<td>0.07</td>
<td>0.07</td>
<td></td>
</tr>
<tr>
<td>Children and Young transformation</td>
<td>0.03</td>
<td>0.03</td>
<td></td>
</tr>
<tr>
<td>CEOV adjustment</td>
<td>3.08</td>
<td>3.08</td>
<td>3.08</td>
</tr>
<tr>
<td>Perinatal Mental Health CSDF- South</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>London and Maudsley NHS Foundation Trust</td>
<td>0.28</td>
<td>0.28</td>
<td></td>
</tr>
<tr>
<td>Quality Premium Awards 2015/16</td>
<td>0.17</td>
<td>0.17</td>
<td></td>
</tr>
<tr>
<td>Healthy London Partnership Underspend</td>
<td>1.04</td>
<td>1.04</td>
<td></td>
</tr>
<tr>
<td>Health in Justice Funding - CYP</td>
<td>0.35</td>
<td>0.35</td>
<td></td>
</tr>
<tr>
<td>OCCG admin levy</td>
<td>0.07</td>
<td>0.07</td>
<td>0.07</td>
</tr>
<tr>
<td>SEL GPFG &amp; Access monies</td>
<td>0.43</td>
<td>0.43</td>
<td>0.43</td>
</tr>
<tr>
<td>TB strategy for Q3 and Q4 - Jeff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Featherstone</td>
<td>0.02</td>
<td>0.02</td>
<td>0.02</td>
</tr>
<tr>
<td>GP WIFI early adopters - A Cheesman</td>
<td>0.11</td>
<td>0.11</td>
<td></td>
</tr>
<tr>
<td>CYP WL &amp; WT Reduction: 2nd tranche</td>
<td>0.07</td>
<td>0.07</td>
<td></td>
</tr>
<tr>
<td><strong>Month 10 Allocations</strong></td>
<td>6.61</td>
<td><strong>419.57</strong></td>
<td><strong>426.18</strong></td>
</tr>
</tbody>
</table>
The Governing Body is asked:

1. to note the refreshed assessment of the CCGs risks undertaken by the Risk Management Group, including Current and Target risk scores as shown within the BAF.

2. to endorse that the CCG has adequate controls in place to mitigate the risks to the Corporate Objectives and where there are gaps in controls there are credible action plans to mitigate them.

1. Introduction

Since the last Governing Body in January 2017, the Risk Management Group and the Integrated Governance Committee has reviewed and updated the Corporate Risk Register and the Board Assurance Framework. Amendments to the BAF are shown in italics for ease of reference at Appendix A, with significant changes identified below.

Throughout the course of the year, the CCG follows a stepped approach to the management of risk through the Risk Management Group. This allows for continuous monitoring and evaluation of Risk, as well as 'Horizon Scanning' to identify any new or escalating risks to the organisation.

2. Changes to the Risk Register

At its meeting on 12th January 2017, the Governing Body requested additional assurance with regards to the specific risks related to the CCG achieving its Corporate Objectives. Of particular concern were the risks related to the NHS Constitutional Standards and Safeguarding. Additionally, the Governing Body raised that there should be timescales on actions and the Risk Management Group would look into actioning this.
The risks highlighted at the Governing Body were reviewed at the Integrated Governance Committee on 26 January 2017, with the Risk Management Group reviewing all risks on the risk register on 07 February 2017. The Integrated Governance Committee reviewed the BAF again at its meeting on 23 February 2017.

The RMG focussed discussion on the top 11 risks to the CCG, to ensure that the current and target scores were accurate and reflective of the current position, and that appropriate actions had been identified against the top risks.

The Heatmap below shows the positions for the 25 risks on the CCG risk register using the current rating as at February 2017. It should be noted that overall there are now fewer risks which have a total current risk score of 12 or above, which are those risks included within the BAF (see section 3)

<table>
<thead>
<tr>
<th>Likelihood</th>
<th>Almost Certain 5</th>
<th>No. of Risks = 1 Risk ID: 78</th>
<th>Likely 4</th>
<th>No. of Risks = 1 Risk ID: 77</th>
<th>Possible 3</th>
<th>No. of Risks = 1 Risk ID: 38</th>
<th>No. of Risks = 1 Risk ID: 76</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unlikely 2</td>
<td>No. of Risks = 2 Risk ID: 21, 59</td>
<td>No. of Risks = 5 Risk ID: 25, 39, 58, 63, 75</td>
<td>No. of Risks = 8 Risk ID: 22, 30, 41, 53, 57, 64, 66, 73</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rare 1</td>
<td>No. of Risks = 1 Risk ID: 74</td>
<td>No. of Risks = 1 Risk ID: 51</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk Matrix</th>
<th>Negligible 1</th>
<th>Minor 2</th>
<th>Moderate 3</th>
<th>Major 4</th>
<th>Catastrophic 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impact</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total Number of Risks = 25

Eight current risk scores decreased:
- Change of ICT Support Contract to NELCSU (Risk 73)
- Safeguarding (Risk 41)
- QIPP (Risk 53)
- Plans for reducing the demand for acute services (for both physical and mental health) in an emergency/urgent situation do not achieve the impact anticipated (Risk 75)
- Improving access to psychological therapies (Risk 58)
- Primary Care Co-Commissioning (Risk 51)
- Implementing Transforming Care (Risk 21)
- CCG office relocation (Risk 74)

The RMG discussed two risks to be accepted: Risk 73 ‘Change of ICT Support Contract to NELCSU’ as the transition of IT providers has now happened and Risk 51 ‘Primary Care Co-Commissioning’ as Level 3 Commissioning, which has now been approved by NHS England.

3. Board Assurance Framework

There are currently 7 risks on the CCG Risk Register that meet the criteria for inclusion (Current Risk Score of 12 or over) on the Board Assurance Framework (BAF) as demonstrated on the heatmap above.

The BAF Summary Table below shows for each risk rated 12 or above (ie “High” or “Very High”) the Original Risk score at the beginning of 2016/17, the Current risk score at February 2017 and the Target risk score. This is a reduction in the number of risks included on the BAF which at the Governing Body meeting in January was 12, and 14 at November 2016.

The discussion at the RMG resulted in the current and target risk scores for Acute Providers – Delivering Quality: Referral to Treatment (RTT) standard (Risk 77) increasing as it was acknowledged that Kings were not going to meet their target before the end of the year and GSTT had slipped but were now back on track.

The RMG also reviewed the scoring for risk 76 Sustainable Operating Plan and Contracts 2017/18 to 2018/19. The current score is unchanged, but the target score has been increased to 15 to reflect risk of increased expenditure in the context of reduced resources.
Full details of each of these risks is included in Appendix A.

More detail about the Current Risk Score of 12 or over is provided at Appendix D.

The Governing Body are asked to note the Current and target risk scores as shown within the BAF.

3.2 Risk Controls

The BAF summarises the controls in place to mitigate the risks to the successful delivery of the Corporate Objectives. It also provides a summary of action planned to be taken to address current gaps in controls to reduce the current risk score to the target risk score.

The Summary Risk Table cross references to specific Governing Body agenda papers where further information is provided about the actions being undertaken to mitigate the risks to the successful delivery of the Corporate Objectives.

The Governing Body are asked to endorse that the CCG has adequate controls in place to mitigate the risks to the Corporate Objectives and where there are gaps in controls there are credible action plans to mitigate them.

Appendices

Appendix A- BAF – March 2017
### PUBLIC ENGAGEMENT

#### HEALTH INEQUALITY DUTY

How does this report take into account the duty to:

- Reduce inequalities between patients with respect to their ability to access health services.
- Reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services.

#### PUBLIC SECTOR EQUALITY DUTY

How does this report take into account the duty to:

- Eliminate discrimination, harassment and victimisation and any other conduct that is prohibited under the Equality Act 2010
- Advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it
- Foster good relations between people who share a relevant protected characteristic and those who do not share it

There is a specific risk with regards to Equalities considerations being effectively included in the CCG plans and activities (Risk Identifier 39). These are monitored through the Corporate Objectives and through the management Equality and Diversity Group.

### RESPONSIBLE MANAGERIAL LEAD CONTACT:

Name: Susanna Masters  
E-Mail: susanna.masters@nhs.net

### AUTHOR CONTACT:

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Page 53
<table>
<thead>
<tr>
<th>Name</th>
<th>E-Mail</th>
</tr>
</thead>
<tbody>
<tr>
<td>Susanna Masters</td>
<td><a href="mailto:susanna.masters@nhs.net">susanna.masters@nhs.net</a></td>
</tr>
<tr>
<td>Victoria Medhurst</td>
<td><a href="mailto:Victoria.medhurst@nhs.net">Victoria.medhurst@nhs.net</a></td>
</tr>
<tr>
<td>Corporate Objective:</td>
<td>High Quality Care and Best Value</td>
</tr>
<tr>
<td>---------------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>Risk</td>
<td>Cancer waiting times (i) Cancer 2 Week Wait; (ii) Cancer 31 days; and (iii) Cancer 62 days (Risk ID 8)</td>
</tr>
<tr>
<td>Risk Description: (What is the risk?)</td>
<td>The risk is: That local providers do not deliver health services that meet the NHS Constitutional commitments on waiting times for patients with cancers or suspected cancers.</td>
</tr>
</tbody>
</table>
| It is caused by: | • Poor performance of commissioned services  
• Provider failure to meet contracted quality and performance standards  
• Poor contract management |
| It could lead to: | • Delays to appropriate treatment and potential harm to patients  
• Failure to meet NHS Constitutional Commitments in Lewisham  
• Loss of reputation |

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

<table>
<thead>
<tr>
<th>Controls: (What are we doing to mitigate the risk?)</th>
</tr>
</thead>
</table>
| • The CCG has an agreed contract with all providers  
• The CCG has included appropriate penalty clauses in its major contracts  
• The CCG has agreed a cancer recovery plan with LGT  
• The CCG Chairs the Contract Management Board (CMB) for its main acute and community provider with appropriate sub committees including the Clinical Quality Review Group (CQRG), Adult Community Services Group, Finance & Performance and the Cancer Pathway Clinical Review Group  
• The CCG has employed an expert multi-disciplinary team from the CSU and the CCG is developing an internal contract management multi-disciplinary team to support  
• Bexley, Lewisham & Greenwich Cancer Locality Group  
• SEL Cancer Improvement Plan agreed by all providers (IGC 29.09.2016) |
| Assurance Sources: | • Contracts with LGT, GSTT and Kings  
  • LGT Contract Management Board and Performance meetings minutes  
  • CQRG Minutes  
  • Cancer Pathway Clinical Review Group Minutes  
  • In year monitoring via Integrated Performance Report to Integrated Governance Committee and Quality reports to CQRGs  
  • SEL 62 days cancer meeting |
|---|---|
| Risk Assurances: (What evidence do we have that the controls are working?) | • Signed contract  
  • Performance Reporting: Governance Committee, Governing Body, Contract Management and CQRG.  
  • LGT has provided a trajectory and plan showing compliance with the Standards throughout financial year 2016/17.  
  • NHS England Stocktakes  
  • At month 9 ITT by 38 days at LGT has improved to near standard and 2 weeks waits has improved to standard. |
<p>| Assurance Type: | Management |
| Assurance level: | Limited |
| Gaps in Risk Controls: | • Recovery plan with milestones and quantified /impact on delivering the trajectory for LGT and KCH. Consequently, the likely exit rate from 2016/17 is unknown. |
| Actions: | • Development of a consolidated recovery plan to be brought back to the IGC in March 2017 (CSU). |
| Last updated: | Diana Braithwaite/Mike Hellier 16.02.2017 |</p>
<table>
<thead>
<tr>
<th>Corporate Objective:</th>
<th>High Quality Care and Best Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk</td>
<td>Unexpected care home and domiciliary care agency or private providers closures (Risk ID 12)</td>
</tr>
<tr>
<td>Risk Description: (What is the risk?)</td>
<td>The risk is: Unexpected care home closures or private providers closure or temporary closure and loss of domiciliary care</td>
</tr>
<tr>
<td></td>
<td>It is caused by:</td>
</tr>
<tr>
<td></td>
<td>• Business failures</td>
</tr>
<tr>
<td></td>
<td>• Enforced closure by a regulator</td>
</tr>
<tr>
<td></td>
<td>• Embargo by commissioners</td>
</tr>
<tr>
<td></td>
<td>• Incident (fore or flood etc)</td>
</tr>
<tr>
<td></td>
<td>It could lead to:</td>
</tr>
<tr>
<td></td>
<td>• Delayed transfers of care.</td>
</tr>
<tr>
<td></td>
<td>• Inability to secure placements at the required quality and cost.</td>
</tr>
<tr>
<td></td>
<td>• Negative impact on patient choice.</td>
</tr>
<tr>
<td></td>
<td>• Possible admissions.</td>
</tr>
<tr>
<td></td>
<td>• Negative impact on Joint Commissioning and social care staff / capacity and workload.</td>
</tr>
<tr>
<td></td>
<td>• Patients are not safeguarded.</td>
</tr>
<tr>
<td></td>
<td>• Poor patient experience.</td>
</tr>
<tr>
<td></td>
<td>• Financial pressures driven by market position.</td>
</tr>
<tr>
<td>Risk Owner:</td>
<td>Carlin, Dee</td>
</tr>
<tr>
<td>Risk Manager:</td>
<td>Hughes, Heather</td>
</tr>
<tr>
<td>Directorate:</td>
<td>Joint Commissioning</td>
</tr>
<tr>
<td>Risk Appetite:</td>
<td>High</td>
</tr>
<tr>
<td>Risk Response:</td>
<td>Accept</td>
</tr>
<tr>
<td>Original Score:</td>
<td>Very High Risk</td>
</tr>
<tr>
<td>Current Score:</td>
<td>High Risk</td>
</tr>
<tr>
<td>Target Score:</td>
<td>High Risk</td>
</tr>
<tr>
<td>Risk Movement:</td>
<td>Accepted</td>
</tr>
<tr>
<td>Impact 4 x</td>
<td>Impact 4 x</td>
</tr>
<tr>
<td>Likelihood 4</td>
<td>Likelihood 3</td>
</tr>
<tr>
<td>Controls: (What are we doing to mitigate the risk?)</td>
<td>Regular contract and quality assurance visits, including clinical visits</td>
</tr>
<tr>
<td></td>
<td>Commissioning network is used to share intelligence</td>
</tr>
<tr>
<td></td>
<td>Any Qualified Provider (AQP) Framework and Contracts</td>
</tr>
<tr>
<td></td>
<td>Market Management meetings with owners</td>
</tr>
<tr>
<td></td>
<td>Provider forums with providers &amp; commissioners</td>
</tr>
<tr>
<td></td>
<td>Domiciliary care providers staff and employment checks</td>
</tr>
<tr>
<td></td>
<td>Homecare Contract agreed for next 3 years by Mayor &amp; Cabinet, starting 1st April 2016</td>
</tr>
<tr>
<td></td>
<td>Business Continuity Plans for CCG / LA.</td>
</tr>
<tr>
<td></td>
<td>QA summit process with NHSE if poor CQC rating or other</td>
</tr>
<tr>
<td>Quality concerns</td>
<td></td>
</tr>
<tr>
<td>------------------</td>
<td></td>
</tr>
<tr>
<td>Joint Provider Failure Policy - September 2016.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Assurance Sources:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contracts Aggregated Dashboards</td>
</tr>
<tr>
<td>Commissioning Network Minutes</td>
</tr>
<tr>
<td>AQP Quality Reports</td>
</tr>
<tr>
<td>Provider Forum Minutes</td>
</tr>
<tr>
<td>CQC Reports</td>
</tr>
<tr>
<td>Exceptional reporting to the Integrated Governance Committee</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk Assurances: (What evidence do we have that the controls are working?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review of lessons learnt from last year's care home closure.</td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th>Gaps in Risk Controls:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blurred regulatory responsibilities for taking enforcement action.</td>
</tr>
<tr>
<td>Updated market intelligence - not due until February 2017.</td>
</tr>
<tr>
<td>Previous learning translated into policy and processes.</td>
</tr>
<tr>
<td>Learning from provider failures - Care Plus Partnership</td>
</tr>
<tr>
<td>Learning Lesson’s</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Actions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint market position statement (as per care Act requirements) - March 2017.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Last updated:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dee Carlin 15th February 2017</td>
</tr>
</tbody>
</table>
**Corporate Objective:** High Quality Care and Best Value

**Risk**

Primary Care - Federations (Risk ID 52)

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

The risk is:
The outcomes and improvements associated with delivery of the GP Federation contracts are not realised.

It is caused by:
- Insufficient internal resources to manage/monitor and performance review contracts; Federation (x4/5)
- GP Federations are not sufficiently developed to deliver contract

It could lead to:
- Non delivery of outcomes including associated QIPP
- There will be delays in realising the benefits and outcome associated with the Co-ordinated Care Contract with GP Federations due to late commencement of the contracts.

<table>
<thead>
<tr>
<th>Risk Owner:</th>
<th>Braithwaite, Diana</th>
<th>Risk Manager:</th>
<th>Braithwaite, Diana</th>
</tr>
</thead>
<tbody>
<tr>
<td>Directorate:</td>
<td>Commissioning &amp; Primary Care Directorate</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Risk Appetite:** Moderate

**Risk Response:** Mitigate

**Original Score:** High Risk

**Current Score:** High Risk

**Target Score:** Moderate Risk

**Risk Movement:** None

<table>
<thead>
<tr>
<th>Impact x</th>
<th>Likelihood</th>
<th>Impact x</th>
<th>Likelihood</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>3</td>
<td>4</td>
<td>1</td>
</tr>
</tbody>
</table>

**Controls: (What are we doing to mitigate the risk?)**

- London Partnership programme supports the development of Federations (currently being delivered PwC).
- Review of contract performance by the Primary Care Programme Board, Primary Care Joint Committee and Governing Body

**Assurance Sources:** Primary Care Programme Board

**Risk Assurances: (What evidence do we have that the controls are working?)**

TBC (Contracts have just been signed)

<table>
<thead>
<tr>
<th>Assurance Type:</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assurance level:</td>
<td>Limited</td>
</tr>
<tr>
<td>Gaps in Risk Controls:</td>
<td></td>
</tr>
<tr>
<td>------------------------</td>
<td></td>
</tr>
<tr>
<td>• Identification and development of internal resources to manage/monitor and performance review contracts; Federation (x4)</td>
<td></td>
</tr>
<tr>
<td>• Development of Co-ordinated-Care contract performance dashboard</td>
<td></td>
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<tr>
<td>Actions:</td>
<td></td>
</tr>
<tr>
<td>• Agree internal resources for Primary Care, which will then support the development of the appropriate reporting tools.</td>
<td></td>
</tr>
</tbody>
</table>

Last updated:
### Corporate Objective:
High Quality Care and Best Value

<table>
<thead>
<tr>
<th>Risk</th>
<th>Quality Primary Care (Risk ID 65)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risk Description: (What is the risk?)</strong></td>
<td>The risk is: That NHS England does not secure the GP core services contract for 2017/18 as part of the national PMS Review.</td>
</tr>
<tr>
<td><strong>It is caused by:</strong></td>
<td>• The contract requirements and Premium specifications are not appropriately defined and agreed with GP practices by NHS England and the CCG</td>
</tr>
<tr>
<td><strong>It could lead to:</strong></td>
<td>• Variation in the quality of service provided by individual practices will not be improved.</td>
</tr>
</tbody>
</table>

| Risk Owner: | Braithwaite, Diana |
| Directorate: | Commissioning & Primary Care Directorate |
| Risk Appetite: | Moderate |
| Risk Manager: | Braithwaite, Diana |
| Risk Response: | Accept |

<table>
<thead>
<tr>
<th>Original Score:</th>
<th>Current Score:</th>
<th>Target Score:</th>
<th>Risk Movement:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very High Risk</td>
<td>High Risk</td>
<td>High Risk</td>
<td>None</td>
</tr>
<tr>
<td>Impact 4 x</td>
<td>Impact 4 x</td>
<td>Impact 4 x</td>
<td></td>
</tr>
<tr>
<td>Likelihood 4</td>
<td>Likelihood 3</td>
<td>Likelihood 2</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Controls: (What are we doing to mitigate the risk?)</th>
<th>Primary Care Joint Committee approves commissioning intentions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Performance &amp; Quality reporting on GP services to the Primary Care Development Board and Primary Care Joint Committee – escalation to the Integrated Governance Committee.</td>
</tr>
<tr>
<td></td>
<td>Development of targetted outlier GP practices programme.</td>
</tr>
<tr>
<td></td>
<td>Development of PMS Premium performance dashboard to review delivery against specifications and KPIs.</td>
</tr>
<tr>
<td></td>
<td>Development of targetted outlier GP practices programme.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Assurance Sources:</th>
<th>Quality &amp; Performance Reports to the Primary Programme Board and Primary Care Joint Committee.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Integrated Performance Reports to Integrated Governance Committee.</td>
</tr>
</tbody>
</table>

| Risk Assurances: (What evidence) | Performance reporting to Integrated Governance Committee (Monthly Performance Reports) IA+ |

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**do we have that the controls are working?)**

| Assurance Type: | Management |
| Assurance level: | Limited |
| Gaps in Risk Controls: | NHS England have not been able to agree the London Offer for the Core Contract with the London-Wide Local Medical Committee. *Quality reports.* |
| Actions: | NHS England continue with negotiations with the London-Wide Local Medical Committee to agree the Core Contract. *Develop quality reporting system for April 2017.* |

**Last updated:**
**Corporate Objective:** Governance - Planning and Control

**Risk**

Sustainable Operating Plan and Contracts 2017/18 to 2018/19
(Risk ID 76)

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

The Risk is that the CCG does not, within required deadlines, 1) agree a two year operating plan that meets NHSE business rules 2) agrees contracts that deliver the STP and operating plan assumptions and commitments 3) identifies sufficient financial risk mitigations

It is caused by:

- The size of QIPP challenge
- Uncertainty over STP control totals for CCGs
- Cost pressures from adjustments to CCG RRL

It could lead to:

- failing to meet planning expectations of IAF for 2017/18
- contract mediation and/or arbitration
- inability to deliver balanced budget on a planning basis
- inability to commit to new investments
- loss of reputation

**Risk Owner:** Braithwaite, Diana  
**Risk Manager:** Read, Tony  
**Directorate:** Corporate Directorate  
**Risk Appetite:** Low  
**Risk Response:** Mitigate

<table>
<thead>
<tr>
<th>Original Score:</th>
<th>Current Score:</th>
<th>Target Score:</th>
<th>Risk Movement:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very High Risk</td>
<td>Very High Risk</td>
<td>High Risk</td>
<td></td>
</tr>
<tr>
<td>Impact 5 x</td>
<td>Impact 5 x</td>
<td>Impact 5 x</td>
<td></td>
</tr>
<tr>
<td>Likelihood 3</td>
<td>Likelihood 3</td>
<td>Likelihood 3</td>
<td></td>
</tr>
</tbody>
</table>

**Controls:** (What are we doing to mitigate the risk?)

- STP Operating plan 2016/17
- Emergency Review Report
- Local Pricing Report
- Draft QIPP plan 2017/18
- Draft activity plan 2017/18
- Reconciliation between SUS SEM And SUS PBR and SLAM data
- Contract negotiation parameters
- Ambulatory Care pathway agreement
- STP targeted CCG financial control total
| Assurance Sources: | Draft Finance summary Plan submitted to NHSE 1 November 2016  
STP submission October 2016 and NHS England feedback  
NHS England assurance following submission of plan  
December 2016  
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk Assurances: (What evidence do we have that the controls are working?)</td>
<td>NHS England Assurance Assessment of Plan to Integrated Governance Committee</td>
</tr>
<tr>
<td>Assurance Type:</td>
<td>None</td>
</tr>
<tr>
<td>Assurance level:</td>
<td>None</td>
</tr>
</tbody>
</table>
| Gaps in Risk Controls: | STP CCG control totals not achieved  
Unidentified QIPP (£800k)  
Net negative risk in financial plan. |
| Actions: | 1. Identify QIPP to eliminate unidentified.  
2. Increase delivery confidence in QIPP plan.  
3. Identify QIPP stretch for 17/18 and 18/19.  
4. Tighten expenditure controls.  
5. Review PMO arrangements. |
| Last updated: | Tony Read/Victoria Medhurst 01/03/2017 |
Corporate Objective: High Quality Care and Best Value

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

Risk Description: (What is the risk?)
The risk is that the acute providers do not deliver against contract requirements including performance and/or quality standard for Referral to Treatment (RTT)

It is caused by:
• The contract requirements and specification are not appropriately defined and agree with providers
• The CCG does no utilise all available resources and processes to manage contract variations against performance and quality standards.
• Poor provider performance

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

Risk Owner: Braithwaite, Diana
Risk Manager: Rahman, Michelle
Directorate: Commissioning & Primary Care Directorate

Risk Appetite: Moderate
Risk Response: Mitigate

Original Score: Current Score: Target Score: Risk Movement:
Very High Risk High Risk High Risk
Impact 4 x Impact 4 x Impact 4 x
Likelihood 4 Likelihood 4 Likelihood 3

Controls: (What are we doing to mitigate the risk?)
• The CCG has a signed contract
• The contract is underpinned by agreed specifications
• The CCG has included appropriate contractual penalty caluses and incentives
• The CCG has employed an expert multi-disciplinary team
The CCG has a Contract Management Board with appropriate sub-committees (Performance and CQRG).

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

**Assurance Sources:**

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

**Risk Assurances:**

(What evidence do we have that the controls are working?)

- Signed contracts and register.
- Integrated Performance Reports to the Integrated Governance Committee.
- Bi-monthly performance reports to the Governing Body.
- Quality indicator reports to CQRGs.
- Lewisham & Greenwich Trust Contract Management Board and Performance Reports.
- Revised RTT Trajectory Plan has been agreed with LGT.
- Bi-weekly teleconference calls with the Trust to review the Patient Tracking List (PTL) and monitor progress towards clearing the backlog (CSU & CCG).

**Assurance Type:** Management

**Assurance level:** Adequate

**Gaps in Risk Controls:**

*KCH validation of 18 weeks waiting list and therefore assurance of delivery of the trajectory is dependent on this second tranche.*

**Actions:**

*The host commissioner via CSU need to provide the CCG with a validated position or milestones for achievement.*

**Last updated:** Diana Braithwaite/Mike Hellier 16.02.2017
## Corporate Objective:
High Quality Care and Best Value

### Risk

**Acute Providers – Delivering Quality: A&E 4 hour standard (Risk ID 78)**

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

The risk is that the acute providers do not deliver against contract requirements including performance and/or quality standards for A&E

**It is caused by:**
- The contract requirements and Premium specifications are not appropriately defined and agreed with providers.
- The CCG does not utilise all available resources and processes to manage contract variations against performance and quality standards.
- Poor provider performance.

**It could lead to:**
- NHS Constitution Standards are not met or agreed local trajectory is not delivered.
- Elective Activity is not in line with plan impacts on the Trust ability to deliver against the constitutional standards.
- A serious safeguarding incident.
- Harm to patients.
- Poor patients experience.
- Inequalities are not reduced.
- Failure to deliver and/or overshoot agreed activity level.
- Failure to deliver within affordable financial resources.

### Risk Owner:
Braithwaite, Diana

### Risk Manager:
Rahman, Michelle

### Directorate:
Commissioning & Primary Care Directorate

### Risk Appetite:
Moderate

### Risk Response:
Mitigate

### Original Score:

<table>
<thead>
<tr>
<th>Impact 4 x Likelihood 4</th>
<th>Current Score: Impact 4 x Likelihood 4</th>
<th>Target Score: Impact 4 x Likelihood 4</th>
<th>Risk Movement: Increased</th>
</tr>
</thead>
</table>

### Controls: (What are we doing to mitigate the risk?)

- The CCG has signed contract with the provider/s, underpinned with specifications and penalties.
- The CCG has employed an expert multi-disciplinary team (MDT) from the South London Commissioning Support Unit (CSU). This has been reinforced by the appointment of a Programme Director role to oversee the workstreams across the emergency pathway for BGL. Interim in post and substantive appointed as of 01/04/17.
- The CCG has a Contract Management Board with appropriate sub-committees (Clinical Quality Review – CQRG and Performance Groups).
- Lewisham & Greenwich Trust A&E Trajectory has been agreed and submitted to NHS England.
- Bexley, Greenwich & Lewisham A&E Delivery Board.

**Assurance Sources:**
- *Reports and minutes: Integrated Governance Committee; BGL A&E Delivery Board; Contract Management Board (CYP and Community); CQRG*
- *NHS England Stocktakes.*

**Risk Assurances: (What evidence do we have that the controls are working?)**
- Signed contracts and contracts register
- Performance reporting to Integrated Governance Committee
- Bi Monthly Performance Reports to Governing Body
- Quality indicator reports to CQRGs
- Lewisham & Greenwich Trust Contract Management Board Reports
- The Lewisham & Greenwich Trust Contract has been agreed as a result of mediation; 6 month block on non-elective activity with an independent audit to be commissioned on emergency admissions
  System Winter Plans submitted to NHSE

**Assurance Type:** Management
**Assurance level:** Adequate

**Gaps in Risk Controls:**
- *There is not a system-wide focussed recovery plan, with identified metrics to support delivery of the trajectory.*

**Actions:**
- *Development and approval of the system-wide focussed recovery plan (See Exception Report).*

**Last updated:** Diana Braithwaite/Mike Hellier 16.02.2017
# Appendix B - Risk Appetite Matrix

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

<table>
<thead>
<tr>
<th>Good Governance Institute 2.2 Nov 2011</th>
<th>Appendix 4 Risk Appetite for NHS Organisations - A maturity matrix to support better use of risk in decision taking</th>
<th>Developed with Southwark BSU</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risk levels</strong></td>
<td><strong>Key elements</strong></td>
<td><strong>5 Values</strong></td>
</tr>
<tr>
<td>D Award</td>
<td>Awareness of risk and uncertainty is a key Corporate objective</td>
<td>Confident in setting high levels of risk appetite because controls, barriers, monitoring and management systems are robust</td>
</tr>
<tr>
<td>I Minimal (LG2)</td>
<td>Performance of all duties expected to be undertaken and all risk to the organisation is known and managed using the risk matrix</td>
<td>Prepared to invest the time and resources needed to enhance the security of the organisation</td>
</tr>
<tr>
<td>2 Cautional (LG3)</td>
<td>Performance of all duties expected to be undertaken and all risk to the organisation is known and managed using the risk matrix</td>
<td>Prepared to invest the time and resources needed to enhance the security of the organisation</td>
</tr>
<tr>
<td>3 Ambitious (LG4)</td>
<td>Performance of all duties expected to be undertaken and all risk to the organisation is known and managed using the risk matrix</td>
<td>Prepared to invest the time and resources needed to enhance the security of the organisation</td>
</tr>
<tr>
<td>4 Risk-taking</td>
<td>Prepared to invest the time and resources needed to enhance the security of the organisation</td>
<td>Prepared to invest the time and resources needed to enhance the security of the organisation</td>
</tr>
<tr>
<td>S Significantly</td>
<td>Prepared to invest the time and resources needed to enhance the security of the organisation</td>
<td>Prepared to invest the time and resources needed to enhance the security of the organisation</td>
</tr>
</tbody>
</table>

| Financial /VFM                       | **Risk Appetite Matrix**                                                                                   | Confident in setting high levels of risk appetite because controls, barriers, monitoring and management systems are robust |
| Compliance / regulatory              | Prepared to accept the possibility of very limited financial loss, offer all stakeholders an opportunity to consider the benefits of complying with the risk and the opportunities associated with not complying | Prepared for the best possible market and accept the possibility of financial loss, offer all stakeholders an opportunity to consider the benefits of complying with the risk and the opportunities associated with not complying |
| Innovation/Quality/Outcomes          | Prepared for the best possible market and accept the possibility of financial loss, offer all stakeholders an opportunity to consider the benefits of complying with the risk and the opportunities associated with not complying | Prepared for the best possible market and accept the possibility of financial loss, offer all stakeholders an opportunity to consider the benefits of complying with the risk and the opportunities associated with not complying |
| Reputation                           | Prepared for the best possible market and accept the possibility of financial loss, offer all stakeholders an opportunity to consider the benefits of complying with the risk and the opportunities associated with not complying | Prepared for the best possible market and accept the possibility of financial loss, offer all stakeholders an opportunity to consider the benefits of complying with the risk and the opportunities associated with not complying |

<table>
<thead>
<tr>
<th><strong>APPETITE</strong></th>
<th><strong>LOW</strong></th>
<th><strong>HIGH</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>[Table Row 1]</td>
<td>[Table Data]</td>
<td>[Table Data]</td>
</tr>
<tr>
<td>[Table Row 2]</td>
<td>[Table Data]</td>
<td>[Table Data]</td>
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<td>[Table Row 3]</td>
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<tr>
<td>[Table Row 4]</td>
<td>[Table Data]</td>
<td>[Table Data]</td>
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<tr>
<td>[Table Row 5]</td>
<td>[Table Data]</td>
<td>[Table Data]</td>
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<tr>
<td>[Table Row 6]</td>
<td>[Table Data]</td>
<td>[Table Data]</td>
</tr>
</tbody>
</table>

*Table Row 1: [Table Data]*
*Table Row 2: [Table Data]*
*Table Row 3: [Table Data]*
*Table Row 4: [Table Data]*
*Table Row 5: [Table Data]*
*Table Row 6: [Table Data]*
## Glossary of terms: Risk

### Risk Definition

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

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

<table>
<thead>
<tr>
<th>A</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Action Required</strong></td>
<td>Work that is required to close assurance gaps</td>
</tr>
<tr>
<td><strong>Action Target Date</strong></td>
<td>The date that the actions are due to be completed</td>
</tr>
<tr>
<td><strong>Assurance Gaps</strong></td>
<td>Where the CCG has no evidence of whether or not its controls are effective</td>
</tr>
<tr>
<td><strong>Assurance Given</strong></td>
<td>The evidence that controls are effective or not</td>
</tr>
<tr>
<td><strong>Assurance Level</strong></td>
<td>The strength of the evidence; None, Limited, Adequate, Significant</td>
</tr>
<tr>
<td><strong>Assurance Source</strong></td>
<td>Where the CCG finds evidence that its controls are effective</td>
</tr>
<tr>
<td><strong>Assurance Type</strong></td>
<td>Whether the evidence was generated and collated by management (Internal Assurance shown as IA+ for positive assurance and IA- in red text for negative assurance) or by an independent body (External Assurance shown as EA+ for positive assurance and EA- in red text for negative assurance)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Controls</strong></td>
<td>What the CCG has put in place to lessen the impact of the risk should it occur and reduce the likelihood of it occurring</td>
</tr>
<tr>
<td><strong>Current Score</strong></td>
<td>The Current (‘residual’) risk score which is the most recent risk assessment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>O</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Original Score</strong></td>
<td></td>
</tr>
</tbody>
</table>
The score that has been assessed at the beginning of the financial year

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

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

Risk appetite is normally smaller or less than risk tolerance.

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

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

**Risk Scores**
Risk Scoring Matrix

<table>
<thead>
<tr>
<th>Likelihood</th>
<th>Almost Certain 5</th>
<th>Likely 4</th>
<th>Possible 3</th>
<th>Unlikely 2</th>
<th>Rare 1</th>
<th>Risk Matrix</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Moderate</td>
<td>High</td>
<td>Very High</td>
<td>Very High</td>
<td>Very High</td>
<td>Negligible 1</td>
</tr>
<tr>
<td></td>
<td>Moderate</td>
<td>High</td>
<td>High</td>
<td>Very High</td>
<td>Very High</td>
<td>Minor 2</td>
</tr>
<tr>
<td></td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
<td>High</td>
<td>Very High</td>
<td>Moderate</td>
</tr>
<tr>
<td></td>
<td>Low</td>
<td>Moderate</td>
<td>Moderate</td>
<td>High</td>
<td>High</td>
<td>Major 4</td>
</tr>
<tr>
<td></td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
<td>Moderate</td>
<td>Moderate</td>
<td>Catastrophic 5</td>
</tr>
</tbody>
</table>

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

Risks are evaluated using the matrix x * y, shown as I * L (Impact * Likelihood), and scored as:
- 1 - 3 (green) Low Risk
- 4 - 6 (yellow) Moderate Risk
- 9 - 12 (amber) High Risk

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

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

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

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

<table>
<thead>
<tr>
<th>T</th>
<th><strong>Target Score</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The Target risk score is the level of risk which the CCG Board has deemed acceptable level, reflecting the CCG’s risk appetite and which the CCG plans to achieve once all the controls are fully applied and proved to be effective.</td>
</tr>
</tbody>
</table>
A meeting of the Governing Body
9th March 2017

EDS2 (Equality Delivery System2) –
Completion of EDS2 2016 and EDS2 Summary Report for 2016/17

| CLINICAL LEAD: Dr David Abraham | Senior Clinical Lead |
| MANAGERIAL LEAD: Charles Malcolm-Smith | Deputy Director (Strategy & Organisational Development) |
| AUTHORS: Valerie Richards | Equality & Diversity Lead, South East Commissioning Support Unit |

RECOMMENDATIONS: The Governing Body is asked to:
- Note the report on the completion of the EDS2 2016/17 process and approve the EDS2 Summary Report to enable it to be published on the CCG website and the NHS England EDS2 Dashboard.

KEY ISSUES:

1. Background

1.1 The EDS2 is an equality performance tool that all CCGs and NHS provider organisations are required to use. The EDS is a vehicle for dialogue which brings together the evidence and perspectives of all stakeholders, including the views of local people, to find areas of potential improvement across the 4 goals – in particular, improvements relevant to those who share one or more protected characteristic. The EDS process can only be complete when external stakeholders have had an opportunity to give their opinion on the performance of their CCG.

1.2 This report provides an update on the completion of Equality Delivery System2 (EDS) process for 2016/17.

2 Completion of Equality Delivery System2 (EDS) process for 2016/17

2.1 The EDS2 process for 2016/17 started in May 2016 below are highlights of events for each Goal:
Fig. 1 Lewisham CCG 2016 Equality Delivery System (EDS) Events

<table>
<thead>
<tr>
<th>EDS2 Goal</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – Better Health Outcomes</td>
<td>Lewisham CCG Public Reference Group takes part in developing case studies shortlist.</td>
</tr>
<tr>
<td>3 – A representative and supported workforce</td>
<td>Staff Survey launch – October 2016 Review of the Staff Survey responses by Equality and Diversity Steering Group on 22 February 2017</td>
</tr>
<tr>
<td>4 – Inclusive leadership</td>
<td>Independent Review of evidence – 1 February 2017</td>
</tr>
</tbody>
</table>

2.2 The EDS2 Grading agreed for each Goal is outlined in Fig 2 below

Fig. 2 Lewisham CCG 2016/17 Equality Delivery System (EDS) Grading

<table>
<thead>
<tr>
<th>EDS2 Goal</th>
<th>Grading achieved 2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – Better Health Outcomes</td>
<td>ACHIEVING</td>
</tr>
<tr>
<td>2 – Improved patient access and experience</td>
<td>DEVELOPING</td>
</tr>
<tr>
<td>3 – A representative and supported workforce</td>
<td>DEVELOPING</td>
</tr>
<tr>
<td>4 – Inclusive leadership</td>
<td>DEVELOPING</td>
</tr>
</tbody>
</table>

2.3 The EDS2 Grading in 2016/17 for Goal 1 is ‘ACHIEVING’. This is based on the outcomes of the stakeholder panel events that looked at three example services: Community Anti-coagulation Monitoring Service, Home Treatment Team for Adults Mental Health - Working Age Adults, and Lewisham Maternity Service.

2.4 The CCG Grading for EDS2 Goal 2 is ‘DEVELOPING’. This means the CCG’s commissioning of the three services reviewed resulted in people from many of the protected groups having good access and experience of the services compared to people overall, but there is still more to be done to ensure that all protected groups have good access and experiences. Actions for improvement have been identified for each of the services, common areas including collection of data and better use of translation services.

2.5 The CCG grade for EDS2 Goal 3 was agreed as ‘DEVELOPING’. This grade took into account the results of the Staff Survey which demonstrated that the data available to the CCG supplied data for most of the protected characteristics therefore, overall most staff members from most protected groups fare as well as the overall workforce. However, the results of the Staff Survey results highlighted areas that require improvement. An action
plan will be prepared and then monitored by the Equality & Diversity Steering Group.

2.6 The CCG grade for Goal 4 was assessed by an Independent Review as ‘DEVELOPING’ which means that more emphasis can be made on Lewisham CCG leading the way on commissioning inclusive health services which meet the specific and general health needs of all people in Lewisham, in particular by focusing on getting services right for those who experience the greatest need and barriers due to sharing one or more protected characteristic. The independent assessor noted a number of improvements in the referencing in reports and discussion of equalities issues, increasing levels of knowledge, and participation. Areas for further development include the need for all clinical leads to provide the examples and evidence to demonstrate this area of leadership. An action plan for improvements in Goal 4 will be developed.

2.7 An EDS2 Summary report with details of the process and evidence reviewed can be found at Appendix 1. This report needs to be approved by the CCG Governing Body, then published on the CCG website and the link to the report put on the NHS England EDS2 Dashboard by 31 March 2017.

3 How does the CCG EDS2 2016 performance compare with 2015/16?

3.1 In 2015/16 the overall EDS2 grading for the CCG was ACHIEVING / DEVELOPING because both were awarded for two each of the four goals. See Fig 3 below for more details.

![Fig.3 Lewisham CCG 2015/16 Equality Delivery System (EDS) Grading](image)

3.2 From 2015/16, there has been a reduction in performance for Goal 2 that was awarded the lower grade of DEVELOPING for 2016/17. The 2015/16 grading was based on different services, and the learning from them has been shared within the CCG and will inform further development and improvement actions.

3.3 The performance for Goal 3 remained at DEVELOPING as in 2015/16, due to the results of the independent review of the Staff Survey results. This is to be addressed by an action plan.

3.4 In 2016/17 the result for Goal 4 remained at DEVELOPING even though, as above, improvement was noted by the independent assessor.
**CORPORATE AND STRATEGIC OBJECTIVES**

The EDS and its assessment processes support the CCG in meeting its statutory equality and diversity responsibilities.

**CONSULTATION HISTORY:** In December 2016 the Strategy and Development Committee session focused on Equalities, particularly EDS2 Goal4 Outcomes 4.1 and 4.

Governing Body members were requested to complete and submit examples of demonstrating their commitment to equalities inside/outside the CCG in during 2016.

**PUBLIC ENGAGEMENT:** Stakeholder workshops were held in September 2016 and January 2017 to determine the gradings for EDS2 Goals 1 and 2.

**HEALTH INEQUALITY DUTY:** The purpose of EDS2 Goals 1 and 2 is to help organisations to understand if the services they have commissioned are providing better health outcomes and improved patient access and experience. The key question of EDS2 is “How well do people from protected groups fare compared with people overall?” Therefore, when Lewisham CCG carries out the EDS2 it is an opportunity to analyse performance, identify any gaps or areas that require improvement and identify any high risk areas priorities for setting objectives.

**PUBLIC SECTOR EQUALITY DUTY:** The EDS was created by the NHS in response to the Equality Act 2010 and if completed well it helps NHS organisations to meet the general and specific duties of the Act. This is because in collecting evidence and engaging with stakeholders the CCG is able to:

- Demonstrate how it is meeting the three aims of the general duty to:
  - Eliminate unlawful discrimination or any other conduct prohibited by or under the Act
  - Advance equality of opportunity between persons who share a protected characteristic and persons who do not share it.
  - Foster good relations between people who share a relevant protected characteristic and people who do not share it.

- Meet the specific duties by using the evidence to inform the Annual Equality Report and to create Equality Objectives.

**RESPONSIBLE MANAGERIAL LEAD CONTACT:**

Name: Charles Malcolm-Smith  
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Telephone: 020 7206 3246

**AUTHOR CONTACT:**

Name: Valerie Richards  
E-Mail: valerierichards@nhs.net  
Telephone: 020 3049 4167
Implementation of the Equality Delivery System – EDS2 is a requirement on both NHS commissioners and NHS providers. Organisations are encouraged to follow the implementation of EDS2 in accordance with the ‘9 Steps for EDS2 Implementation’ as outlined in the 2013 EDS2 guidance document. The document can be found at: http://www.england.nhs.uk/wp-content/uploads/2013/11/eds-nov131.pdf

This EDS2 Summary Report is designed to give an overview of the organisation’s most recent EDS2 implementation. It is recommended that once completed, this Summary Report is published on the organisation’s website.

**NHS organisation name:**
Lewisham CCG

**Organisation’s Board lead for EDS2:**
David Abraham, Senior Clinical Lead

**Organisation’s EDS2 lead (name/email):**
Charles Malcolm-Smith charles.malcolm-smith@nhs.net / Valerie Richards valerierichards@nhs.net

**Level of stakeholder involvement in EDS2 grading and subsequent actions:**

For Goals 1 and 2 the CCG held two EDS2 Stakeholder Panel events. The panels included representatives from:
- Healthwatch in Lewisham
- Lewisham Public Reference Group Members
- Lewisham residents with an interest in Lewisham health services
- Service Users
- Lewisham Health LLP representative
- Pharmacist with special interest in Anticoagulation
- Senior Clinician, SLaM
- Heads of Midwifery, Lewisham and Greenwich NHS Trust

- Consultant Midwife
- Consultant Midwife in Public Health
- Maternity Services Liaison Committee (MSLC) member
- Joint Commissioner, Children & Young People
- For Goal 3 and Outcome 4.3 an assessment was carried out on the basis of feedback from a staff survey 2016 (which received a 75% response rate).

To assess Goal 4 73% of Governing Body members provided feedback giving examples of their commitment to equality and diversity.

**Organisation’s Equality Objectives (including duration period):**

The Equality Objectives associated with Goals 1 and 2 for 2015/16 include: Support for people with Long Term Conditions: Reduce the gap between BME patients experience and White British patients experience in relation to patients feeling supported with their Long Term Conditions.

The Equality Objectives for Goals 3 and 4 include:
To ensure Lewisham CCG is an organisation that is representative of its population and has a workforce that is supported.
Headline good practice examples of EDS2 outcomes (for patients/community/workforce):

(a) Home Treatment Team for Adults Mental Health –

Working Age Adults The following good practice was identified for this service area:

• The service is having a positive effect according to impact assessments.

• Discharge planning begins straight away; handover to other services is through face to face meetings to which carers are invited.

• High uptake of physical health checks, issues of self-neglect likely to be picked up

(b) Community Anti-coagulation Monitoring Service

• The following good practice was identified for this service area:

  • Pharmacists receive same training as registrars at hospitals
  • Convenience of local services, eases access, saves time
  • Service extended to housebound thereby further improving access
  • Personalised service and care described as excellent which leads to service users feeling informed and supported in decisions around their care and provider very positive experiences of their care.

  • Pharmacists maintain good relationships with GPs

  • Safety and safeguarding is good partly due to good communication between the hospital, GPs and pharmacists.

  • Monthly audit of pharmacists state all clients must be controlled with an 80% medical safety score.

  • All pharmacists offering the service are part of the Healthy Living pharmacists scheme

(c) Lewisham Maternity Service

• The following good practice was identified for this service area:

  • Services was reviewed two years ago and a collaborative group including the MSLC took part in the redesign. The redesign was the beginning of alliance with CYP Team.

  • Commissioners requested qualitative data from the provider (as part of the service specification that looks at specific needs of ethnic groups, subsets diabetes, high blood pressure, disability, ethnic groups.

  • Peri-natal leads now in each unit that ensure IAPT referrals must be seen assessed in two weeks.

  • A peri-natal mental health specialist midwife is being recruited.

  • The tariff demonstrates that the service is responsive to the varying needs presenting

  • Good communication between GPs and Maternity Service. Maternity Service inform GPs of patients who directly refer themselves and ask GPs to share health information on the patient.

  • Head of Midwifery regularly makes presentations to the CQRG on performance.

  • SIs are minimal and deep dives have been conducted in response to trends identified, e.g. Still birth and following concerns about increasing LSCS (lower segment Caesarean section).

  • Midwives work with other services to meet the needs of client

  • CQUIN has helped with language/communication and disability
<table>
<thead>
<tr>
<th>Goal</th>
<th>Outcome</th>
<th>Grade and reasons for rating</th>
<th>Outcome links to an Equality Objective</th>
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<td>Better health outcomes</td>
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<td><strong>Services are commissioned, procured, designed and delivered to meet the health needs of local communities</strong></td>
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<td><strong>Individual people’s health needs are assessed and met in appropriate and effective ways</strong></td>
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<td><strong>Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed</strong></td>
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<tr>
<td>Better health outcomes, continued</td>
<td>1.4</td>
<td><strong>When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse</strong>&lt;br&gt;&lt;br&gt;<strong>Grade</strong>&lt;br&gt;Undeveloped (Red) Developing (Orange) Achieving (Green) Excelling (Purple)&lt;br&gt;<strong>Which protected characteristics fare well</strong>&lt;br&gt;Age, Disability, Race, Religion or belief, Sex, Sexual orientation, Pregnancy and maternity, Marriage and civil partnership&lt;br&gt;&lt;br&gt;<strong>Evidence drawn upon for rating</strong>&lt;br&gt;Home Treatment Team for Adults Mental Health - Working Age Adults: The EDS2 Stakeholder Panel noted that the service that the service ensures that all risk assessment and safeguarding protocols are adhered to and this is regularly audited at clinical review meetings. Community Anti-coagulation Monitoring Service: The EDS2 Stakeholder Panel noted the services complies with</td>
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<td>1.5</td>
<td><strong>Screening, vaccination and other health promotion services reach and benefit all local communities</strong>&lt;br&gt;&lt;br&gt;<strong>Grade</strong>&lt;br&gt;Undeveloped (Red) Developing (Orange) Achieving (Green) Excelling (Purple)&lt;br&gt;<strong>Which protected characteristics fare well</strong>&lt;br&gt;Age, Disability, Race, Religion or belief, Sex, Sexual orientation, Pregnancy and maternity, Marriage and civil partnership&lt;br&gt;&lt;br&gt;<strong>Evidence drawn upon for rating</strong>&lt;br&gt;Home Treatment Team for Adults Mental Health - Working Age Adults: The EDS2 Stakeholder Panel noted that the team assesses for substance misuse and can provide psychological interventions. Also the team will signpost to other relevant health promotion services, i.e. sexual health, dieticians, Carers Lewisham, the Lewisham LifestyleHub.</td>
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<td>Improved patient access and experience</td>
<td>2.1</td>
<td><strong>People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds</strong>&lt;br&gt;&lt;br&gt;<strong>Grade</strong>&lt;br&gt;Undeveloped (Red) Developing (Orange) Achieving (Green) Excelling (Purple)&lt;br&gt;<strong>Which protected characteristics fare well</strong>&lt;br&gt;Age, Disability, Race, Religion or belief, Sex, Sexual orientation, Pregnancy and maternity, Marriage and civil partnership&lt;br&gt;&lt;br&gt;<strong>Evidence drawn upon for rating</strong>&lt;br&gt;Home Treatment Team for Adults Mental Health - Working Age Adults: The EDS2 Stakeholder Panel noted that the data routinely collected on service users’ access covered four of the protected characteristics. The service is for adults aged 18-65 who are resident in Lewisham and in mental health crisis. No one is denied access to the service on any basis other than their age or address.</td>
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<td>People are informed and supported to be as involved as they wish to be in decisions about their care</td>
<td>2.2</td>
<td><strong>Grade</strong>&lt;br&gt;Undeveloped  Developing  Achieving  Excelling  &lt;br&gt;<strong>Which protected characteristics fare well</strong>&lt;br&gt;Age  Disability  Gender reassignment  Marriage and civil partnership  Pregnancy and maternity  Race  Religion or belief  Sex  Sexual orientation</td>
<td>- Home Treatment Team for Adults Mental Health - Working Age Adults: The EDS2 Stakeholder Panel noted Care plans are written collaboratively wherever possible and a copy of the care plan is given to the service user. Service users' views about their care are regularly elicited and documented. Community Anti-coagulation Monitoring Service:</td>
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<td>People report positive experiences of the NHS</td>
<td>2.3</td>
<td><strong>Grade</strong>&lt;br&gt;Undeveloped  Developing  Achieving  Excelling  &lt;br&gt;<strong>Which protected characteristics fare well</strong>&lt;br&gt;Age  Disability  Gender reassignment  Marriage and civil partnership  Pregnancy and maternity  Race  Religion or belief  Sex  Sexual orientation</td>
<td>- Home Treatment Team for Adults Mental Health - Working Age Adults: The EDS2 Stakeholder Panel noted that all service users are given the opportunity to give their views and comments about the service by completing a Community Survey. The survey is anonymous and results are collated externally. The feedback received is generally very complimentary and positive.</td>
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<td>People’s complaints about services are handled respectfully and efficiently</td>
<td>2.4</td>
<td><strong>Grade</strong>&lt;br&gt;Undeveloped  Developing  Achieving  Excelling  &lt;br&gt;<strong>Which protected characteristics fare well</strong>&lt;br&gt;Age  Disability  Gender reassignment  Marriage and civil partnership  Pregnancy and maternity  Race  Religion or belief  Sex  Sexual orientation</td>
<td>- Home Treatment Team for Adults Mental Health - Working Age Adults: The EDS2 Stakeholder Panel noted that Informal complaints are responded to within 24 hours by a senior member of the team and a face to face meeting to discuss the concerns raised is always offered. Formal complaints are responded to within the timeframes set by the Trust’s Complaints Department.</td>
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<td>A representative and supported workforce</td>
<td>3.1</td>
<td>Fair NHS recruitment and selection processes lead to a more representative workforce at all levels</td>
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<td>Grade</td>
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<tr>
<td>Undeveloped</td>
<td>Age</td>
<td>Standardised recruitment and selection processes, use of common application forms and interview questions. Staff survey 2016 results</td>
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<td>Standardised recruitment and selection processes, use of common application forms and interview questions. Staff survey 2016 results</td>
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<td>The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations</td>
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<td>CCG utilises Agenda for Change pay structure and terms and conditions of employment for staff.</td>
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<td>Training and development opportunities are taken up and positively evaluated by all staff</td>
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<td>When at work, staff are free from abuse, harassment, bullying and violence from any source</td>
<td>3.4</td>
<td>Undeveloped: Age, Disability, Gender reassignment, Marriage and civil partnership. Developing: Pregnancy and maternity, Race, Religion or belief, Sex. Achieving: Sexual orientation. Evidence drawn upon for rating: Staff survey 2016 results.</td>
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<td>Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives</td>
<td>3.5</td>
<td>Undeveloped: Age, Disability, Gender reassignment, Marriage and civil partnership. Developing: Pregnancy and maternity, Race, Religion or belief, Sex. Achieving: Sexual orientation. Evidence drawn upon for rating: Staff survey 2016 results - Flexible working policy in place.</td>
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<td>Staff report positive experiences of their membership of the workforce</td>
<td>3.6</td>
<td>Undeveloped: Age, Disability, Gender reassignment, Marriage and civil partnership. Developing: Pregnancy and maternity, Race, Religion or belief, Sex. Achieving: Sexual orientation. Evidence drawn upon for rating: Staff survey 2016 results.</td>
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<td><strong>Inclusive leadership</strong></td>
<td>4.1</td>
<td><strong>Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations</strong></td>
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<td><strong>4.1</strong></td>
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<td><strong>Marriage and civil partnership</strong></td>
<td><strong>Sex</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Sexual orientation</strong></td>
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<td></td>
<td></td>
<td></td>
<td><strong>Evidence drawn upon for rating</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Staff survey 2016 results</strong></td>
</tr>
</tbody>
</table>
Governing Body
9th March 2017

Report from the Chair of the Strategy & Development Workshop

Date of Meeting(s) reported: 2nd February 2017
Author: Dr David Abraham

Main Issues discussed

The aims of the workshop were to review strategic developments in mental health care, to review cancer outcomes data, to review the results of the Governing Body self-assessment, and to identify and agree improvement areas for the Strategy & Development workshop.

- **Mental Health Update**
  
  The presentation on strategic developments in mental health commissioning and services covered local QIPP and STP priorities for 2017-18, adult mental health acute activity, and developments within the Lewisham integration programme, in primary care, and the psychological therapies programme. A further report is scheduled for later in 2017.

- **Cancer Data**
  
  This item was a follow-up to the strategic outcomes reviewed at the meeting of October 2016. It presented further data on rates of cancer premature mortality, screening rates for bowel, breast and cervical cancer, and two week wait referrals. Discussion covered rates of referral and diagnosis, and approaches to screening, and to education and awareness raising.

- **Governance Review: Governing Body Self-Assessment**
  
  The workshop received a report on the outcomes of the Governing Body self-assessment. This included an overview of the ratings given to the Governing Body composition, information, accountability, dynamics, training and the working of committees. Individual committees will also receive reports on their ratings and identified improvement areas. The format and content of the Integrated Governance Committee was subject to particular discussion.

**Achievements**

The mental health update identified clear priorities for action over the short, medium and longer term periods. This will provide clear areas to improve service delivery.

**Challenges**

Each of the main items identified challenges. For instance, the mental health strategic update highlighted the need for greater balance between inpatient and community care in a context of increased demand. The cancer outcomes data highlighted the lower bowel
cancer screening rates that are currently lower than London and England rates, and a decline in cervical screening rates.

**Inequality & Fairness**

The Workshop identified the need for greater understanding of the equalities aspects arising from the cancer outcomes data, for instance by ethnicity and age, and this will be supported through the cancer JSNA being developed by the Public Health team.

The Governing Body self-assessment looked at how well it meets its responsibilities in respect of equality and diversity and health inequalities, and no specific improvements needs were identified in this area.
RECOMMENDATIONS:

The Governing Body are asked to:

- agree the high level summary of the Corporate Objectives for 2017/18;
- endorse the proposed ‘Next Steps’;
- agree to the Integrated Governance Committee (IGC) being responsible for overseeing the monitoring of the in-year delivery of the Corporate Objectives and the management of risks in 2017/18, on behalf of the Governing Body.

Summary

This Report sets out the work which has been undertaken to develop the CCG’s Corporate Objectives and the further work planned to finalise the Corporate Objectives, the monitoring framework and the Board Assurance Framework for 2017/18.

Corporate Objectives 2017/18

1. Planning Process to develop the Corporate Objectives

The CCG’s Corporate Objectives summarise the specific commissioning areas we will focus on in 2017/18 to deliver the CCG’s Operating Plan, together with locally agreed priorities to take forward the CCG’s strategic aims – to commission high quality health services (‘Best Care’) which improve the health outcomes and reduce inequalities for Lewisham people (‘Better Health’) in a way which is financially affordable and sustainable (Best Value’).
The CCG’s Operating Plan for 2017/18 was informed by our Partnership Commissioning Intentions 2017-2018 which identified three areas of focus for taking forward Community Based Care:

- Prevention and Early Action
- Planned care
- Urgent and Emergency Care

The Partnership Commissioning Intentions recognised that Prevention and Early Action, Planned Care and Urgent and Emergency Care were interdependent:

![Diagram showing the interdependence of Prevention and Early Action, Planned Care, and Urgent and Emergency Care]

It is not an easy process, to identify the CCG's priority areas of work, given the many different challenges facing the CCG.

The key challenges were summarised in the Partnership Commissioning Intentions 2017-2019, including:

- high quality care is not consistently available all the time - there is great variation in the current quality of local care commissioned in Lewisham;
- local services are under significant day to day pressures – all our commissioned services are facing increasing demands and pressures to deliver quality care within constrained and/or deteriorating financial parameters;
- our commissioning portfolio is skewed towards hospital/acute care - yet our strategic aim is to have a greater focus on prevention and proactive, coordinated, planned care based in the community, which will reduce our need and demand for emergency care;
- the CCG is not meeting some NHS Constitutional Standards for example waiting times in A&E, for cancer and planned treatment.
- the financial challenge to deliver targets and value for money in accordance with NHS England’s requirements, in an environment where NHS prices and activity are increasing faster than the income growth.

2. Proposed Corporate Objectives 2017/18

2.1 Overview

The Corporate Objectives have been developed jointly by the CCG’s Senior Management Team and Clinical Directors. It has required difficult decisions to be made to strive to achieve the best balance of both improving quality of commissioned care and financial targets in 2017/18 and a stepped change in the way care is commissioned in 2018/19 and beyond which is financially sustainable.

The Corporate Objectives are not intended to cover the whole scope of the CCG’s responsibilities and work.

The purpose of Corporate Objectives is to ensure that the CCG focuses its energy and effort on the commissioning areas where it will result in the greatest impact in improving the three strategic domains of Better Health, Best Care and Best Value for Lewisham people. This includes delivering a Quality, Innovation, Productivity and Prevention (QIPP) Programme of over £14 million in 2017/18.

It is proposed that the Corporate Objectives for 2017/18 for the CCG focus on the following three commissioning areas:

- Planned Care
- Urgent and Emergency Care
- Contract Management

It should be noted that the CCG’s actions on ‘prevention and early action’ is within ‘planned care’ and ‘urgent and emergency care’ and there are specific contractual aspects, particularly as part of the GP Federation and community health services contracts. The CCG will continue to work in partnership with other commissioners, the public and local providers to increase the focus on prevention and early action, working with the Health and Wellbeing Board and other partners in Lewisham Borough.

2.2 Planned Care

The planned care corporate objective is to support people with long term conditions better with proactive, holistic care which improves the quality of their lives, provided ‘out of hospital’ and reducing the requirement for hospital based outpatient attendances and inpatient admissions.

The key actions to achieve the planned care objective will include:

- Improving GPs’ care for people with long terms conditions through consistent, systematic identification of people at risk (‘risk stratification’), care planning, better multidisciplinary working at a neighbourhood level, enhanced mental health support from SLaM, peer review of elective referrals and easier access to specialist advice
and guidance.

- Enhancing the range of information and advice to support people with long term conditions to make it easier for them to self-manage their health and wellbeing and support them to engage and take control to meet their needs.

- Strengthening the management of patients with COPD and asthma by supporting self-management, piloting community clinics and improving diagnosis with enhanced spirometry training for primary care practitioners.

- Improving outcomes for people with diabetes by enhancing the primary and community skills to support better self-care and self-management, earlier identification, diagnosis and management e.g. re-procuring structured education for Type 2 Diabetes.

- Improving outcomes for people with cancer with better early diagnosis and urgent referrals for specialist advice (e.g. cancer two week wait).

- Increasing GP support to care homes to manage effectively people with more complex long term conditions.

- Delivering part of the QIPP programme for 2017/18 (£1.7m) and identifying the QIPP programme for planned care for 2018/19 onwards based on a review of the opportunities for redesign, based on Rightcare data analysis.

2.3 Urgent and Emergency Care

The Urgent and Emergency care objective is to commission Urgent care service which aligns the adult and children's physical and mental health services and addresses urgent care as early as possible 'upstream' – 'right care, right time, right place'. This is the first phase of working towards commissioning an integrated Primary and Urgent care system.

The key actions to achieve the Urgent and Emergency care objective will include:

- Redesigning the Front Door of A&E by reviewing the Urgent Care Centre and the Walk in Centres and ensuring the effective implementation of GP assessment at Lewisham’s A&E, GP Extended Access and the ambulatory care unit.

- Preventing admissions from the community by reviewing the use of community beds and re-designing the Rapid Response Team (RRT).

- Redesigning discharge pathways – the 'back door' - to facilitate earlier discharge from acute hospital and enable patients to have an assessment of their care needs in their own home.

- Aligning the adult mental health urgent and crisis care service with the urgent
care service for adults with physical health problems - including the Crisis Resolution and Home Treatment Teams and the extended psychiatric liaison service - to reduce delays in receiving treatment and the need for inpatient admission.

- **Integrating children's urgent and crisis care service** including the redesign of CAMHS to improve access and the integration of children's community nursing across Children's Community Nursing Team and Special Needs Nursing Team with the Hospital at Home.

- Delivering part of the QIPP programme for 2017/18 (£4.5m) and identifying the QIPP programme for Urgent and Emergency Care for 2018/19 onwards, based on the learning in 2017/18 and analysis of Rightcare.

### 2.4 Contract Management

The Contract Management corporate objective is to manage effectively the CCG’s contract portfolio to ensure that the CCG’s Operating Plan’s commitments are met in 2017/18. This includes ensuring our financial targets are met and value for money is delivered.

The key actions to achieve the contract management objective will include:

- **Acute Contracts** – ensuring a strong grip on contract management including the delivery of the agreed waiting times trajectories for 4 hour A&E, Referral to Treatment (RTT) and Cancer. Also improving the quality of care and implementing advice and guidance using Commissioning for Quality and Innovation (CQUIN) payments as a contract lever.

- **Community Contracts** - securing the implementation of the improved leg ulcer service and the community falls team, reviewing Musculoskeletal (MSK) services and Minor Eye Conditions Service (MECS) pathway, agreeing a new service specification for a comprehensive children’s community nursing with re-directing from the Emergency Department.

- **GP Contracts** – reducing variation in the quality of care provided by GPs, increasing appropriate access and improving prevention and early detection of Long Term conditions using the Provider Medical Services (PMS) Premium and the Coordinated Care Contract with the GP Federation; establishing arrangements and governance for delegated GP practice commissioning.

- **Mental Health Contracts** - delivering the agreed trajectories for Improving Access to Psychological Therapies (IAPT), First Episode Psychosis (FEP) and dementia diagnosis rates and improving the quality of care by reducing delays in transfers of care and the patient experience on inpatient wards.

- Delivering part of the QIPP programme for 2017/18 (£7.8m) and identifying further contractual efficiencies and effective risk sharing arrangements for 2018/19 onwards.
3. Next Steps

3.1 Priority Actions

Work is underway to specify more clearly the Actions required to deliver the above three commissioning objectives during 2017/18. As has been done in previous years, the CCG’s Executive team are working to ensure that each priority action is SMART ie:

- Specific – target a specific area for improvement.
- Measurable – quantify impact and/or identify an indicator of progress.
- Assignable – specify who will do it.
- Realistic – state what results can realistically be achieved, given available resources.
- Time-related – specify when the result(s) can be achieved.

As part of this work, draft success measures are being identified for each action, which cross reference to the CCG Improvement and Assessment Framework and link to STP objectives.

3.2 Monitoring Process

It is proposed that the Management Team will monitor the progress of the delivery of the Corporate Objectives on a monthly basis. It is intended that the key success criteria measures will form the basis of a Performance Management dashboard which will support the Management Team to monitor progress through the year.

For 2017/18 it is proposed that the Integrated Governance Committee (IGC) takes on the responsibility to oversee the quarterly monitoring of the in-year delivery of all the Corporate Objectives and the management of risks, on behalf of the Governing Body. In previous years, this responsibility has been shared with the Strategy and Development Committee. It is intended that these revised monitoring arrangements will simplify the reporting to the Governing Body and provide greater assurance.

3.3 Working Smarter

The Clinical Directors and the SMT are working together to ensure that CCG’s clinical and managerial capacity and capabilities are aligned with the Corporate Objectives. This includes identifying and agreeing those commissioning areas which will not be a focus for proactive action during 2017/18.

Also the Clinical Directors and the SMT are reviewing the way the CCG delivers the proposed corporate objectives by working across commissioning teams and with other commissioners, in different ways. To work smarter, the CCG will maximise the opportunities of working collaboratively with other commissioners across the Borough of Lewisham and south east London.
### 3.4 Assessment of Risks

It is planned that during April work will be undertaken to identify the risks associated with the delivery of Corporate Objectives. The CCG will be exposed to different risks depending on the approach it decides to take to achieve the Corporate Objectives. The risk assessment will inform the Corporate Risk Register and develop the Board Assurance Framework (BAF). The draft Board Assurance Framework for 2017/18 will be presented to the Governing Body in May 2017 for its consideration and approval.

### CONSULTATION HISTORY:

- Joint Clinical Directors and SMT 2nd March 2017 - agreed the overview of the Corporate Objectives;
- Senior Management Team (SMT) – 21st February; 28th February 2017
- Membership Forum – 8th February 2017 – progress report on the Corporate Objectives
- Joint Clinical Directors and SMT - 2nd February 2017 - discussed the emerging Corporate Objectives
- Senior Management Team (SMT) – 24th January 2017; 31st January 2017
- Governing Body - 10th November – approved the Partnership Commissioning Intentions
- Governing Body - 8th September - noted the progress being made to develop the Partnership Commissioning Intentions for 2017/18 and 2018/19
- Membership Forum – 10th August 2016

### PUBLIC ENGAGEMENT

Work is underway to align the wider CCG’s engagement work with the proposed Corporate Objectives. The CCG’s intention is that Membership and Public engagement activities will be embedded within the delivery of the Corporate Objectives.

### HEALTH INEQUALITY DUTY

How does this Report take into account the duty to:

- reduce inequalities between patients in respect of their ability to access health services.
- reduce inequalities between patients in respect of 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.

Work is underway to align the CCG’s Equalities and Diversity work programme for 2017/18 with the proposed Corporate Objectives. The CCG’s intention is that the Equalities and Diversity work will be embedded within the delivery of the Corporate Objectives.

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ENCLOSURE XX
2017/18 Draft Revenue Budget

RESPONSIBLE LEAD:  Tony Read, Chief Financial Officer

AUTHOR:  Tony Read, Chief Financial Officer
          Paul McAuliffe, Interim Head of Finance

RECOMMENDATIONS:
The Governing Body is asked to:

- Note the revenue allocations for 2017/18
- Note the risks in the 2017/18 financial plan
- Approve the start revenue budget for 2017/18
- Note the 2018/19 indicative budget.

Summary:
This paper sets out the draft revenue budget for 2017/18, which supports the CCG’s 2017/18 operating plan.

KEY ISSUES:
For 2017/18 the CCG’s baseline total recurrent revenue allocation is £422.051m.
  - £415.400m relates to Programme expenditure
  - £6.651m relates to CCG Running Cost Allowance.

Further to the publication of the original recurrent allocation, NHS England published non recurrent adjustments reducing the allocation for:
  i) £(3.043m) transfers of specialist activity to NHSE Specialised Commissioning; and
  ii) £(1.193m) changes to acute prices on introduction of the new HRG4+ tariff

As a result the Total Notified Allocation for 2017/18 is £417.815m.

To enable the CCG to maintain a planned in-year nil movement in control total in 2017/18 the maximum expenditure for the year is £417.815m.

The budget includes a minimum level of net QIPP savings at £14.0m.

The start revenue budget does not exceed the CCG confirmed allocations, and supports the
CCG’s Operating Plan for 2017/18. It delivers the following key planning requirements of NHS England:

- Maintains the CCG’s reported year end forecast surplus as at Month 10 2016/17
- Delivers a 1% cumulative surplus
- Includes a 0.5% general contingency
- Sets aside 1% non-recurrent budget. For 2017/18 NHS England requires the CCG to have no planned expenditure commitments against one half of this, i.e. 0.5% non-recurrent budget.
- Includes the Better Care Fund contribution as per the advised CCG allocations

The start budget supports the NHS England (London) CCG control total planning expectations as follows:

- Nil drawdown (zero in-year control total movement)
- Contributes 0.15% to transformational changes such as the Healthy London Partnership programmes.
- Contributes to meeting the SEL CCG STP wide Control Total

The main risks associated with the draft budget are as follows,

- Acute and mental health contract expenditure might exceed plans. A proportion of the CCG’s acute general and mental health contracts are block arrangements for 2017/18. This limits risk exposure. However the CCG’s acute contract with its main provider, Lewisham and Greenwich Trust, is a cost and volume contract that does not include specific risk management arrangements.
- QIPP savings targets are £14m (3.3% of RRL). At the time of this report £560k is unidentified and there is a risk of under-delivery against the QIPP programme.
- CCG reserves are set at minimum levels required by NHS England planning guidance. The financial plan shows negative net risk.
- No provision has been made in the draft budget for any potential increased CCG expenditure arising as a consequence of council savings plans for 2017/18 for adult social care or public health commissioning.
- The 2017/18 budget of £1.4m for seasonal resilience is significantly less than anticipated funding requests from providers.
- The inability to plan expenditure commitments against half of the 1% non-recurrent budget and the lack of clarity over its use in year effectively reduces the CCG’s flexibility to invest and/or manage local financial risks by £2m.

CORPORATE AND STRATEGIC OBJECTIVES
The 2017/18 start revenue budget is aligned to the published CCG allocations, the 2017/18 Operating Plan and SEL STP and national and local planning assumptions.

CONSULTATION HISTORY:
2017/18 to 2020/21 CCG allocations - Governing Body January 2016
2017/18 to 2018/19 Operating Plan and Contracts – Governing Body January 2017
PUBLIC ENGAGEMENT
None to date

HEALTH INEQUALITY DUTY AND GENERAL EQUALITY DUTY
The CCG’s financial plans support the strategic and operational commissioning plans and objectives which include delivering the health inequality and the public sector general equality duties

STAKEHOLDER INVOLVEMENT
To be communicated to the GP Membership.
To be agreed by the Governing Body in public

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1. Introduction

1.1 This paper presents the draft start revenue budget for 2017/18 and an indicative budget for 2018/19. The budget will be used as the basis for monitoring and reporting the CCG’s operations throughout the year. Changes to allocations and budgets will be reported in the monthly finance report throughout the year.

1.2 The budget should be considered in conjunction with the CCG’s Operating Plan, the NHS national priorities for 2017/18 to 2018/19 and the South East London Sustainability and Transformation Plan (STP).

1.3 The financial scenario for 2017/18 is more challenging than ever and becomes increasingly challenging through to 2020/21. This will require a stronger focus on expenditure decisions, efficiencies and controls from 2017/18.

1.4 The CCG Governing Body will need to consider how best resources are deployed to support broader transformational changes going forward and will need to critically appraise how to maximise benefits to the CCG.

1.5 The CCG will need to identify further cost savings schemes, and “invest to save” schemes to achieve its financial targets. At present programme for future years lacks detail. This is a key priority.

2. Recommendation

2.1 The Governing Body is asked to:

- Note the revenue allocations for 2017/18
- Note the risks in the 2017/18 financial plan
- Approve the start revenue budget for 2017/18
- Note the 2018/19 indicative budget.

3. Background

3.1 In January 2016 the Chief Financial Officer presented details of the CCG’s revenue allocations, published by NHS England to the Governing Body. These include three year allocations for 2017/18 to 2018/19 and indicative allocations for the two years 2019/20 to 2020/21. In March 2016 a draft budget for 2017/18, compiled at a controls total level in support of the CCG’s draft operating plan for 2017/18, was agreed by the Governing Body. An update was provided to the Governing Body in May 2016.

3.2 The expectation of the NHS is that there will be an overall balanced financial position across the DH governmental department; CCGs, Trusts, NHSE and the DH, including specialised commissioning, and primary care. This is one of the key
conditions, along with agreed trajectories to improve NHS Constitutional standard performance towards standard in all sectors of care and waiting times where performance levels are currently below standard.

3.3 The CCG submitted financial plans as part of the operating plan for 2017-18 to 2018-19 on 31 October (draft) and financial, activity and constitutional standards plans on 24 November (draft), 23 December 2016 and 27 February 2017.

4. Resources Available in 2017/18 and 2018/19 - Revenue Resource Limit (RRL or allocation), Target and Distance From Target (DfT)

4.1 The available revenue resources consist of our recurrent revenue resource limit, running cost budget, and any non-recurrent sums we are anticipating. This presentation excludes primary care budgets that may be delegated as part of level 3 co-commissioning. It also excludes anticipated allocations in respect of the national GP forward view to improve extended access to primary care.

4.2 The allocations included in the “Five Year Forward View” were issued in December 2015. This gave CCGs greater certainty of their budgets for 2016-17 and 2017-18, and a forecast for later years to 2020-21. There has since been a financial reset in summer 2016. The allocation for the CCG has not been changed to date as a result. However, there have been adjustments relating to changes in specialised commissioning identification rules (IR) and the introduction of new prices based on HRG4+.

4.3 The rates of allocation increases for the CCG reduce in the coming two years, and increase in 2020. In 2016-17 Lewisham CCG received an uplift of 3.0%. This is lower than the London average of 4%; as we are deemed over our capitation target spend level. For 2017-18 and 2018-19 we shall receive circa 2.5% in each year. This increases to 3.7% in 2020-21.

4.4 The CCG has received funding growth of 2.52% on the programme allocation for 2017/18, over the recurring revenue allocation for 2016/17 (as at Month 10 2016/17).

4.5 Table 1 gives comparative allocations year on year of:

<table>
<thead>
<tr>
<th>Financial Year</th>
<th>2016-17</th>
<th>2017-18</th>
<th>2018-19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recurrent Allocation</td>
<td>405,174</td>
<td>415,400</td>
<td>426,168</td>
</tr>
<tr>
<td>Running Costs allocation</td>
<td>6,608</td>
<td>6,651</td>
<td>6,694</td>
</tr>
<tr>
<td><strong>Total Opening Resources</strong></td>
<td><strong>411,782</strong></td>
<td><strong>422,051</strong></td>
<td><strong>432,862</strong></td>
</tr>
</tbody>
</table>

4.6 Table 2 shows the revenue resource limit for each year. The opening revenue allocation for 2017-18 and 2018-19 has been reduced by £4.236m and £4.303m respectively for changes in specialised commissioning Identification Rules (IR) and the introduction of new national prices based on HRG4+.
4.7 The total in-year allocation is therefore £417.815m (£422.051m less £4.236m) for 2017/18. This is the maximum expenditure for the year to enable the CCG to deliver its targeted in-year control total in 2017/18.

Table 2: Revenue Resource Limit for 2016-17 to 2018-19

<table>
<thead>
<tr>
<th>£'000</th>
<th>2016/17</th>
<th>2017/18</th>
<th>% change</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Programme Baseline Allocation</td>
<td>405,174</td>
<td>415,400</td>
<td>2.52%</td>
<td>426,168</td>
</tr>
<tr>
<td>Recurrent Changes In-Year</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Co-Commissioning</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Running Cost Allocation</td>
<td>6,608</td>
<td>6,651</td>
<td>0.65%</td>
<td>6,694</td>
</tr>
<tr>
<td>Total Notified Allocation</td>
<td>411,782</td>
<td>422,051</td>
<td>2.49%</td>
<td>432,862</td>
</tr>
</tbody>
</table>

Non Recurrent Allocations

| Other Non Recurrent allocations | 6,752   | (4,236) | (4,303) |
| In-Year drawdown/(drawup)       | 2       | -       | -       |
| Non Recurrent Requirement       | (4,052) | (4,154) | (4,262) |
| Non Recurrent Return            | 4,052   | 4,154   | 4,262   |
| Marginal Rate Non Elective Collection| -     | -       | -       |
| Marginal Rate Non Elective Return| -     | -       | -       |
| Total Non-Recurrent Allocation  | 6,754   | (4,236) | (4,303) |

Total In-Year Allocation

| 418,536 | 417,815 | 428,559 |

4.8 Table 3 shows the “other” non-recurrent revenue resource allocation for each year (as at Month 10 2016-17).

Table 3 non-recurrent revenue resource allocation for 2016-17 to 2018-19

<table>
<thead>
<tr>
<th>Other non-recurrent allocation</th>
<th>2016/17</th>
<th>2017/18</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Premium</td>
<td>165</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CEOV</td>
<td>3,075</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Winter Funding</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GP Access</td>
<td>27</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vanguard Funding</td>
<td>111</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capital Grants</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional MH</td>
<td>606</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public Health (latent TB)</td>
<td>69</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IM&amp;T / Dispensing doctors(16/17)</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IR Changes</td>
<td>(3,043)</td>
<td>(3,091)</td>
<td></td>
</tr>
<tr>
<td>HRG4 changes</td>
<td>(1,193)</td>
<td>(1,212)</td>
<td></td>
</tr>
<tr>
<td>Other Inter Org Non-Rec Transfers</td>
<td>2,699</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>6,752</td>
<td>(4,236)</td>
<td>(4,303)</td>
</tr>
</tbody>
</table>
4.9 Separate allocations are received for Programme expenditure and for CCG Running Cost Allowances (RCA). For 2017/18 the CCG’s baseline recurrent revenue resource limit is £422.051m, comprising £415.400m for Programme expenditure and £6.651m for the CCG’s running costs.

4.10 Table 5 shows the movement from the CCG’s confirmed combined revenue allocation at Month 10 2016/17 to the baseline allocation used to calculate the 2017/18 allocation.

<table>
<thead>
<tr>
<th>Total In-Year Allocation</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less Other non-recurrent allocation</td>
<td></td>
</tr>
<tr>
<td>Quality Premium</td>
<td>(165)</td>
</tr>
<tr>
<td>CEOV</td>
<td>(3,075)</td>
</tr>
<tr>
<td>Winter Funding</td>
<td>-</td>
</tr>
<tr>
<td>GP Access</td>
<td>(27)</td>
</tr>
<tr>
<td>Vanguard Funding</td>
<td>(111)</td>
</tr>
<tr>
<td>Capital Grants</td>
<td>-</td>
</tr>
<tr>
<td>Additional MH</td>
<td>(606)</td>
</tr>
<tr>
<td>Other</td>
<td>-</td>
</tr>
<tr>
<td>Public Health</td>
<td>(69)</td>
</tr>
<tr>
<td>Other Inter Org Non-Rec Transfers</td>
<td>(2,699)</td>
</tr>
<tr>
<td>Total Other non-recurrent allocation</td>
<td>(6,752)</td>
</tr>
<tr>
<td>Total</td>
<td>411,784</td>
</tr>
<tr>
<td>Growth</td>
<td>10,267</td>
</tr>
<tr>
<td>Total baseline allocation</td>
<td>422,051</td>
</tr>
</tbody>
</table>

4.11 We have been successful in some of our bids for capital monies through the Estates and Technology Transformation Fund (ETTF) with awards for the development of a primary care hub for Neighbourhood 2 and for the population based IT programme. We will continue to look for opportunities to bid for other sources of funds for our transformation work, and across SEL generally. Some funds may be available for OD and training the SEL workforce, and around service redesign in key areas. There should be some further GP Forward View (GPFV) monies to be agreed, that will give some local discretion on primary care investment.

4.12 The national business rules state that the minimum requirement is a 1% cumulative surplus for CCGs. Lewisham CCG’s 2016/17 planned surplus is 1.8% of RRL. As per NHS England planning guidance CCGs are expected to request a reduction in their surplus, through drawdown of funding (i.e. part of our surplus carried forward from year to year under Treasury rules) if currently surpluses are greater than 1%. This is to be applied over 2017/18 to 2019/20. The drawdown can be used non-recurrently to support transformation. The CCG had intended to drawdown £1.1m in 2017/18 and
£0.7m in 2018/19. This has not been possible in order to meet NHS England’s issued Sustainability and Transformation Plan (STP) wide control total for SEL CCGs.

<table>
<thead>
<tr>
<th>Financial Year</th>
<th>2016/17</th>
<th>2017/18</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Amount of Drawdown of surplus requested in our operating plan, to tie in with NHSE control targets</td>
<td>Nil</td>
<td>Nil</td>
<td>Nil</td>
</tr>
<tr>
<td>Amount of Drawdown of surplus requested in our draft plan, pre NHSE control targets</td>
<td>Nil</td>
<td>1,101</td>
<td>702</td>
</tr>
</tbody>
</table>

4.13 The business rules also set out that the CCG must maintain a 1% reserve for non-recurrent pressures (c. £4m for Lewisham). In 2016/17 CCGs were unable to commit expenditure against this 1% reserve. For 2017/18 CCGs may commit 0.5%. This has effectively released £2m in 2017/18, to use in year as a general risk/investment reserve, compared to 2016/17.

4.14 Distance From Target

Table 4 shows the deemed distance from targeted allocation for the CCG. For CCG programme allocations Lewisham is deemed to be over target by 2.52% in 2016/17 reducing to 2.06% by the end of 2018/19. Lewisham CCG therefore receives lower than maximum allocation growth year on year.

<table>
<thead>
<tr>
<th>Table 4 Distance From Target</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Estimated registered population</td>
</tr>
<tr>
<td>Final per capita allocation</td>
</tr>
<tr>
<td>Final per capita growth</td>
</tr>
<tr>
<td>Final closing DfT</td>
</tr>
</tbody>
</table>
5. Expenditure Budgets

5.1 Table 7 shows the total net revenue budget for 2017/18. It should be noted that a QIPP savings requirement of £14.0m has been netted off the expenditure total.

Table 7: RRL vs. net revenue budget

<table>
<thead>
<tr>
<th>Year</th>
<th>2016/17</th>
<th>2017/18</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£ 000</td>
<td>£ 000</td>
<td></td>
</tr>
<tr>
<td>Revenue Resource Limit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recurrent</td>
<td>411,782</td>
<td>422,051</td>
<td>2.49%</td>
</tr>
<tr>
<td>Non-Recurrent</td>
<td>6,754</td>
<td>(4,236)</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>418,536</td>
<td>417,815</td>
<td>(1.76)%</td>
</tr>
<tr>
<td>Income and Expenditure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Programme Costs</td>
<td>411,810</td>
<td>409,223</td>
<td>(0.63)%</td>
</tr>
<tr>
<td>Running Costs</td>
<td>6,378</td>
<td>6,442</td>
<td>1.0%</td>
</tr>
<tr>
<td>Contingency</td>
<td>2,098</td>
<td>2,150</td>
<td>2.48%</td>
</tr>
<tr>
<td>Total Costs</td>
<td>420,286</td>
<td>417,815</td>
<td>(0.59)%</td>
</tr>
</tbody>
</table>

5.2 Expenditure by key spend category (as at Month 10 2016/17) is shown in Table 8 as follows:

Table 8 Expenditure budgets

<table>
<thead>
<tr>
<th>Income and Expenditure</th>
<th>2016/17 Forecast</th>
<th>2017/18 Plan</th>
<th>2018/19 Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Acute</td>
<td>234,197</td>
<td>229,291</td>
<td>235,629</td>
</tr>
<tr>
<td>Mental Health</td>
<td>69,224</td>
<td>67,804</td>
<td>68,113</td>
</tr>
<tr>
<td>Community</td>
<td>39,480</td>
<td>39,587</td>
<td>41,643</td>
</tr>
<tr>
<td>Continuing Care</td>
<td>14,675</td>
<td>13,825</td>
<td>13,459</td>
</tr>
<tr>
<td>Primary Care</td>
<td>43,451</td>
<td>43,786</td>
<td>45,036</td>
</tr>
<tr>
<td>Other Programme</td>
<td>12,881</td>
<td>14,930</td>
<td>15,991</td>
</tr>
<tr>
<td>Primary Care Co-Commissioning</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total Programme Costs</td>
<td>413,908</td>
<td>409,223</td>
<td>419,870</td>
</tr>
<tr>
<td>Running Costs</td>
<td>6,378</td>
<td>6,442</td>
<td>6,485</td>
</tr>
<tr>
<td>Contingency</td>
<td>-</td>
<td>2,150</td>
<td>2,205</td>
</tr>
<tr>
<td>Total Costs</td>
<td>420,286</td>
<td>417,815</td>
<td>428,560</td>
</tr>
</tbody>
</table>
5.3 For 2017/18 the Programme budget for the CCG is £409.223m. 2016/17 values include expenditure in relation to non recurrent allocations received.

5.4 The main planning assumptions in developing the start revenue budgets are outlined below and are in line with NHS England’s Planning guidance:

- The CCG is required to plan for a 0.5% general contingency on a recurring basis
- For 2017/18 the CCG is required to set aside 1.0% of its total programme allocation on a non-recurrent basis. This equates to £4.15m. In 2017/18, NHSE requires that CCGs make no planned expenditure commitments against half of this budget; i.e. 0.5% compared with 1.0% in 2016/17).
- The budgets include the impact of projected population and non-demographic growth against activity based contracts. Population growth is based upon the Greater London Authority (GLA) projections at 1.2% for 2017/18 and 0.8% for 2018/19.

5.5 The main reasons for reductions in the 2017/18 plan compared to 2016/17 forecast out-turn are as follows:

- Acute - Spend £1.75m less to break even (run rate) £1.750m
- Acute - Spend against other 2016/17 non recurrent allocations £1.755m
- Acute - IR and HRG4+ £4.236m
- Mental Health - Spend against other 2016/17 non recurrent allocations £1.755m
- CHC – reversing the expenditure increase £1.000m

5.6 We have little opportunity to invest in quality improvements and/or new activities. Instead the financial position requires a sharp focus on expenditure efficiency, reduction and “invest to save” opportunities, to achieve permanent change in the local health system. This requires us to have some flexibility to vary contracts at relatively short notice and to have adequate risk mitigations. We have reviewed our contracts to identify opportunities for re-commissioning at greater scale and impact or de-commissioning services that have come to the end of their contract.

5.7 In 2016/17 we invested in medicines optimisation, dementia services, continuing healthcare capacity, establishing Local Care Networks and GP Federations. Our planned investments targeting reductions in hospital inpatient activity and delayed transfers of care have and will continue to be sourced mainly from the BCF. In 2016-17 we deferred investments in enhanced care and support, rapid response services and home ward. These are built into our BCF financial plans 2017/18.

6. Quality, Innovation, Productivity and Prevention (QIPP)

6.1 NHS England expects an overall 3% minimum efficiency to be delivered by CCGs in 2017/18. The CCG’s draft budget assumes QIPP savings delivery at £14.0m (3.3%).

6.2 The CCG has a requirement for £14.0m QIPP savings in 2017/18. £13.4m has been identified to date with plans in place/under development. The 2016/17 target was
6.3 The budgets in Table 9 are stated net of the £14.0m QIPP requirement.

6.4 QIPP plans for 2017/18 are reasonably well developed with detailed project implementation documents being prepared for challenge sessions with the directors and CDs. Our track record is of fully achieving the programme we set. This is £6.8m in 2016/17 but higher in previous years. The national requirement is to have at least a 3% QIPP programme going forward and this is reflected below in table 7.

Table 9 Net QIPP programme 2017/18 and 2018/19

<table>
<thead>
<tr>
<th></th>
<th>2016/17</th>
<th>2017/18</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Acute services and</td>
<td>3,920</td>
<td>8,369</td>
<td></td>
</tr>
<tr>
<td>Community services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental health /client groups</td>
<td>1,300</td>
<td>1,521</td>
<td>1,200</td>
</tr>
<tr>
<td>Corporate services</td>
<td>0</td>
<td>86</td>
<td>108</td>
</tr>
<tr>
<td>Continuing Care/ primary care / transformation</td>
<td>0</td>
<td>1,452</td>
<td></td>
</tr>
<tr>
<td>Prescribing</td>
<td>1,500</td>
<td>2,000</td>
<td>1,982</td>
</tr>
<tr>
<td>Running costs</td>
<td>100</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>Unidentified</td>
<td>0</td>
<td>559</td>
<td>8,352</td>
</tr>
<tr>
<td><strong>Total QIPP programme- net of investment</strong></td>
<td><strong>6,820</strong></td>
<td><strong>14,012</strong></td>
<td><strong>13,309</strong></td>
</tr>
<tr>
<td>% of notified resource</td>
<td>1.6%</td>
<td>3.3%</td>
<td>3.1%</td>
</tr>
<tr>
<td>% unidentified</td>
<td>0.0%</td>
<td>4.0%</td>
<td>62.8%</td>
</tr>
</tbody>
</table>

NB- 2018/19 includes many provisional figures - to be redistributed across budget areas

7. reserves, Risk and Risk Mitigation

7.1 The most significant risk to the CCG’s financial position in recent years has been the growth in acute hospital non elective activity costs, the costs associated with delivering A&E 4 hour standard and elective activity to meet the referral to treatment standards. This budget is based on 2016/17 out-turn activity plus population and non-demographic growth before applying the impact of demand management plans.

7.2 Prescribing, which has delivered regular savings each year, is expected to continue at a lower than previous level due to the impact of national price changes.

7.3 We have seen some variability in the activity and cost associated with mental health placements and inpatient treatments in recent years.

7.4 The budget allows for only minimal levels of contingency and reserves. In accordance with NHS business rules the CCG has set aside 1% of its budget, of which one half is uncommitted, as a reserve to meet non recurrent pressures in year. We have also budgeted for a 0.5% general contingency fund and an additional 0.15% transformation fund for local or London wide projects such as Healthy London Partnerships.
7.5 Table 7 shows the planned reserves for 2017/18 and the opening reserves in 2016/17. The 2016/17 reserves started at £9.9m and were fully utilized in 2016/17 to offset cost pressures and to meet additional in year investments against NHS priorities such as constitutional standards whilst delivering an overall targeted surplus of £7.6m. It should be noted that opening 2017/18 reserves are £3.1m less than 2016/17. The CCG’s capacity to manage in year risk is significantly reduced from 2016/17, potentially further impacted by the uncertainty around the 1% non-recurrent set aside.

7.6 The national business rules change in 2017. The CCG must keep 0.5% Non-recurrent reserve uncommitted, so our plans assume application of the remaining funds here. There is still a requirement to keep 0.5% general contingency as a buffer, and beyond this it is our local judgement set against our risks, the type of contracts we can secure and other issues.

Table 10 Overall planned level of reserves 2016/17-2018/19

<table>
<thead>
<tr>
<th></th>
<th>2016/17</th>
<th>2017/18</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Set aside for Non recurrent pressures</td>
<td>£4,052</td>
<td>£2,077</td>
<td>£2,131</td>
</tr>
<tr>
<td>Healthy London Partnership contribution</td>
<td>In budgets</td>
<td>In budgets</td>
<td>In budgets</td>
</tr>
<tr>
<td>Deferred investments</td>
<td>In budgets</td>
<td>In budgets</td>
<td>0</td>
</tr>
<tr>
<td>General contingency 0.5 %</td>
<td>£2,098</td>
<td>£2,150</td>
<td>£2,205</td>
</tr>
<tr>
<td>Continuing Care Retrospective National Risk Pool Inc. in 1% NR above</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>General risk reserve</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Return of non-recurrent resource from NHSE</td>
<td>£1,650</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Contract reserve</td>
<td>In budgets</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Approved drawdown of surplus</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total Reserves available</td>
<td>£8,455</td>
<td>£4,222</td>
<td>£4,336</td>
</tr>
<tr>
<td>% of total budget</td>
<td>2.0%</td>
<td>1.0%</td>
<td>1.0%</td>
</tr>
</tbody>
</table>

7.7 The above should be seen as a minimum requirement, but can only be increased if we can vary budgets and contracts at a lower level than we have currently.

7.8 The CCG plans identify negative net financial risk in 2017/18 of £5m, worsening to £10m in 2018/19. It is essential that we promptly identify actions to improve the risk profile.

8. Budget Exclusions and Changes

8.1 The CCG’s published allocations and this budget excludes primary care and specialised services. Separate work streams will determine the CCG allocations, budgets and financial implications when commissioning responsibility is delegated. The Chief Financial Officer will report all budget changes to the Governing Body in year.

Tony Read
Chief Financial Officer
1st March 2017
A meeting of the Governing Body
Thursday 9th March 2017

South East London Treatment Access Policy 2017

CLINICAL LEAD: Dr David Abraham, Clinical Director, Lewisham Clinical Commissioning Group
MANAGERIAL LEAD/S: Alison Browne, Director of Nursing & Quality and Diana Braithwaite Director of Commissioning & Primary Care, Lewisham Clinical Commissioning Group

1. RECOMMENDATIONS:
The Governing Body is asked to;

(i) Approve the 2017 South East London Treatment Access Policy;
(ii) Note the CCGs intention to work in collaboration with the South East London CCGs to conduct a fuller review of the policy and pathway in 2017/18.

2. SUMMARY:
The policy has been developed and reviewed by the South East London (SEL) Public Health Commissioning Support Group in partnership with the six South East London CCGs; Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark.

3. KEY ISSUES:
South East London CCGs have collaborated on this policy for a number of years. The policy is reviewed annually and updated to reflect changes in clinical evidence-base, national guidance or to provide clarification on identified issues over preceding 12 months.

The emphasis of the 2017 review has focussed on; (a) providing additional clarification of specific policy areas to enable improved and equitable application; and (b) changes in commissioning responsibilities between NHS England and Clinical Commissioning Groups. A summary of revisions to the policy are listed below;

- Bariatric Surgery: From the 1st April 2017 the commissioning of adult service and complex obesity surgery services will be the responsibility of Clinical Commissioning Groups. The TAP has been amended to reflect this and the NHS England eligibility criteria will apply. However, commissioners will be reviewing the pathway to ensure consistent management in the pathway for obesity in South East London to improve patient experience and outcomes.
- Breast Reduction: The amendment provides clarification of the language used.
- Pinnaplasty (Correction of prominent or Bat Ears): Measuring guidance has been provided.
- Fertility Treatments: Clarification on the eligibility criteria with regard with regard to NHS funded attempts.

During 2017 the South East London CCGs will be conducting a comprehensive review of the pathways and criteria.

4. CORPORATE AND STRATEGIC OBJECTIVES:
- High Quality Care and Best Value
- Governance – planning and development
## 5. Consultation History Including Members Engagement:

- South East London Public Health Commissioning Support Group
- South East London Directors of Commissioning & Finance Group
- South East London Chief Officers Group
- Medical Directors – Acute Providers

## 6. Public Engagement:

There are a number of requirements that must be met when discussions are being made about the development or changes to services, particularly if any of these will impact on the way these services can be accessed by patients. Such requirements include:

- Section 242 of the NHS Act 2006
- Section 244 of the NHS Act 2006
- Section 234 of the Local Government and Public Involvement in Health Act 2007
- The four ‘tests’
- The NHS Constitution

The amendments to the policy are not considered substantial or material. However, where material changes are proposed to the policy the CCG will adhere to its Public Engagement Policy/Charter and statutory obligations.

## 7. Health Inequality and Public Sector Equality Duties:

- It is essential that all policies CCG policies will have due regard to; (i) **eliminate unlawful discrimination**, harassment, victimisation and any other conduct prohibited by the Equality Act 2010; (ii) **advance equality of opportunity** between people who share a protected characteristic and people who do not share it; and (iii) **foster good relations** between people who share a protected characteristic and people who do not share it.
- The implementation of a constituent approach and criteria across South East London should improve equity for all residents.
- An Equalities Screening Tool has been completed (See Appendix 1) as the amendments to the policy are not considered substantial nor material.

## 8. Responsible Managerial Lead/ Contact:

Name: Alison Browne, Director of Nursing & Quality
Appendix 1: Equality Impact Screening Tool

<table>
<thead>
<tr>
<th>Date of Assessment:</th>
<th>17th February 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessor Name(s) &amp; Job Title(s):</td>
<td>Diana Braithwaite, Director of Commissioning &amp; Primary Care</td>
</tr>
<tr>
<td>Organisation:</td>
<td>Lewisham Clinical Commissioning Group</td>
</tr>
<tr>
<td>Name of the policy, function, service development:</td>
<td>South East London Treatment Access Policy (TAP) 2017</td>
</tr>
<tr>
<td>Aim/Purpose of the policy, function, service development:</td>
<td>South East London Treatment Access Policy (TAP) 2017 addresses treatments and procedures for which restricted access criteria has been agreed.</td>
</tr>
</tbody>
</table>

1. Do you consider the policy/function/service development to have an adverse equality impact / health inequality impact on any of the protected groups as defined by the Equality Act 2010? Write either ‘yes’ or ‘no’ next to the appropriate group(s)

<table>
<thead>
<tr>
<th>Protected Group</th>
<th>Yes or No</th>
<th>Protected Group</th>
<th>Yes or No</th>
<th>Protected Group</th>
<th>Yes or No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>N</td>
<td>Pregnancy/Maternity</td>
<td>N</td>
<td>Marriage/Civil Partnership (employment matters)</td>
<td>N</td>
</tr>
<tr>
<td>Disability</td>
<td>N</td>
<td>Race</td>
<td>N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td>N</td>
<td>Religion/Belief</td>
<td>N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender Reassignment</td>
<td>N</td>
<td>Sexual Orientation</td>
<td>N</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. If you answered ‘yes’ to any of the above, give your reasons why

3. If you answered ‘no’ to any of the above, give your reasons why

- All protected groups will see no change as a result of these minor clarifications to the SEL TAP Policy; consequently there will be neither adverse equality nor health inequality impact.
- Any material or substantial changes to the policy will always be assessed against the Equality Analysis Screening Tool to determine if a full Equality Impact Assessment is required.

4. Please indicate if a Full Equality Analysis is recommended: NO

<table>
<thead>
<tr>
<th>Commissioning Lead (Name):</th>
<th>Diana Braithwaite</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature of reviewing SECSU Equality and Diversity Lead (Name):</td>
<td>Valerie Richards</td>
</tr>
</tbody>
</table>
South East London

Treatment Access Policy

2017

Version 4.0 (final)

This policy has been developed by the South East London Public Health Commissioning Support Group, a collaboration of the six CCGs in south east London – Bexley, Bromley, Greenwich, Lambeth, Lewisham, and Southwark, and Public Health representatives from each borough.
South East London

Treatment Access Policy

This policy deals with treatments and procedures for which restricted access criteria have been agreed.

Background
The six Clinical Commissioning Groups (CCGs) in the South East London Sector have been working on developing a joint policy and process for dealing with Individual Funding Requests (IFRs). There are a number of reasons for a sector-wide process for dealing with IFRs.

Limited Resources
There will always be competing calls for limited resources and therefore a need for a clearly defined and co-ordinated approach to ensure that the resources are used in an equitable and effective way and that clear, consistent and fair procedures are in place. These are based on the principles of cost effectiveness found in the IFR policy.

Local Variations
Local variations in treatment funding decisions (postcode prescribing) are clearly undesirable, but there has been very little guidance at national level on the process of setting priorities for funding. The National Institute for Health and Care Excellence (NICE) has been established to provide guidelines on the implementation and introduction of new drugs and technologies. However, for a majority of requests for funding that are submitted to commissioners, no guidelines are available. Development of joint policies and processes across the South East will clearly be beneficial in terms of reducing the variations between the CCGs.

Efficiency
Joint working will avoid duplication of work and efforts across the area. It will also maximize the use of expertise and skills, building upon previous experience. This joint process will also enhance joint working and communication between the CCGs.

Review
This policy will be reviewed and updated annually.

PLEASE NOTE

The treatments and interventions listed in Section 1 of this document will not receive funding from the funding commissioner unless they have been reviewed by the relevant Individual Funding Request Panel and prior funding agreed. Those listed in Section 2 will not require prior agreement, however the commissioners will monitor this activity and audit as required.
Equality Statement:
“This document demonstrates the organizations’ commitment to create a positive culture of respect for all individuals, including staff, patients, their families and carers as well as community partners. The intention is, as required by the Equality Act 2010, to identify, remove or minimize discriminatory practice in the nine named protected characteristics of age, disability, sex, gender reassignment, pregnancy and maternity, race, sexual orientation, religion or belief, and marriage and civil partnership. It is also intended to use the Human Rights Act 1998 and to promote positive practice and value the diversity of all individuals and communities”.

Services Now Commissioned By NHS England

Some services previously included in the Treatment Access Policy (TAP) from April 2013 are now commissioned by NHS England (NHSE). These are:

- Implantable cardiac defibrillators (ICDs)
- Cochlear Implants,
- Treatment of Gender dysphoria,
- Hyperbaric oxygen for decompression sickness.

Details of services commissioned by NHSE can be found on their website [https://www.england.nhs.uk/commissioning/spec-services/key-docs/](https://www.england.nhs.uk/commissioning/spec-services/key-docs/)

Whilst paediatric dentistry is included in The Manual, commissioning for adult Dental and Orthodontic procedures is now through the dental team of NHSE; [https://www.england.nhs.uk/commissioning/primary-care-comm/dental/dental-specialities/](https://www.england.nhs.uk/commissioning/primary-care-comm/dental/dental-specialities/) they can be contacted on England.lon-dental-funding@nhs.net

Whilst paediatric dentistry is included in The Manual commissioning for adult Dental and Orthodontic procedures is now through the dental team of NHSE, they can be contacted on England.lon-ne-dental@nhs.net

Should you wish to submit an IFR for a service commissioned by NHSE, the general policies and application form can be found on their website [https://www.england.nhs.uk/commissioning/policies/gp/](https://www.england.nhs.uk/commissioning/policies/gp/)

You can submit requests for funding to england.ifr@nhs.net

Bariatric Surgery

Commissioning of surgery for severe and complex adult obesity became the responsibility of CCGs from 1 April 2017. The SEL Clinical Commissioning Groups will use the NHS England eligibility criteria as outlined within their clinical guidances until further review.


Procedures and treatments not mentioned in the SEL TAP

Clinical Commissioning Groups (CCG) do not have policies in place for every procedure that a patient might request. If a particular procedure/approach is not listed within local policies then it is not commissioned and not available.
## ELIGIBILITY CRITERIA FOR SPECIFIC PROCEDURES

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SECTION 1 – PROCEDURES REQUIRING PRIOR APPROVAL

Procedures in Section 1 will still require prior approval through the ‘Individual Funding Request Process’ even if the restricted access criteria outlined are met.

All patients requiring a consultant opinion for diagnostic or symptomatic advice should continue to be referred by General Practitioners e.g. skin lesions that may be malignant.

1.1 COSMETIC PROCEDURES

General Remarks

Cosmetic procedures are generally effective but they are considered to be of low priority by local commissioners and will only be funded in exceptional circumstances.

To qualify under the Treatment Access Policy the patient should be over the age of 18.

Individual Procedures

Detailed exceptions to the general restriction on cosmetic surgery are listed here:

i) Blepharoplasty (Eyelid Reduction)

This procedure is not available on cosmetic grounds. An exception may be made if the upper eyelid skin interferes with the visual field or if there is evidence that eyelids impinge on visual fields reducing field to 120° laterally and 40° vertically.

ii) Cosmetic Breast Surgery

This does not refer to breast reconstruction following treatment for cancer.

iii) Breast Augmentation

This procedure is not available on cosmetic grounds. An exception may be made for congenital absence or gross asymmetry (difference in size minimum 2 cup sizes).

iv) Breast Reduction

This procedure is not available on cosmetic grounds. An exception may be made for true virginal hyperplasia when the proposed volume of reduction is greater than 500g per side, gross asymmetry or if the patient has at least one of the following:

- unresponsive to treatment for ulceration of the shoulder from the bra straps
- unresponsive to treatment for intertrigo between the breasts and the chest wall
- severe pain, unresponsive to treatment and directly related to breast size
- ulnar pain from the thoracic nerve root compression

The patient should also meet both of the following criteria:

- Body Mass Index (BMI) of 25 (kg/m2) or less
- bra cup size of H or more
v) **Mastopexy (relocating the nipple and improving the shape of the breast)**

This procedure is not available on cosmetic grounds. Breast ptosis is inevitable in most women due to a combination of maturity, gravity and pregnancy/lactation. An exception may be made in gross cases when a nipple areola lies below the infra-mammary fold (Grade 3 ptosis).

vi) **Revision Mammaplasty**

This procedure is not available on cosmetic grounds unless the original procedure was performed locally on the NHS because of health reasons, and the patient now has a gross deformity.

vii) **Breast Implants**

Breast implants and instant replacements are not available on the NHS. Ruptured breast implants, however, will be removed on the NHS if they are considered to be of danger to the patient. Replacement implants must not be inserted as part of the same procedure even if the patient wishes to self-fund this part of the treatment.

viii) **Gynaecomastia**

This procedure is not available on cosmetic grounds. Exceptional cases brought to the individual funding request panel for consideration would need to meet the following criteria:

- True gynaecomastia (i.e. breast tissue is present as opposed to adipose tissue) has been diagnosed.
- Gynaecomastia is classified as Grade III (marked breast enlargement with major skin redundancy\(^1\)).
- The BMI is less than or equal to 25 kg/m\(^2\)
- Screening for endocrinological or drug related causes has taken place.
- Underlying malignancy should be excluded, clinically or otherwise.

ix) **Correction of Congenital Nipple Inversion**

This procedure is not available on cosmetic grounds. Nipple inversion is a common condition which responds well to conservative treatment, e.g. use of Niplette device.

x) **Body Contouring (Abdominoplasty or Tummy Tuck, Thigh Lift and Buttock Lift, Excision of Redundant Skin or Fat Liposuction)**

These procedures are not available on cosmetic grounds. An exception may be made for post-traumatic surgery for contouring at diabetes injection sites or for lymphoedema.

xi) **Dermabrasion (Chemical Peel)**

This procedure is not available for skin rejuvenation.

xii) **Face or Brow Lift**

This procedure is not available on cosmetic grounds. An exception may be made for the treatment of facial palsy.

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xiii) **Male Pattern Baldness (Hair Grafting and Flaps with or without Tissue Expansion)**

This procedure is not available on cosmetic grounds. Baldness is a natural condition.

xiv) **Female baldness and alopecia – Hair replacement**

This procedure is not available on cosmetic grounds.

xv) **Pinnaplasty (Correction of prominent or Bat Ears)**

This procedure is not available on cosmetic grounds to adults. An exception may be made for children under the age of 18 at the time of referral for significant prominent or bat ears, where the prominence measures >30mm (using the measuring guide below):

**Measuring guide**

One of the most consistent methods for measuring the degree of prominence is the helical-mastoid (H-M) distance. Typically, the HM distance is 18-20 mm. As the H-M distance increases, the ear is perceived to be increasingly prominent.

Measure from the posterior aspect of the Helix.

Prominence = H-M distance > 20mm

Pinnaplasty will only be considered in patients who have a >30mm prominence, unless there are other considerations e.g. in helping to retain hearing aids.

xvi) **Repair of Lobe of External Ear**

This procedure is not available on cosmetic grounds.

xvii) **Septo-rhinoplasty (Reshaping of the Nose)**

This procedure is not available on cosmetic grounds. Septo-rhinoplasty will be considered in cases involving severe nasal deformity with chronic and complete obstruction of at least one nostril due to congenital or traumatic causes and severe functional limitation must be demonstrated.

xviii) **Scar Revision**

This procedure is not available on cosmetic grounds. An exception may be made with certain scars which interfere with function (e.g. following burns) or for treatment of keloid and post-surgical scarring.

xix) **Tattoo Removal**

This procedure is not available on cosmetic grounds.

xx) **Removal of Birthmarks**

This procedure is not available on cosmetic grounds to adults. An exception may be made for children up to the age of 18 for permanent large or prominent lesions on face or neck.

xxi) **Other Benign Skin Lesions**

Other benign skin lesions e.g. skin tags, fibroepithelial polyps, dermatofibromata, seborrheic warts will not be removed on cosmetic grounds. However, if symptomatic and inflamed at the time of consultation, removal will be considered.
Epidermoid (Sebaceous) cysts are always benign and are not removed in the Dermatology Department. Some may become infected and symptomatic and referral to General Surgeons is indicated in these cases.

**xxii) Viral Warts and Molluscum Contagiosum in Children under 16 Years of Age**

These are self-limiting viral infections. Warts are appropriately treated in Primary Care by topical keratolytics. Cryotherapy is too painful and no other treatment is offered in Secondary Care for either condition.

**xxiii) Viral Warts in Adults**

Properly compliant treatment with keratolytics is as effective as cryotherapy.

**xxiv) Cosmetic Genital Surgery**

This procedure is not available on cosmetic grounds.

### 1.2 NON-MEDICAL CIRCUMCISIONS

**General Remarks**
Circumcision is an effective operative procedure with a range of medical indications. Some circumcisions are also requested for social, cultural or religious reasons, these procedures will not be funded on the NHS.

**Medical Indications**

Circumcisions should continue to be performed for medical indications only

- phimosis seriously interfering with urine flow and/or associated with recurrent infections
- some cases of paraphimosis
- suspected cancer or balanitis xerotica obliterans
- congenital urological abnormalities when skin is required for grafting
- interference with normal sexual activity in adult males

### 1.3 ALTERNATIVE THERAPIES

**Osteopathy**
- Osteopathy remains a low priority treatment due to the limited evidence of clinical effectiveness
- Future referral for osteopathy is not available on the NHS.

**Acupuncture**
- Acupuncture remains a low priority treatment due to the limited evidence of clinical effectiveness
- Future referrals for acupuncture should be made in exceptional circumstances only. Funding for cases of nausea and vomiting and back pain shall be considered by the local Individual Funding Request (IFR) Panels.

**Homeopathy**
- Homeopathy should remain a low priority treatment due to the authoritative evidence that homeopathy has no biological effectiveness.
- South London CCGs that hold contracts with the Royal London Hospital for Integrated Medicine may wish to consider terminating these but with arrangements to honour funding for existing patients currently being treated and patients currently on the waiting list.
• Future requests for homeopathy will only be agreed by the local IFR Panels in exceptional circumstances.

**All Other Complementary Therapies**
The CCGs will not purchase these services in the Acute Sector.

**1.4 REVERSAL OF VASECTOMY OR FEMALE STERILISATION**

The decision to be sterilized is taken by mature adults on the understanding that it is an irreversible contraceptive choice. Therefore, any reversal or subsequent fertility treatment should be the responsibility of the individual and will not be funded by the CCG. Any requests with possible exceptions may be referred to the IFR Panel for consideration. There should be no live children from either of the partners.

**Female**
- The woman should not be older than 35 years
- The procedure should be conducted in a Regional Centre by a surgeon performing sufficient procedures to report a success rate of over 50%

**Male**
- The reversal of vasectomy should not be performed more than 10 years after the original sterilization procedure.
- The female partner should not be more than 36 years old

**1.5 CAESAREAN SECTION FOR NON-CLINICAL REASONS**

Caesarean section is only available for clinical reasons. Elective Caesarean section for non-clinical reasons, including maternal request, will not be funded on the NHS unless prior approval has been obtained. Such approval will only be granted if such an elective caesarean section justified using recently published NICE guidelines\(^2\). Applicants will have to document carefully how the case fulfils those guidelines.

**1.6 SURGERY FOR ASYMPTOMATIC GALLSTONES\(^3\)**

Approximately 10-20% of people in western countries have gallstones, and some 50-70% are asymptomatic at the time of diagnosis. Asymptomatic disease has a benign natural course and progression to symptomatic disease is relatively low, ranging from 10-25%. The majority of patients rarely develop gallstone-related complications without first having at least one episode of pain.

There is no evidence, and in particular no evidence from randomized controlled trials that surgery for asymptomatic gallstones is beneficial and it will not therefore be routinely funded.

**1.7 HAIR REMOVAL**

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This procedure will not be funded on the NHS as there is no evidence of permanent effect with any type of hair removal treatment.

SECTION 2 – PROCEDURES NOT REQUIRING PRIOR AGREEMENT

The following procedures do not require prior agreement providing the restricted access criteria are met. An audit of these procedures will be undertaken routinely.

If the patient does not meet the relevant access criteria, but the clinician feels he/she has exceptional clinical circumstances, the request for funding should be taken through the Individual Funding Request process (IFR).

2.1 EXCISION OF OTHER SKIN LESIONS

General Remarks

If a GP or consultant is concerned that any skin lesion may be malignant the patient should continue to be referred and treated promptly. The general remarks about other cosmetic procedures also apply to the excision of benign skin lesions. Some benign skin lesions will continue to be excised in the acute sector for differential diagnosis. Some GPs also offer these procedures as part of their general practice, although not all patients currently have access to these services.

i) Pigmented Lesions

Removal of obviously clinically benign moles is not available on cosmetic grounds. In most cases the distinction between suspicious and purely benign moles is clear cut but suspicious pigmented lesions should always be subjected to excision biopsy.

ii) Tunable Dye Laser

This treatment is offered for the removal of vascular birthmarks (port wine stains) often present on the neck and face and is the only successful treatment for this type of birthmark. The criteria for patients requiring this type of treatment will be:

- On the face or neck above the collar line in children up to the age of 18 years OR
- Chest area on women

Patients above the age of 18 years will be considered on an individual basis taking into account psychological and psychiatric effects of the birthmarks on the patient.

Referrals should be made on a tertiary basis usually by a Consultant Dermatologist.
2.2 VARICOSE VEINS

Varicose veins are swollen and enlarged veins, usually blue or dark purple in colour. They may also be lumpy, bulging or twisted in appearance. They mostly occur in the legs. They are usually asymptomatic, but can be complicated by inflammation, skin changes including ulceration, rupture and bleeding as well as pain and discomfort.

Asymptomatic and Mild Varicose Veins
Asymptomatic and mild varicose veins present as a few isolated, raised palpable veins with little or no associated pain, discomfort or skin changes. They should be managed in primary care and patients offered advice and information. This will include:

- An explanation of varicose veins, possible causes, and the likelihood of progression.
- Treatment options aimed at symptom relief and an explanation of the limited role of compression therapy. Compression hosiery for symptomatic varicose veins should not be offered unless interventional treatment is unsuitable.
- The likelihood of progression and possible complications, including deep vein thrombosis, skin changes, leg ulcers, bleeding and thrombophlebitis. Address any misconceptions the person may have about the risks of developing complications.
- Advice on symptom relief, which should include advice on weight loss, the benefit of light to moderate physical activity, avoiding activities that make symptoms worse (standing for long periods) and when and where to seek further help.

South East London CCGs do not routinely commission surgery for asymptomatic and mild varicose veins. Therefore surgical treatment for patients presenting to primary care with mild or asymptomatic varicose veins will only be funded under exceptional clinical circumstances.

Moderate to Severe Varicose Veins
Moderate varicose veins present as local or generalised dilatation of subcutaneous veins with associated pain or discomfort and slight ankle swelling. Severe varicose veins may present with phlebitis, ulceration and haemorrhage.

People should be referred to a vascular service if they have any of the following:

- Bleeding varicose veins (immediate referral).
- Symptomatic (veins found in association with troublesome lower limb symptoms - typically pain, aching, discomfort, swelling, heaviness and itching) primary or symptomatic recurrent varicose veins where other causes of these symptoms can be ruled out.
- Lower-limb skin changes, such as pigmentation or eczema, thought to be caused by chronic venous insufficiency.
- Superficial vein thrombosis (characterised by the appearance of hard, painful veins) and suspected venous incompetence.
- A venous leg ulcer (a break in the skin below the knee that has not healed within 2 weeks)
- A healed venous leg ulcer.

There is some evidence that the clinical severity of venous disease is worse in obese persons, so advice on weight loss may help reduce symptoms and would make any intervention safer.

Assessment of Individuals with Moderate to Severe Varicose Veins
Duplex ultrasound should be used to confirm the diagnosis of varicose veins and the extent of truncal reflux, and to plan treatment for people with suspected primary or recurrent varicose veins.
Following assessment, patients with confirmed varicose veins and truncal reflux should be referred on for appropriate interventional treatment.

**Interventional Treatment**

The main options include:

- Endothermal ablation, usually via radiofrequency or laser ablation (these methods heat the vein from inside causing irreversible damage to the vein and its lining and closes it off).
- If endothermal ablation is unsuitable, offer ultrasound guided foam sclerotherapy (sclerosant foam (irritating agent) is injected into the vein to cause an inflammatory response which consequently closes it)
- If foam sclerotherapy is unsuitable, offer truncal vein stripping surgery (a traditional treatment that involves surgical removal by 'stripping' out the vein or ligation (tying off the vein))
- If incompetent varicose tributaries are to be treated, consider treating them at the same time.

**Funding of Interventional Treatment**

Treatment may be given providing the following criteria are fulfilled.

1. **There is documented evidence of at least one of the following:**
   
   a. Varicose eczema
   b. Lipodermatosclerosis or a venous ulcer
   c. A venous ulcer that has taken over two weeks to heal
   d. One or more episodes of documented superficial thrombophlebitis
   e. A major episode of bleeding from a varicosity.
   
   **AND**

2. The patient has followed the above pathway

   **AND**

3. The diagnosis of varicose veins has been confirmed and there is evidence of truncal reflux

   **AND**

4. The patient has a normal BMI, or there is evidence that NICE guidance on measures to lose weight have been followed over a period of at least one year.

   **AND**

5. There is documented evidence that the patient is aware of the complications and limitations of the treatment

Treatment outside the criteria outlined will not be funded unless there are exceptional circumstances and approval has been gained via the Individual Funding Request (IFR) process.

Interventional treatment for varicose veins in pregnancy will not be funded unless exceptional circumstances apply and agreement is sought via the IFR process.
2.3 FERTILITY TREATMENTS

Infertility is a condition that requires investigation, management and treatment in accordance with national guidance. As part of the provision of prevention, treatment and care Commissioners are committed to ensuring that access to NHS fertility services is provided fairly and consistently.

Initial Assessment
It will be the responsibility of the General Practitioners to initially assess that the person meets the local CCG’s criteria for treatment for NHS funded cycles. Further support and advice is available from the CCG Medicines Optimisation Teams, Public Health Department and Commissioning team in implementing this guidance.

Referral to Hospital
Assisted conception services are provided by agreed providers. The units must comply with the Human Fertilisation and Embryology Authority (HFEA) regulations and follow appropriate protocols. Couples must take up the offer of Intracytoplasmic sperm injection (ICSI)/Invitro Fertilisation (IVF) within 3 months or risk being removed from the NHS waiting list.

Prescribing of medication
- The clinical prescribing of all drugs will be the responsibility of the providing Trust or the GP.
  (for local agreement)
- If a patient has started a privately funded cycle, the CCG will not fund the provision of prescribed drugs, which forms part of that treatment.

Timescale for treatment
Couples must be made aware at the time of being placed on the waiting list of the likely waiting time and the treatment for which the CCG will pay.

ELIGIBILITY CRITERIA
All couples must be registered with a General Practitioner within the boundaries of the CCG and be eligible for NHS treatment. Patients whose sperm or eggs have been stored prior to chemotherapy or radiotherapy will be entitled to NHS funded infertility treatment provided they meet the eligibility criteria.

The criteria for GP referrals for investigation and management of infertility should be in accordance with the following:

- Couples should be living together and in a stable relationship.

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Kanani N. A Review of ICSI: Indications, Cost Effectiveness and Safety. NHS Bromley, June 2010

The partner who is to receive treatment must be aged between 23 and 39 years old (up to 39 years and 364 days) at the time of treatment.*

Couples who have been diagnosed as having male factor or female factor problems or have had unexplained infertility for at least 3 years, taking into consideration both age and waiting list times.

Persons aged under 23 years old will be considered for treatment where medical investigations have confirmed that conception is impossible without fertility treatment, e.g. following unsuccessful fallopian tube surgery.

The female partners must not have had more than 2 previous Intrauterine insemination (IUI)/IVF/ICSI attempts (either NHS or privately funded).

The female partner should not have had any previous NHS funded attempts at IVF or ICSI and not more than three NHS funded attempts at IUI.

Women will be only considered for treatment if their BMI is between 19 and 30 (kg/m2).

Women with the BMI>30 should be referred to the appropriate obesity management pathway.

Couples should be non-smoking at the time of treatment. Couples who smoke should be referred to smoking cessation.

IVF cannot be used as a substitute for reversal of sterilization.

There are no problems with signing a form concerning the welfare of the child.

There must be no other medical problems making the chance of success less than 20%.

This service will be only be available at agreed providers and will include all clinically prescribed drugs.

Fertility treatment will only be offered to couples where the following two criteria are met:
   a) where there are no living children in the current relationship
   b) where neither partner has children from previous relationships.

No individual (male or female) can access more than the number of NHS funded fertility treatments under any circumstances, even if they are in a new relationship.

Where the eligibility criteria are not met but clinicians feel there are exceptional reasons, a case should be referred to the Individual Funding Requests Panel for consideration.

**Eligible Couples will be offered:**
   3 cycles of IUI,
   and / or
   1 full cycle of IVF +/- ICSI

*NICE Guidance (CG 156, Feb 2013) have been noted but, due to resources prioritization, assisted conception will continue to be funded according to the current criteria.*
**Surrogate Pregnancy**

The implications of a number of important legal points related to surrogate pregnancy mean that fertility treatment involving a surrogate mother will not be funded.\(^5\)

**Same Sex Couples**

As the consequence of the above legal opinion related to surrogacy, assisted conception for couples where both partners are male will not be provided by the SE London CCGs.

Where both partners are female, funding can be provided as long as the relevant criteria above are met. Infertility needs to be demonstrated in the partner who is seeking to become pregnant; that partner has to have undergone at least three attempts of IUI, but should not have had more than two previous attempts at IVF or ICSI (either NHS or privately funded).

If three cycles of privately funded IUI have been unsuccessful, the couple will be eligible for one NHS funded cycle of IVF or ICSI.

A final criterion for these couples is that they meet the HFEA requirements for parenthood and that both partners consent to be parents of the child. The HFEA guidance and a suitable statement for both partners to sign are available on request.

**Single Women**

Because of the known disadvantage that providing assisted conception to a single woman would cause both the child and the mother, funding of assisted conception for single women is not available in SE London.\(^6\)

Funding of assisted conception for single women is not available in SE London.\(^7\)

**Definition of one full cycle (NICE, CG156, 2013):**

The CCGs will fund up to 2 frozen embryos per patient for 2 years. This will include the cost of freezing and storage. For unsuccessful patients, i.e. those not resulting in a live birth, the CCG will also fund the transfer of these frozen embryos (maximum 2 frozen embryo transfers per patient). The age of mother at the time that the embryos are frozen is required to be within the age limits set out in the policy. This does not apply to the age at transfer.

A full cycle of IVF treatment, with or without intracytoplasmic sperm injection (ICSI), should comprise 1 episode of ovarian stimulation and the transfer of any resultant fresh and frozen embryo(s).

**Egg Donation/Donor Insemination**

The CCG does not routinely fund these procedures.

**Sperm Washing (for HIV and Other Viral Infections)**

As this is not a treatment for infertility sperm washing is not covered by this policy. NICE guidelines should be followed.\(^4\)

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\(^5\) Cheshire and Merseyside Specified Services Commissioning team Addendum to the Cheshire and Merseyside fertility Policy. May 07 Appendix 1 Legal Advice from Hill Dickenson


\(^7\) Surwar U. Fertility treatment for single women and same sex couples. SE London and Public Health Acute Commissioning Group. June 2011
2.4 FERTILITY PRESERVATION TECHNIQUES

The following preservation techniques: semen cryostorage, oocyte cryostorage, embryo cryostorage, will be routinely funded by South East London CCGs in the following circumstances:

- Where a man or a woman requires medical or surgical treatment that is likely to have a permanent harmful effect on subsequent sperm or egg production. Such treatment includes radiotherapy or chemotherapy for malignant disease
- OR
- Where a man or a woman requires on going medical treatment that, whilst on treatment, causes harmful effects on sperm or egg production, impotence or has possible teratogenic effects, and in whom stopping treatment for a prolonged period of time to enable conception is not an option.

It is important to note that the eggs are extracted for cryostorage using drugs and procedures of egg collection normally used for assisted conception; therefore the funding includes assisted conception drugs and procedures as well as the storage costs. This will not progress to IVF/ICSI or any other assisted conception procedures to form an embryo in these cases, unless this is sought separately later through the assisted conception pathway.

**Note:**

- Women should be offered oocyte or embryo cryostorage (without simultaneous assisted conception treatment) as appropriate if they are well enough to undergo ovarian stimulation and egg collection, provided this will not worsen their condition and that sufficient time is available.
- Women preparing for medical treatment that is likely to make them infertile should be informed that oocyte cryostorage has very limited success, and that cryopreservation of ovarian tissue is still in an early stage of development.

**Storage**

- If agreed, will be funded for five (5) years. The HFEA would grant a license to cryostore oocytes for ten years. The further extension up to ten years can still be offered to the patient but as a self-funded process.
- Will not be available where a man or woman chooses to undergo medical or surgical treatment whose primary purpose is that it will render her infertile, such as sterilisation.
- Will not be available where a man or woman requests cryostorage for personal lifestyle reasons, such as wishing to delay trying to conceive.

**Post-storage Treatment**

Funding of assisted conception treatments would be made available on the same basis as other patients who have not undergone such storage.

**Self-funding following cessation of NHS funding**

Once the period of NHS funding ceases, patients can elect to self-fund for a further period, not to exceed appropriate HFEA regulations on length of storage.
Embryo Cryostorage after NHS funded assisted conception

Suitable embryo’s that are not transferred in IVF/ICSI cycle - Storage will be funded for a minimum period of one (1) year.

2.5 HYSTERECTOMY FOR HEAVY MENSTRUAL-BLEEDING

Hysterectomy is an appropriate treatment for certain conditions such as malignancy. Its effectiveness in conditions such as heavy menstrual bleeding and fibroids where there are a number of treatment options is less clear cut. Funding for hysterectomy for heavy menstrual-bleeding and fibroids will be approved only when:

- There has been a prior trial with a LNG-IUS (levonorgestrel intra-uterine system) intra-uterine device (unless contraindicated) or other hormonal treatments in line with NICE guidance\textsuperscript{8}, which has not successfully relieved symptoms
- Other treatments [such as Non-Steroidal Anti-Inflammatory Drugs (NSAIDs), Tranexamic Acid, Endometrial ablation and uterine-artery embolization] have failed, are not appropriate or are contra-indicated in line with NICE guidelines.

Contraindications to LNG-IUS are:

- Severe anaemia, unresponsive to transfusion or other treatment whilst a LNG-IUS trial is in progress
- Distorted or small uterine cavity (with proven ultrasound measurements)
- Genital malignancy
- Active trophoblastic disease
- Pelvic inflammatory disease
- Established or marked immunosuppression
- In relation to a fibroid uterus above 12 weeks size, the LNG-IUS or ablation techniques are unlikely to work.
- For those who for ethical reasons cannot accept the use of LNG-IUS they should have tried at least two of the alternative treatments (NSAIDs, Tranexamic Acid, Endometrial ablation, uterine-artery embolisation).

Rationale

- The LNG-IUS device has been shown to be effective in the treatment of heavy menstrual-bleeding.
- It is cost effective.

A number of effective conservative treatments are available as second line treatment after failure of LNG-IUS or where LNG-IUS is contra-indicated.

2.6 FILTERED / COLOURED LENSES

These are not offered for specific reading difficulties.

\textsuperscript{8} National Institute for Health and Care Excellence: Heavy menstrual bleeding: assessment and management, NICE Clinical Guideline Published: 24 January 2007 nice.org.uk/guidance/cg44
2.7 COMMON HAND CONDITIONS

◆ Ganglion

Cystic degeneration from joint capsule or tendon sheath. Lesions at the base of the digits are often small but very tender (Seed Ganglion). Mucoid cysts arise at the distal interphalangeal joint and may disturb nail growth. Ganglions arising at the level of the wrist are rarely painful and most will resolve spontaneously within 5 years. The recurrence rate after excision of wrist ganglia is between 10-45%.

Refer:
- Painful seed ganglia
- Mucoid cysts that are disturbing nail growth or have a tendency to discharge (risk of septic arthritis in distal interphalangeal joint)

There is no indication for the routine excision of simple wrist ganglia. These should not generally be referred.

◆ Carpal Tunnel Syndrome

Patients typically present with nocturnal dysesthesia in the hands which wears off with activity. The presence of a positive Phalen’s (wrist flexion test) or Tinel’s sign confirms the diagnosis. Nerve conduction studies are NOT generally needed to confirm the diagnosis. In elderly patients the condition may develop insidiously. Conservative treatment may include adjustment of activities or posture with night splintage in neutral wrist position. Steroid injections may be of value in uncomplicated cases (requires clinical experience). Refer:

- Acute severe symptoms (fewer than 5% of patients) uncontrolled by conservative measures, particularly pregnancy
- Mild to moderate symptoms with failure of conservative management (4 months)
- Neurological deficit i.e. sensory blunting or weakness of thenar abduction

◆ Dupuytren’s Disease

Nodular or cord-like thickening of the palmar skin. May tend to cause tethering of the digits with loss of extension range. Refer:

- Loss of extension in one or more joints exceeding 25 degrees
- Patients under 45 years with disease affecting 2 or more digits and loss of extension exceeding 10 degrees.

◆ Trigger Finger

Snapping of the fingers as they are extended from a fully flexed posture, associated with a tender nodule in flexor tendon at base of finger or thumb. Conservative treatment may include rest from precipitating activities or NSAIDs. Injection of hydrocortisone into the tissue in front of the tendon at the level of the distal palmar crease will often settle early cases (requires clinical experience). Refer:

- Failure to respond to conservative treatment (maximum 2 injections)
- Fixed flexion deformity that cannot be corrected
2.8 TONSILLECTOMY

Tonsillectomy will not be funded except in cases of suspected malignancy or significant severe impact on quality of life indicated by:

- 5 or more episodes of sore throat per year
- symptoms for at least a year
- the episodes of sore throat are disabling and prevent normal functioning
- documented evidence of absence from school or attendance at GP or other health care setting.

Rationale:
Tonsillectomy offers relatively small clinical-benefit, measured best in terms of time taken away from school. The benefit in the year after the operation is roughly 2.8 days less taken away from school. Tonsillectomy carries a risk of mortality estimated to lie between 1 in 8,000 and 1 in 35,000 cases.

2.9 GROMMETS

CCGs will fund insertion of grommets (ventilation tubes) in:

- Children with persistent bilateral Otitis media with effusion (OME) documented over a period of 3 months with a hearing level in the better ear of 25-30 Decibel Hearing Level (dBHL) or worse, averaged at 0.5, 1, 2 and 4 kHz (or equivalent Decibel A-weighting (dBA) where dBHL not available)

- Children with persistent bilateral OME with a hearing loss less than of 25-30 dBHL where the impact of the hearing loss on the child's developmental, social or educational status is judged to be significant (e.g. documented absence from school)

- Children with Down's syndrome or cleft palate if this is considered clinically appropriate by a multidisciplinary team of professionals with expertise in assessing and treating such children

2.10 ADENOIDECTOMY FOR OTITIS MEDIA IN CHILDREN

Adenoidectomy combined with grommets may be considered in children who fulfil the criteria for grommets (see 2.8).

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2.11 KNEE WASHOUT AND DEBRIDEMENT FOR OSTEOARTHRITIS\textsuperscript{10}

NICE Guidance (2008) states that “exercise should be a core treatment for people with osteoarthritis, irrespective of age, comorbidity, pain severity or disability”. Analgesia for pain relief is also important and is detailed in the NICE document. Neither Cochrane reviews nor NICE found benefits from knee washout or debridement for the treatment of osteoarthritis. Therefore, as recommended by NICE 2008:

Referral for arthroscopic lavage and debridement should not be offered as part of treatment for knee osteoarthritis, \textit{unless} the person has a clear history of mechanical locking (not gelling, ‘giving way’ or X-ray evidence of loose bodies).

2.12 HAEMORRHOIDS\textsuperscript{11}

First or second-degree internal haemorrhoids (or third-degree haemorrhoids that are quite small) usually respond to conservative treatments such as changing bowel habit, diet and lifestyle, and by using stool softeners or laxatives. Only about 10\% of people eventually require surgery to alleviate their symptoms.

Non-conservative treatments include rubber band ligation, sclerotherapy, infra-red photocoagulation and surgery (e.g. haemorroidectomy, stapled haemorroidectomy, haemorrhoidal artery ligation). These are indicated for:

- Failure to respond to conservative treatment.
- Fourth-degree haemorrhoids, or third-degree haemorrhoids that are either too large for non-operative measures or have not responded to them.
- Thrombosed haemorrhoids when bleeding is problematic, or there is chronic irritation or leakage.
- People with large skin tags that need removing.


2.13 BOTULINUM TOXIN TYPE A FOR HYPERHIDROSIS IN ADULTS

Botulinum toxin therapy for the treatment of Hyperhidrosis is considered a low priority treatment and funding will only be considered for severe (defined as Hyperhidrosis Disease Severity Scale (HDSS) score 3 or 4) focal primary hyperhidrosis of the axillae, when the patient has had a documented, 6 month trial of conservative management, including all the following:

- The use of topical aluminium chloride or extra-strength antiperspirants, which has been ineffective or resulted in a severe rash which does not resolve with topical steroids/recommended treatment;
- General measures have been addressed, including wearing light coloured, non-tight fitting clothing; identifying and avoiding triggers e.g. spicy food, consider treating any underlying anxiety.

Funding for further treatments, at intervals of no less than 16 weeks, will only be approved provided at least a 2 point reduction on HDSS score can be shown during the 4 months following initial treatment.

The Hyperhidrosis Disease Severity Scale is a validated 4-point scale in which the patient rates the tolerability of their underarm sweating and the resulting interference with daily activities, as follows:

Score 1: My underarm sweating is never noticeable and never interferes with my daily activities
Score 2: My underarm sweating is tolerable but sometimes interferes with my daily activities
Score 3: My underarm sweating is barely tolerable and frequently interferes with my daily activities
Score 4: My underarm sweating is intolerable and always interferes with my daily activities

Please note: Botulinium toxin preparations are not interchangeable. Botox ® is the only preparation licensed for severe, axillary hyperhidrosis in adults.

At time of writing, none of the available botulinum toxin preparations are licensed for the treatment of hyperhidrosis in children. If the patient is a child (aged < 18 years) but the clinician feels he/she has exceptional clinical circumstances, the request for funding should be taken through the Individual Funding Request process.

Pregnant women and nursing mothers should avoid treatment.
Blepharoplasty (Eyelid Reduction)
OPCS 4 Procedure codes C131 C132 C133 C134 C138 C139

Cosmetic Breast Surgery
OPCS 4 Procedure codes B301 B302 B303 B308 B309 B311 B312 B313 B314 B318 B319

Breast Augmentation
OPCS 4 Procedure codes B312 B301 B303 B308 B309

Breast Reduction
OPCS 4 Procedure code B311

Breast Reduction
OPCS 4 Procedure code B311

Mastopexy (relocating the nipple and improving the shape of the breast)
OPCS 4 Procedure code B313

Revision Mammaplasty
OPCS 4 Procedure codes B314 B302

Breast Implants
OPCS 4 Procedure codes B312 B301 B303 B308 B309

Gynaecomastia
OPCS 4 Procedure code B311

Correction of Congenital Nipple Inversion
OPCS 4 Procedure codes B351 B353 B354 B356 B358 B359

Body Contouring (Abdominoplasty or Tummy Tuck, Thigh Lift and Buttock Lift, Excision of Redundant Skin or Fat Liposuction)
OPCS 4 Procedure codes S021 S022 S028 S029 S031 S032 S033 S038 S039

Dermabrasion (Chemical Peel)
OPCS 4 Procedure codes S601 S602

Face or Brow Lift
OPCS 4 Procedure codes S011 S012 S013 S014 S015 S016

Male Pattern Baldness (Hair Grafting and Flaps with or without Tissue Expansion)
OPCS 4 Procedure codes S331 S332 S333 S338 S339

Pinnaplasty (Correction of prominent or Bat Ears)
OPCS 4 Procedure code D033

Repair of Lobe of External Ear
OPCS 4 Procedure codes D031 D032 D034 D038 D039

Rhinoplasty (Reshaping of the Nose)
OPCS 4 Procedure codes E021 E022 E023 E024 E025 E026 E028 E029 E027

Scar Revision
OPCS 4 Procedure codes S604
Tattoo Removal
OPCS 4 Procedure codes S091 S092 S065 S068 S069
ICD10 Z411 L818

Removal of Birthmarks
ICD 10 diagnostic code Q825

Other Benign Skin Lesions
ICD 10 diagnostic codes D170 D171 D172 D173
ICD 10 diagnostic codes D23 D230 D231 D232 D233 D234 D235 D236 D237 D239 L720 L721 L722 L728 L729

Viral Warts and Molluscum Contagiosum in Children under 16 Years of Age
ICD 10 diagnostic codes B07X

Viral Warts in Adults
ICD 10 diagnostic codes B081

Non-Medical Circumcisions
OPCS 4 Procedure codes N303
ICD10 Z412

Reversal of Vasectomy or Female Sterilisation
OPCS 4 Procedure codes Q291 Q292 Q298 Q299 Q371 Q378 Q379 N181

EXCISION OF OTHER SKIN LESIONS

Pigmented Lesions
ICD 10 diagnostic codes L810 L811 L812 L813 L814 L815 L816 L817 L818 L819
ICD10 diagnostic codes (moles) Q825 D220 D221 D222 D223 D224 D225 D226 D227 D228 D229 I781

Tunable Dye Laser
ICD 10 diagnostic codes Q825

Varicose Veins
ICD 10 diagnostic codes I831 I839

Dilatation and Curettage
OPCS 4 Procedure codes Q103

Hysterectomy for Heavy Menstrual-Bleeding
OPCS 4 Q071 Q072 Q073 Q074 Q075 Q078 Q079 Q081 Q082 Q083 Q088 Q089
ICD10 N920 N921 N924

Ganglion
OPCS 4 Procedure codes T591 T592 T593 T594 T598 T599 T601 T602 T603 T604 T608 T609
ICD 10 diagnostic code M674

Codes Appendix
Page 133
Carpal Tunnel Syndrome
ICD 10 diagnostic code G560

Dupuytren's Disease
ICD 10 diagnostic code M720

Trigger Finger
ICD 10 diagnostic code M653

Tonsillectomy
OPCS4 F341 F342 F344 F345 F346 F347 F348 F349

Grommets
OPCS 4 Procedure code D151
ICD 10 diagnostic code H650 H651 H652 H653 H654 H659

Adenoidectomy for Otitis Media in Children
OPCS 4 Procedure code E201 E208 E209
ICD 10 diagnostic code H650 H651 H652 H653 H654 H659

Knee Washout And Debridement For Osteoarthritis
OPCS 4 Procedure code W852;
In addition, an ICD-10 code from category M17-(arthrosis of the knee) would be recorded

Haemorrhoids
OPCS 4 Procedure codes H511 H512 H513 H518 H519 H521 H522 H523 H524 H528 H529 H531 H532 H533 H538 H539 H558 H559 H568 H569 H482

Surgery for Asymptomatic Gallstones
OPCS 4 Procedure codes J181 J182 J183 J184 J185 J188 J189 J211
ICD10 code K802
A meeting of the Governing Body
09 March 2017

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<tr>
<th>Terms of Reference</th>
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<tr>
<td>LEAD: Martin Wilkinson</td>
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<td>MANAGERIAL LEAD: Susanna Masters</td>
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<td>AUTHOR(s): Victoria Medhurst</td>
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The Governing Body is asked to:

1. review and approve the Terms of Reference for each of the following Committees, reflecting the changes to the composition of the Governing Body 01 April 2017.
   - Audit Committee
   - Remuneration Committee
   - Integrated Governance Committee
   - Finance and Investment Committee

2. note the proposed arrangements to manage any actual or perceived conflicts of interest as a result of Alison Browne, Director of Nursing and Quality being appointed to the position of Registered Nurse member of the Governing Body.

1. Background

In June 2016, NHS England published revised statutory guidance on managing Conflicts of Interest for clinical commissioning groups (CCGs).

The management of Conflicts of Interest is part of effective commissioning. The national guidance includes a number of safeguards to strengthen the way in which commissioners mitigate the risk of real and perceived conflicts of interest arising in CCGs. At the Governing Body meeting in November 2016 the Conflicts of Interest Policy was approved which included the amendment to the composition of the Governing Body to include a third Lay Member. It is proposed that to reflect the responsibilities of the role that it is referred to as the Lay Member lead for primary care commissioning.

To enact this change, and as highlighted at the November Governing Body, Terms of Reference for all committees have been reviewed and amended, and are presented within this paper for approval.

Subsequently, the CCG has appointed Alison Browne, Director of Nursing and Quality, to the position of Registered Nurse member of the Governing Body. This is a two year term of
office. The posts of Director of Nursing and Quality and Governing Body Registered Nurse member are held separately though all Governing Body Committees terms of reference have been reviewed to identify any actual or perceived conflicts of interest that may arise through this arrangement.

2. Terms of Reference

Audit Committee
The Audit Committee Terms of Reference have been updated to include all three lay members and was approved by the Audit Committee in October 2016.

Whilst the Registered Nurse position remains within the membership of the committee, as the new postholder is also an employee of the CCG and therefore may not be considered to be independent, it is recommended that she should not take up this membership.

Quoracy occurs when 3 members are present; at least one of which must be a lay member. The membership includes 6 members, reducing to 5 members following this recommendation; quoracy should therefore be achievable (See Appendix I).

Remuneration Committee
The membership has been updated to include the Lay Member lead for primary care commissioning, so that all three Lay Members are members of this Committee.

The proposed draft Terms of Reference have been approved by the Remuneration Committee in December 2017.

While the Registered Nurse position remains within the membership of the committee, as the new postholder is also an employee of the CCG and therefore may not be considered to be independent, it is recommended that she should not take up this membership.

Quoracy states “The meeting will be quorate when two members are present, with at least one Lay Member also present on the Committee.
In relation to business concerning the remuneration of Lay Members, the quorum shall consist of any 2 members excluding the Lay Members.”

Quoracy should only therefore be impacted when business concerning remuneration of Lay Members is being discussed. It is recommended that all matters regarding this subject should be remitted for decision by the Governing Body in a part 2 meeting, with appropriate arrangements for the management of conflicts of interest.

Integrated Governance Committee
The membership of the Integrated Governance Committee has been amended to two Lay Members, and has been left non-specific to enable any sharing or re-distribution of responsibilities to occur. However, it is expected that the Lay Member lead for primary care commissioning to join the Lay Member for Finance and Audit (See Appendix III).

Quoracy is unaffected.
**Finance and Investment Committee**

The terms of reference for the Finance and Investment Committee has been changed to include two lay members, which it is expected to be the lead for Finance and Audit and the Lay Member lead for primary care commissioning.

Quoracy for the committee states “at least 2 independent members of the Governing Body of which 1 must be a lay member and 1 a clinician”. Given the dual role of the Registered Nurse there may be occasions when quoracy is not possible due to actual or perceived conflicts of interest. Whilst this may not necessitate the Registered Nurse being excluded from the discussion the decision may need to be deferred to the next meeting or proposed to the Governing Body to ratify. In this scenario, the Chair of the committee should undertake this assessment, in accordance with the CCG Conflicts of Interest Policy (see Appendix IV).

**Primary Care Commissioning Committee (new)**

The Primary Care Commissioning Committee is a new committee being established following the approval from NHS England for delegated responsibility for Primary Medical Services (general practice). The Terms of Reference are included in the paper on Delegated Commissioning – General Practice.

The Terms of Reference for Strategy and Development Workshop, Public Engagement and Equalities Forum (PEEF) and the SEL Committee in Common remain unchanged and are not included as part of this paper.

The **Governing Body** is asked to approve the Terms of Reference for each of the Committees and note the arrangements for managing perceived or real conflicts of interest with respect to the nurse member appointments.

**Appendix I – Terms of Reference Audit Committee**

**Appendix II – Terms of Reference Remuneration Committee**

**Appendix III – Terms of Reference Integrated Governance Committee**

**Appendix IV – Terms of Reference Finance and Investment Committee**

**CORPORATE AND STRATEGIC OBJECTIVES**

Robust management of Conflicts of Interest underpins the achievement of all of the Corporate Objectives, and this has been strengthened through the changes made to the composition of the Governing Body.

**CONSULTATION HISTORY:**

- Governing Body: agreement to the third Lay Member in November 2017
- IGC TOR: discussed at the Committee in February 2017.
- Audit Committee: agreed at the Committee in January 2017.
Rem Comm: agreed at the Committee in December 2016.

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<td>• Reduce inequalities between patients with respect to the outcomes achieved for them by the provision of health services.</td>
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<td>• Eliminate discrimination, harassment and victimisation and any other conduct that is prohibited under the Equality Act 2010</td>
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<td>• Advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it</td>
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<td>• Foster good relations between people who share a relevant protected characteristic and those who do not share it</td>
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Both the Conflicts of Interest and Procurement Policies aim to ensure that decision making throughout the CCG is fair and transparent.

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<tr>
<td>Name: Susanna Masters</td>
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<td>E-Mail: <a href="mailto:susanna.masters@nhs.net">susanna.masters@nhs.net</a></td>
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<tr>
<td>E-Mail: <a href="mailto:Victoria.medhurst@nhs.net">Victoria.medhurst@nhs.net</a></td>
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1. Introduction

1.1 The Audit Committee (the Committee) is established in accordance with the Lewisham Clinical Commissioning Group’s (CCG) Constitution, Standing Orders and Scheme of Delegation. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Committee and shall have effect as if incorporated into the CCG’s Constitution and Standing Orders.

2. Purpose

2.1 The Committee provides the CCG’s Governing Body with an independent and objective view of the CCG’s financial and control systems, financial and business information and compliance with laws, regulations and directions governing the CCG in so far as they relate to quality, finance, control systems and risk management. The Governing Body has approved and keeps under review the terms of reference for the Audit Committee.

2.2 The Committee shall critically review the clinical commissioning group’s quality and financial reporting and internal control systems and ensure an appropriate relationship with both internal and external auditors is maintained.

3. Areas of Focus

3.1 Integrated governance, risk management and internal control

3.1.1 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the CCG’s activities that support the achievement of the CCG’s objectives, including core business services provided to the CCG (for example commissioning support services).

3.1.2 Its work will dovetail with that of any Committee(s), which the CCG has established to seek assurance that robust clinical quality is in place. In particular, the Committee will review the adequacy and effectiveness of:

- All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any appropriate independent assurances, prior to endorsement by the CCG.

- The underlying assurance processes that indicate the degree of achievement of CCG objectives the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.
• The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification.

• The arrangements for and effectiveness of Internal and External Audit.

• The policies and procedures for and effectiveness of all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud and Security Management Services.

• The arrangements for and effectiveness of services provided by Commissioning Support providers, including Internal Audit arrangements and alignment with CCG audit plans.

3.1.3 In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

3.1.4 This will be evidenced through the Committee’s use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

3.2 Internal audit

3.2.1 The Committee shall ensure that there is an effective internal audit function that meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Accountable Officer and CCG. This will be achieved by:

• Consideration of the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal.

• Review and approval of the internal audit strategic and operational plans and more detailed programmes of work, including the statutory requirements, ensuring that this is consistent with the audit needs of the organisation, as identified in the assurance framework.

• Considering the major findings of internal audit work (and management’s response) and ensuring co-ordination between the internal and external auditors to optimise audit resources.

• Ensuring that the internal audit function is adequately resourced and has appropriate standing within the clinical commissioning group.

• An annual review of the effectiveness of internal audit.
• Receiving Head of Internal Audit opinions

3.3 External audit

3.3.1 The Committee shall review the work and findings of the external auditors and consider the implications and management’s responses to their work. This will be achieved by:

• Agreement of fees

• Consideration of the performance of the external auditors, as far as the rules governing the appointment permit.

• Discussion and agreement with the external auditors, before the audit commences, on the nature and scope of the audit as set out in the annual plan, and ensuring co-ordination, as appropriate, with other external auditors in the local health economy.

• Discussion with the external auditors of their local evaluation of audit risks and assessment of the clinical commissioning group and associated impact on the audit fee.

• Review of all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the CCG and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

3.3.2 The Committee shall fulfil the role of an Independent Auditor Panel, as described in the Local Audit and Accountability Act 2014

3.4 Counter fraud

3.4.1 The Committee shall satisfy itself that the CCG has adequate arrangements in place for countering fraud. This will be achieved by:

• Approving the counter fraud work plans and programme.
• Reviewing the progress against the counter fraud plan and outcomes of counter fraud work
• Reviewing the effectiveness of the counter fraud service.
• Reviewing the CCG’s assessments against NHS Protect’s qualitative assessments.
• Receiving the counter fraud, anti-bribery and other relevant policies
• Receiving the counter fraud annual report.
3.5 Financial management and reporting

3.5.1 The Audit Committee shall monitor the integrity of the financial statements of the clinical commissioning group and any formal announcements relating to the CCG’s financial performance.

3.5.2 The Committee shall ensure that the systems for financial reporting to the CCG, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the CCG. This will include:

- Reviewing proposed changes to the CCG’s prime financial policies
- Reviewing reported losses and special payments
- Authorising the write off of debts
- Reviewing all instances where requirements of prime financial policies have been formally waived.

3.5.3 The Audit Committee shall review the annual report and financial statements before submission to the Governing Body and the CCG, focusing particularly on:

- The wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee;
- Changes in, and compliance with, accounting policies, practices and estimation techniques;
- Unadjusted mis-statements in the financial statements;
- Significant judgements in preparing the financial statements;
- Significant adjustments resulting from the audit;
- Letter of representation; and
- Qualitative aspects of financial reporting.

3.6 Management

3.6.1 The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

3.6.2 The Committee may also request specific reports from individual functions within the clinical commissioning group as they may be appropriate to the overall arrangements.
3.7 Other assurance functions

3.7.1 The Audit Committee shall review the findings of other significant assurance functions, both internal and external, including quality, and consider the implications for the governance of the CCG.

3.7.2 These will include, but will not be limited to, any reviews by Department of Health arm’s length bodies or regulators/inspectors (for example, the Care Quality Commission and NHS Litigation Authority) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges and accreditation bodies).

3.7.3 The Committee will contribute to the CCG’s compliance with the national CCG Assurance Framework.

6. Meeting Schedule

6.1 The Committee will meet sufficiently to fulfil its work plan or no fewer than four times per year as a minimum. The Governing Body reserves the right to call a meeting at any time (with appropriate notice) if an urgent matter arises.

6.2 The external auditors or Head of Internal Audit may also request a meeting if they consider that one is necessary.

6.3 A notice period of at least 14 days shall be given before the Committee meets. The Agenda and supporting papers will be circulated 7 days prior to the meeting.

7. Accountability

7.1 The Committee will be accountable to the Governing Body through the distribution of its minutes and work plan in addition to the production of a report detailing its activities at least annually.

7.2 The Committee will have access to regular CCG performance and quality reports, strategies and plans.

8. Committee Membership

8.1 The Committee shall be appointed by the CCG as set out in the CCG’s constitution.

8.2 Members:

- Chair – the lay member of the Governing Body who has qualifications, expertise or experience in financial management and audit matters;

- The lay member of the Governing Body appointed as lead on patient and public participation matters

- The Third Lay Member (lead for primary care commissioning)
- Senior Clinical Director with lead for quality
- Secondary Care Consultant Governing Body member
- Registered Nurse Governing Body member

8.3 The provisions for appointment and tenure of the members of the Committee are defined in the Standing Orders relating to these posts in the CCG Constitution.

8.4 In the event of the Chair of the Audit Committee being unable to attend all or part of a meeting, he or she will nominate a replacement from within the membership to deputise for that meeting.

8.5 Individuals in regular attendance but who are not members of the Committee include the CCG’s Accountable Officer, Chief Financial Officer and representatives from internal and external audit services.

8.6 At least once a year the Committee will meet privately with the external and internal auditors without any director or senior officer present.

8.7 Representatives from Local Counter Fraud Services and NHS Protect may be invited to attend meetings and will normally attend at least one meeting each year.

8.8 Regardless of attendance, external audit, internal audit, local counter fraud and local security management providers will have full and unrestricted rights of access to the Audit Committee.

8.9 The Accountable Officer will be invited to attend and discuss, at least annually with the Committee, the process for assurance that supports the Annual Governance Statement. He or she will also normally attend when the Committee considers the draft internal audit plan and the annual accounts.

8.10 Any other directors (or similar) may be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that director.

8.11 The Chair of the Governing Body may attend any meeting each year in order to form a view on, and understanding of, the Committee’s operations. However the Chair of the Governing Body may not be a member of the Audit Committee.

8.12 The Audit Committee may recruit or co-opt additional members that are independent of the CCG Governing Body.

9. Quorum Rules and Responsibilities of Members

9.1 The meeting will be quorate when three members are present; at least one of which must be a lay member.

9.2 The Committee shall conduct its business in accordance with national guidance, relevant codes of practice including the Nolan Principles and the Conflict of Interest policy. Members should make every effort to attend Committee meetings.

10. Reporting Arrangements

10.1 The Committee Chair shall report formally to the CCG Governing Body on its proceedings after each meeting on all matters within its duties and responsibilities. The Chair of the Committee shall draw to the attention of the Governing Body any
issues that require disclosure to the full Governing Body, or require executive action. The Committee shall make recommendations to the Governing Body on any area within its remit where action or improvement is needed.

10.2 Items that are confidential or commercially confidential and any associated minutes will be reported to the Governing Body not in public.

11. Monitoring adherence to the Terms of Reference

11.1 The Group will report to the CCG Governing Body annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and effectiveness of risk management in the organisation and the integration of governance arrangements.

12. Review

12.1 These Terms of Reference will be reviewed on an annual basis or sooner if required with recommendations made to the CCG Governing Group for approval.

12.2 Any resulting changes to the terms of reference will be approved by the Governing Body.

13. Resources and support

13.1 The Committee will be supported by a Director of the CCG, who will be responsible for:

- overseeing of Committee agendas, minimising the duplication of discussion and decision-making
- assisting those chairing the Committee with preparation for meetings
- bringing together in accessible form the reports and information necessary to the support discussion and decision-making of the Committee
- producing and distributing minutes within five working days of meetings
- tracking progress on actions, identifying and rectifying any lapses in communication.

13.2 Meeting dates will be agreed on an annual basis and will not be changed without the permission of the Chair.

13.3 Agendas for the meeting will be distributed no less than seven days before the meeting.

13.4 Papers for the meeting will be distributed no less than five days before the meeting.

32.5 Any exceptions to this will require written notification to the Chair, and subsequent agreement on distribution arrangements.
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<td>03/05/2016</td>
<td>Section 3.7.3 added reference to the CCG’s Assurance Framework. Paragraph 8.11 amended to clarify position of the Chair of the Governing Body</td>
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<td>4.1</td>
<td>10/10/2016</td>
<td>Addition of third Lay member following amended guidance from NHS England on Conflict of Interest.</td>
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1. Introduction

The Remuneration Committee (the Committee) is established in accordance with the Lewisham Clinical Commissioning Group’s Constitution, Standing Orders and Scheme of Delegation. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Committee and shall have effect as if incorporated into the Clinical Commissioning Group’s Constitution and Standing Orders.

2. Purpose

The Committee is delegated to determine and approve pay and remuneration for employees of the Clinical Commissioning Group and people who provide services to the Clinical Commissioning Group and allowances under any pension scheme it might establish as an alternative to the NHS pension scheme.

3. Areas of Focus

Specifically, the Committee will be responsible for:

- Approving the terms and conditions, remuneration and travelling or other allowances for Chair, Senior Clinical Directors and Clinical Directors of the Governing Body, including pensions and gratuities.
- Approving the terms and conditions, remuneration and travelling or other allowances for the independent members of the Governing Body, that is the lay members, the secondary care doctor and the registered nurse.
- Approving the terms and conditions of employment for all employees of the group on VSM (Very Senior Managers pay scales) including, pensions, remuneration, fees and travelling or other allowances payable to such employees (see Appendix 1 for the decision-making process in respect of salaries exceeding £142,500)
- Reviewing recommendations concerning pensions, remuneration, fees and allowances payable to the above persons.
- Approving fees and allowances paid to all other persons providing services to the group.
These responsibilities encompass:

- Monitoring and evaluating the performance and achievements of those employees on VSM and determining annual salary awards and other payments as appropriate.
- Considering the contractual arrangements and severance payments of the Accountable Officer and of other senior staff, seeking HM Treasury approval as appropriate in accordance with the guidance 'Managing Public Money'.

The Committee should also remain aware that each individual NHS organisation is corporately responsible for ensuring that its pay arrangements are appropriate in terms of Equal Pay requirements and other relevant legislation.

The Committee will at all times apply best practice in the decision making processes. When considering individual remuneration the committee will:

- Comply with current disclosure requirements for remuneration;
- On occasion seek independent advice about remuneration for individuals; and
- Ensure that decisions are based on clear and transparent criteria.

The Committee will have full authority to commission any reports or surveys it deems necessary to help it fulfil its obligations.

A decision put to a vote at a meeting shall be determined by a majority of the votes of the members present. In the case of an equal vote, the Chair of the Committee shall have a second and casting vote.

4. Meeting Schedule

The committee will meet sufficiently to fulfil its work plan or at least bi-annually as a minimum. The Governing Body reserves the right to call a meeting at any time (with appropriate notice) if an urgent matter arises.

A notice period of at least 14 days shall be given before the Remuneration Committee meets. The Agenda and supporting papers will be circulated 7 days prior to the meeting.

5. Accountability

The Committee will be accountable to the Governing Body and shall report to the Governing Body on any area within its remit where action or improvement is needed.

6. Committee Membership
The Committee shall be appointed by the Clinical Commissioning Group from amongst its Governing Body members and must not have a Member Practice majority. Only members of the Remuneration Committee have the right to attend Remuneration Committee meetings:

Members:
- Chair of the Committee (Lay Member, the lead for audit who is also Vice Chair of the Governing Body)
- Deputy Chair of the Committee (Lay Member)
- Lay Member
- Secondary Care Consultant
- Registered Nurse

Other parties may attend at the request of the Committee and only to provide advice and information. This may include the Accountable Officer, Chief Financial Officer, or other employees or external advisors.

Staff will not be present for the discussion of matters relating to their own remuneration, performance or terms of service.

7. Quorum Rules and Responsibilities of Members

The meeting will be quorate when two members are present, with at least one Lay Member also present on the Committee.

In relation to business concerning the remuneration of Lay Members, the quorum shall consist of any 2 members excluding the Lay Members.

A decision put to a vote at the meeting shall be determined by a majority of the votes of members present. In the case of an equal vote, the Chair of the Committee shall have a second and casting vote.

The Committee shall conduct its business in accordance with national guidance, relevant codes of practice including the Nolan Principles and the Conflict of Interest policy.

The Remuneration Committee will:

- Observe the highest standards of propriety involving impartiality, integrity and objectivity in relation to the stewardship of public funds and the management of the bodies concerned;
8. Reporting Arrangements

The Committee Chair shall report formally to the CCG Governing Body on its proceedings after each meeting on all matters within its duties and responsibilities. The report shall be presented to the confidential meeting of the Governing Body, respecting individual confidentiality.

9. Monitoring adherence to the Terms of Reference

As part of the annual reporting process to the Governing Body.

10. Review

These Terms of Reference will be reviewed on an annual basis or sooner if required with recommendations made to the CCG Governing Group for approval.

Any resulting changes to the terms of reference will be approved by the Governing Body.

11. Resources and support

The committee will be supported by a Director of the CCG, who will be responsible for:

- overseeing of Governing Body and committee agendas, minimising the duplication of discussion and decision-making
- assisting those chairing the Governing Body and committee with preparation for meetings
• bringing together in accessible form the reports and information necessary to the support discussion and decision-making of the Governing Body and its committees
• producing and distributing minutes within five working days of meetings
• tracking progress on actions, identifying and rectifying any lapses in communication.

Meeting dates will be agreed on an annual basis and will not be changed without the permission of the chair.

Agendas for the meeting will be distributed no less than seven days before the meeting.

Papers for the meeting will be distributed no less than five days before the meeting. Any exceptions to this will require written notification to the chair, and subsequent agreement on distribution arrangements.
Appendix 1 - Process for approving salaries above £142,500

1. Senior post advertised at the agreed rate fails to attract a suitable candidate

   - Chief Officer (or Chair in the case of the appointment of a Chief Officer) drafts a case for paying more than £142,500, having reviewed comparable salaries in London and other reasons for the failure to recruit

   - Remuneration Committee considers the case and decides whether or not to present it to the Governing Body for noting

   - Remuneration Committee agrees proposals and presents them to Governing Body

   - Remuneration Committee rejects proposals and the post is readvertised at the set rate

   - Governing Body notes the decision of Remuneration Committee

   - Chair writes to NHS England to seek views of ministers before advertising at more than £142,500

     - Ministers ask the CCG to reconsider

     - Remuneration Committee considers advice and reports to Governing Body to agree next steps

     - Ministers agree to proposals
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TERMS OF REFERENCE

NHS LEWISHAM CLINICAL COMMISSIONING GROUP

Integrated Governance Committee (v5.1)

1. Introduction

Integrated Governance Committee (the Committee) brings together the systems and processes by which NHS Lewisham CCG leads, directs and controls its functions in order to achieve organisational objectives and quality of commissioned services, and by which NHS Lewisham CCG relates to patients and carers, the wider community and partner organisations.

The Integrated Governance Committee is a standing Committee of NHS Lewisham CCG, which exists to oversee the delivery of the CCG’s Operational Plan including the implementation of change and the realisation of benefits.

2. Purpose

- Oversee the delivery of the CCG’s Operational Plan and associated work
- Encourage a culture of openness and transparency in its reporting and learning and development

3. Areas of Focus

- To monitor performance and take assurance against the Operating Plan commitments and targets for:
  - Quality – covering the domains of quality as set out in the CCG’s Quality Improvement Strategy comprising:
    - Safety - protects people from avoidable harm
    - Effectiveness - based on best practice and with good outcomes
    - Patient experience
    - Well led organisations that provide strong leadership and support their staff
    - Responsive to the individual needs of people and communities and responds positively to feedback from the public
  - Health outcomes – national and local; including meeting the Public Sector Equality Duty
  - NHS Constitution Standards
  - Key performance indicators – national and local
  - Corporate objectives
  - Activity
  - Expenditure

- To agree and monitor mitigation and recovery plans when delivery is off track

- To consider the linkages between performance in terms of quality, outcomes, standards, activity and expenditure

- To identify and address any barriers to delivery

- To identify, assess and monitor risks to ensure that in year risks to the delivery of the operating
plan are effectively mitigated and brought to the attention of the Governing Body

- To review key reports from priority commissioning areas
- To identify, escalate, monitor and learn from patient feedback, patient safety and quality incidents and issues. To agree and oversee implementation of mechanisms for sharing learning with providers and to inform future commissioning plans
- Where deep-seated barriers to delivery are identified, which cannot be resolved through routine corrective action, refer exploration and resolution to the Clinical Directors Committee or Strategy and Development Workshop as appropriate.
- To oversee the development, implementation and monitoring of the CCG’s annual Quality Innovative, Productivity and Prevention (QIPP) programme
- To track benefits realisation plans following the CCG’s investment decisions
- To provide assurance to the Governing Body that the CCG has sufficient grip to deliver its Operational Plan
- To ratify clinical policies, protocols, procedures and guidance in accordance with national and local best practice requirements

4. NHSE CCG Assurance Framework

The Committee will contribute to the CCG’s compliance with the national CCG Improvement and Assurance Framework.

5. Meeting Schedule

The Committee will meet on a monthly basis, with meeting dates coordinated to achieve best fit with the availability of timely performance information. Additional meetings may be held if required, for example to review Serious Incidents and emerging clinical risks.

6. Accountability

The Committee will be accountable to the Governing Body through distribution of its minutes and work plan in addition to the production of a report detailing its activities at least annually.

7. Committee Membership

The Chair of the CCG is an ex-officio member of this Committee and sub groups with full voting rights.

Core members
Chief Officer (Chair of the Committee)
1 Senior Clinical Director – with a lead role for quality (deputy Chair)
2 Clinical Directors
Chief Financial Officer
Commissioning Director (or deputy)
Director of Nursing and Quality (or deputy)
Head of Joint Commissioning (or deputy)
The Committee is authorised to co-opt other non-voting members as appropriate to its work.

8. Quorum Rules and Responsibilities of Members

The following members must attend for the Committee to be quorate.

1 Senior Clinical Director
1 Clinical Director
Chief Officer or nominated deputy
1 further Director

The Chair of the GB and any of the elected Senior Clinical Directors and Clinical Directors present will count towards the meeting being quorate

Committee Members will follow the code of conduct contained in the CCG’s constitution.

9. Subgroups

The Committee is authorised to establish sub-committees and working groups as required to deliver its terms of reference.

Standing sub groups of the Integrated Governance Committee will be:

- Individual Funding Request Panels
- Prescribing and Medicines Management Group
- Information Governance Steering Group
- System Resilience Group
- Health Safeguarding Group

10. Authority

The Integrated Governance Committee is authorised by the Governing Body to:

- investigate any activity within its terms of reference.
- seek any information it requires from any employee or provider of services commissioned by NHS Lewisham CCG and employees are directed to co-operate with any request made by the Committee
- Obtain outside legal, clinical or other independent professional advice and to secure the attendance
of external experts and advisors with relevant experience and expertise if it considers this necessary.

11. Reporting Arrangements

The Committee will maintain clear records for the purpose of effective communication, openness and transparency of the process and for accountability.

The Committee will provide a Committee Chair’s report of its meetings to the CCG Governing Body and the minutes of each Committee meeting will also be provided for information.

12. Escalation

The Committee may require exception reports to be prepared if it is not assured that the safety, effectiveness and patient experience of the services commissioned by the CCG at least meet minimum standards and show continual quality improvement to achieve the highest possible standards.

The Committee may refer issues to the Clinical Directors Committee or the Strategy and Development workshop for further consideration where appropriate.

The Corporate Risk Register will also provide the vehicle for escalation to the Governing Body.

13. Monitoring adherence to the Terms of Reference

As part of the reporting process to the Governing Body

14. Review

Terms of Reference will be reviewed annually.

15. Resources and support

The Committee will be supported by the Corporate Director of the CCG, who will be responsible for:

- overseeing of Governing Body and Committee agendas, minimising the duplication of discussion and decision-making
- assisting those chairing the Governing Body and Committee with preparation for meetings
- ensuring that any actual or potential Conflicts of Interest are identified and dealt with in accordance to the CCG Policy on Conflict of Interest
- bringing together in accessible form the reports and information necessary to the support discussion and decision-making of the Governing Body and the Committee
- producing and distributing minutes within five working days of meetings
- tracking progress on actions, identifying and rectifying any lapses in communication.

Meeting dates will be agreed on an annual basis and will not be changed without the permission of the Chair.

Agendas for the meeting will be distributed no less than seven days before the meeting. Papers for the meeting will be distributed no less than seven days before the meeting.

Any exceptions to this will require written notification to the chair, and subsequent agreement on distribution arrangements.
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<td>19/04/2016</td>
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<td>Susanna Masters, Corporate Director – incorporating changes from the Integrated Governance Committee meeting on 28th April 2016:</td>
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<td></td>
<td></td>
<td>• The purpose to include learning and development (Section 2)</td>
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<td>• The areas of focus – to expand Quality to cover the three domains and include Corporate Objectives (Section 3)</td>
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<td>• compliance with the national CCG Assurance Framework (section 4)</td>
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<td>• Committee Membership – to exclude Public Health as part of the core membership; identification of a deputy chair (Section 7)</td>
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1. Introduction

The Finance and Investment Committee is established as a standing Committee of NHS Lewisham CCG.

2. Purpose

2.1 The purpose of the Committee is

2.1.1 to maintain a detailed overview of the CCG’s assets and resources in relation to the achievement of financial targets and business objectives and the financial stability of the CCG. This will include:-

- scrutiny and approval of business cases
- oversight of the capital programme
- oversight of the use of non-recurring budgets, reserves and contingencies
- reviewing financial planning assumptions
- considering financial risk evaluation, measurement and management

2.1.2 provide oversight over the CCG’s major procurements

2.2 As a Committee of the CCG Governing Body it will:

- Make decisions within the scheme of delegation
- Advise and make recommendations to the Governing Body, including investment decisions that exceed delegated limits
- Routinely conduct business in confidence, unless expressly stated as public.

3 Areas of Focus

3.1 Business Cases

- To perform a preliminary review of proposed major investments.
- To establish the overall controls which govern business case investments and to approve the CCG’s Business Case Procedure.
- In accordance with the Business Case Procedure and Scheme of Delegation rigorously review and approve business cases.
- To ensure that robust processes are followed, evaluating, scrutinising and monitoring investments so that benefits realisation can be confirmed.
- To ensure testing of all relevant options for larger business cases prior to detailed workup
- To focus on financial metrics within cases e.g. payback periods, rate of return.

3.2 Capital Programme oversight

- To oversee the development and management of the rolling capital programme including scrutiny of the prioritisation process, forecasting and remedial action

3.3 Oversight of Non Recurring Budgets
• To oversee use of non-recurring budgets not delegated in the CCG budget for specific purposes

3.4 Financial Planning Assumptions

• To consider the Financial Strategy, ensuring that the financial objectives are consistent with the strategic direction and quality and performance priorities.
• To review the long term financial model
• To review key medium term planning assumptions

3.5 Financial Risk Management

• To review financial risk and advise the Audit Committee and Governing Body accordingly:
• Review and evaluation of key financial risks (e.g. tariff changes, commissioning intentions, achievement of savings, control of recruitment costs, underlying activity levels
• Deep dive into risk management processes around significant evaluated risks linking to Assurance Framework providing assurance around active financial risk management (Note: the formal link between the finance risk register and Corporate Risk Register will be through the Integrated Governance Committee)

3.6 Scrutiny over major procurements

• To receive assurance that appropriate procurement routes are considered and selected
• Review procurement related risk
• Monitor procurement process

4. NZSE CCG Assurance Framework [New Section]

4.1 The Committee will contribute to the CCG’s compliance with the national CCG Assurance Framework.

5 Delegated Authority

5.1 The Governing Body delegates the above functions to the Committee. The Governing Body also delegates decisions not of a significant nature. In practice what is significant will depend on the judgment of members but committees must refer the following types of issue to the Governing Body.

Any matter which will:
• Change the strategic direction of the CCG.
• Conflict with statutory obligations.
• Contravene national policy decisions or governmental directives.
• Have significant revenue, capital or cash implications.
• Have significant governance implications.
• Be likely to arouse significant public or media interest.

5.2 In recognition of 4.1 above the Committee will not make decisions contrary to the strategic direction of the CCG or agreements made by the CCG at the Strategic Committee in Common for Decision Making. Any such matters will be referred to the Governing Body.

5.3 The Committee will be expected to take decisions in its areas of responsibility unless there are wider implications for the CCG, requiring the matter to be referred to the Governing Body
5.4 The Governing Body delegates to the Committee the specific function of reviewing and approving business cases for capital and revenue investment falling within the following categories:

- Business cases with an anticipated annual revenue spend of up to £500,000 per annum (the highest annual cost). For business cases with an anticipated annual revenue spend in excess of £500,000, the Committee will make recommendations to the Governing Body.
- Business cases requiring capital investment up to the value of the CCG’s capital resource limit.
- The Committee is authorised to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience if it considers this necessary.

6 Meeting Schedule

The Finance and Investment Committee will meet at least 6 times per annum. Meetings may be held more regularly or scheduled as the need arises.

7 Accountability

The Committee will be accountable to the Governing Body.

8 Committee Membership

The Chair of the Finance and Investment Committee will be an independent member of the Governing Body.

The Chair of the CCG is an ex-officio member of this Committee with full voting rights.

Core members
2x Lay Members
2x Independent GB Members (Secondary care Doctor and Registered Nurse)
Senior Clinical Directors
Chief Officer
Chief Financial Officer

In attendance
Head of Finance
Management and/or clinical leads as required

9 Quorum Rules and Responsibilities of Members

9.1 The following members must attend for the Committee to be quorate:

At least 2 independent members of the Governing Body of which 1 must be a lay member and 1 a clinician and at least one of either the Chief Officer or Chief Financial Officer.

9.2 Committee Members will follow the code of conduct contained in the CCG’s constitution.

9.3 The CCG’s Conflicts of Interest policy will be strictly applied.

10 Subgroups

The Finance and Investment Committee is authorised to establish sub-committees and working groups as required to deliver its terms of reference.
11 Reporting Arrangements

The majority of Committee business is either confidential or commercially sensitive at the time of decision making. The Committee will routinely report to Part II of the Governing Body. Summary notes, outlining major decisions, will be produced for Part I of the Governing Body meeting held in public, where there is no confidentiality or commercial restriction.

12 Confidentiality and Conflicts of Interest

12.1 The business and records of the Finance and Investment Committee are confidential by default except where specific confidentiality requirements are deemed not to exist.

12.2 Matters must be treated as entirely confidential by the Committee. Confidential minutes shall be maintained for considerations of confidentiality, including commercial confidentiality.

12.3 Summary reports, outlining major decisions and key messages, will be produced for Governing Body meetings. Confidential reports will be presented to Part II Governing Body meetings. Non confidential reports will be presented to Part I Governing Body meetings held in public.

12.4 All attendees are required to declare their interests as a standing agenda item for every committee before the item is discussed.

12.5 The chair of the meeting has ultimate responsibility for deciding whether there is a conflict of interest and for taking the appropriate course of action in order to manage the conflict of interest.

12.6 In the event that the chair of a meeting has a conflict of interest, the vice chair is responsible for deciding the appropriate course of action in order to manage the conflict of interest. If the vice chair is also conflicted then the remaining non-conflicted voting members of the meeting should agree between themselves how to manage the conflict(s).

12.7 In making such decisions, the chair (or vice chair or remaining non-conflicted members as above) may wish to consult with the Conflicts of Interest Guardian or another member of the governing body.

12.8 The chair should ask at the beginning of each meeting if anyone has any conflicts of interest to declare in relation to the business to be transacted at the meeting. Each member of the group should declare any interests which are relevant to the business of the meeting whether or not those interests have previously been declared. Any new interests which are declared at a meeting must be included on the CCG’s relevant register of interests to ensure it is up-to-date.

12.9 Further guidance on managing Conflicts of Interest can be found in Lewisham CCGs policy (http://www.lewishamccg.nhs.uk/news-publications/Policies/Documents/Lewisham%20CCG%20Conflicts%20of%20Interest%20Policy%20November%202016.pdf)

13 Monitoring adherence to the Terms of Reference

As part of the reporting process to the Governing Body

14 Review

Terms of reference will be reviewed annually.
15 Resources and support

15.1 The committee will be supported by a Director of the CCG, who will be responsible for:

- overseeing of Governing Body and committee agendas, minimising the duplication of discussion and decision-making
- assisting those chairing the Governing Body and committees with preparation for meetings
- bringing together in accessible forms the reports and information necessary to the support discussion and decision-making of the Governing Body and its committees
- producing and distributing minutes within five working days of meetings
- tracking progress on actions, identifying and rectifying any lapses in communication.

15.2 Meeting dates will be agreed in advance.

15.3 Agendas for the meeting will be distributed no less than seven days before the meeting

15.4 Papers for the meeting will be distributed no less than seven days before the meeting.

15.5 Any exceptions to this will require written notification to the chair, and subsequent agreement on distribution arrangements.

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|         |            | - To oversee the implementation of major procurements and associated procurement processes (para 2.1)
|         |            | - To revise the delegated authority in terms of £500,000 per annum for revenue expenditure (para 5.4)
|         |            | - To strengthen confidentiality of business (para 12)                          |
| 1.1     | 03/05/2016 | Revised to clarify interface with other Committees (para 5.2)                 |
| 1.2     | 19/01/2017 | Revised due to changes in COI
|         |            | a) reflecting the engagement of third lay member for CCG.
|         |            | b) Inclusion of COI section                                                  |
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A meeting of the Governing Body
Thursday 9th March 2017

Delegated Commissioning – General Practice

CLINICAL LEAD: Marc Rowland, Chair, Lewisham Clinical Commissioning Group
MANAGERIAL LEAD/S: Martin Wilkinson, Chief Officer, Lewisham Clinical Commissioning Group
AUTHOR: Diana Braithwaite, Director of Commissioning & Primary Care, Lewisham Clinical Commissioning Group

1. RECOMMENDATIONS:

The Governing Body is asked to;

(i) Note that under Chairs action granted by the Governing Body on 10th November 2016, to progress the CCGs level 3 delegated commissioning application; that in order for delegation to be granted the CCG will complete the delegation agreement (as per Appendix 1 and 2), which will be returned to NHS England by the nationally required date of 8th March 2017.

(ii) Once finalised, that chairs action is taken to agree Schedule 7 of the delegation agreement identifying resourcing arrangements between NHS England and the CCG in respect of staff assignment.

The Governing Body is also asked to approve the Terms of Reference for the Primary Care Commissioning Committee as per Appendix 3.

2. SUMMARY:

2.1 At the Governing Body meeting on 10th November 2016, approval was given for; (i) an application for level 3 primary care (General Practice) commissioning arrangements (Full Delegation) to be submitted to NHS England; and (ii) that Chairs action is taken to progress the final application on behalf of the Governing Body by the due date of 5th December 2016.

2.2 The application was submitted on the 5th December 2016 and on the 14th February 2017, the CCG received notification that the application had been successful. NHS Lewisham CCG has been approved to take forward these new arrangements from 1st April 2017 subject to signing of the delegation agreement.

3. KEY ISSUES:

3.1 In summary the functions that will be delegated to the CCG from the 1st April 2017 are as follows;

(a) GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing breech/remedial notices and removing a contract)

(b) Newly designed enhanced services

(c) Design of local incentives schemes as an alternative to Quality Outcomes Framework (QOF)

(d) decisions in relation to the establishment of new GP practices (including branch surgeries) and closure of GP practices;

(e) Approving practice mergers;

(f) Making decisions on ‘discretionary’ payments (e.g. returner/retainer schemes).

(g) Decisions about commissioning urgent care (including home visits as required) for out of area registered patients;
(h) Planning primary medical care services in the Lewisham including carrying out needs assessments;
(i) Undertaking reviews of primary medical care services in the Lewisham;
(j) Decisions in relation to the management of GP practice performance and including (and without limitation); decisions and liaison with the Clinical Quality Commission (CQC), where there is reported non-compliance with standards (excluding any decisions in relation to the performers list);
(k) Management of the delegated funds in the Lewisham;
(l) Premises Costs Directions functions;
(m) Co-ordinating a common approach to the commissioning of primary care services with other commissioners in the area where appropriate; and
(n) Such other ancillary activities as are necessary in order to exercise the Delegated Functions.

3.2 The *Reserved Functions* remaining the responsibility of NHS England are as follows;
(o) Management of the national medical performers list;
(p) Management of the revalidation and appraisal process;
(q) Administration of payments in circumstances where a performer is suspended and related performers list management activities;
(r) Capital expenditure functions;
(s) Section 7A functions under the NHS Act;
(t) Functions in relation to complaints management;
(u) Decisions in relation to the Prime Minister’s Challenge Fund;
(v) Commissioning of dental, community pharmacy and eye health services;
(w) Such other ancillary activities as are necessary in order to exercise the *Reserved Functions*.

3.3 To ensure consistency the delegation is a standard format with no local variation with the exception of Schedule 7.

3.4 Schedule 7 is intended to describe resourcing arrangements between NHS England and the CCG and details of any particular service that staff assigned by NHS England to the CCG will provide.

3.5 At the time of writing, Schedule 7 is in the process of being finalised by NHS England (London and therefore, will be agreed by the requested chairs action prior to submission by 8th March 2017.

3.6 There will be memoranda of understanding (MOU) arrangements in place between the CCGs and with NHS England regarding the operation of these arrangements.

3.7 CCGs are asked to complete, and return the relevant part of the delegation arrangement to NHS England by 8th March 2017.

3.8 Following the return of that agreement, NHS England will issue a delegation document.

4. CORPORATE AND STRATEGIC OBJECTIVES:

*Governance – planning and development*

Medium Term Planning – commissioning and contracting for population health

(i) Develop commissioning frameworks to take forward local implement the STP
(ii) Level 3 commissioning for GP Services preparation is completed by 1st April 2017

5. CONSULTATION HISTORY INCLUDING MEMBERS ENGAGEMENT:

<table>
<thead>
<tr>
<th>Date</th>
<th>Meeting/Board</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.08.2016</td>
<td>Primary Care Programme Board</td>
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<td>10.08.2016</td>
<td>Membership Forum</td>
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<tr>
<td>31.08.2016</td>
<td>Lewisham Local Medical Committee</td>
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<tr>
<td>07.09.2016</td>
<td>Neighbourhood 2 – Central</td>
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<td>08.09.2016</td>
<td>Governing Body</td>
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</tbody>
</table>
6. PUBLIC ENGAGEMENT:

06.10.2016: CCG Public Reference Group

7. HEALTH INEQUALITY AND PUBLIC SECTOR EQUALITY DUTIES:

- Lewisham CCG must comply with the Public Sector Equality Duty (PSED) when carrying out its functions. The PSED is non-delegable. This means that the duty will always remain the responsibility of the organisation subject to the duty. In relation to taking on delegated responsibility for commissioning primary care – essentially this means that the CCG must ensure that its providers (GP practices) take certain steps (such as monitoring service users), in order to enable the CCG to demonstrate that it is meeting its continuing legal obligation to comply with the PSED.

- There is a risk that without due diligence around equalities compliance, taking on this new role will expose the CCG to the risk of judicial review and reputational damage if the General Practice services we commission do not meet the needs of diverse communities.

8. RESPONSIBLE MANAGERIAL LEAD/ CONTACT:

Name: Diana Braithwaite, Director of Commissioning & Primary Care
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Guide to the Delegation Agreement

January 2017
This document provides a summary of the Delegation Agreement and should be read in conjunction with the Delegation Agreement and Delegation Agreement Completion Instructions.

Replaces version issued January 2016 - revised dates

N/A

england.co-commissioning@nhs.net

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1. Delegation and Delegation Agreement

1.1. The Delegation (a copy of which can be found at Annex E to NHS England’s guidance Next steps towards primary care co-commissioning) will set out the statutory delegation of primary medical care commissioning functions to CCGs.

1.2. The Delegation will be supplemented by the Delegation Agreement, which sets out the detailed arrangements for how the CCG will exercise its delegated primary medical care commissioning functions. There is one standard form Delegation Agreement that NHS England and each relevant CCG receiving delegated functions will be required to sign.

2. Structure of the Delegation Agreement

2.1. The Delegation Agreement is divided into:

2.1.1. The Particulars: contain the sections which require local completion (including details of the parties to the Delegation Agreement, the addresses for notices and other information);

2.1.2. The Terms and Conditions: contain the terms and conditions governing the delegation of the primary medical care commissioning functions to the CCG and how these are to be exercised by the CCG; and

2.1.3. The Schedules: contain further detailed provisions including in relation to the Delegated Functions, the Reserved Functions, finances, staffing and other provisions.

3. About this Summary

3.1. For the sake of completeness, the Delegation Agreement is a lengthy document. It has been produced with, and reviewed by, CCG colleagues, but we are aware that it is a detailed and sometimes technical document. For ease of reading and reference, this summary guide has been produced.

3.2. A guide to each of the clauses in the Delegation Agreement is set out at Appendix 1 below. This guide is only a summary of the key provisions of
the Delegation Agreement to assist the CCG. It should not be viewed as an interpretation of the Delegation Agreement. In the event of a conflict between this guide and the Delegation Agreement, the terms of the Delegation Agreement will prevail.
## Appendix 1

**Guide to the Delegation Agreement**

<table>
<thead>
<tr>
<th>Clause</th>
<th>Clause Name</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Particulars</strong></td>
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<tr>
<td>1</td>
<td>Particulars</td>
<td>The Particulars contain elements of the Delegation Agreement for local completion (which must be completed prior to signing the Delegation Agreement). Information to be inserted here includes the name of the Local NHS England Team, the name of the CCG, the relevant Area and contact information for the Parties.</td>
</tr>
<tr>
<td><strong>Terms and Conditions</strong></td>
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<tr>
<td>2</td>
<td>Interpretation</td>
<td>This clause confirms that the Delegation Agreement should be interpreted in accordance with the definitions set out in Schedule 1. In order to avoid disputes, clause 2.3 sets out an order of precedence to resolve any conflict or inconsistency. The Particulars and Terms and Conditions take precedence over the Schedules and any Local Terms.</td>
</tr>
<tr>
<td>3</td>
<td>Background</td>
<td>This clause contains background information on the delegation of functions by NHS England to the CCG. Clause 3.4 confirms that functions relating to the commissioning of primary care pharmacy, dental and optical contracts are not delegated to the CCG under the Delegation.</td>
</tr>
<tr>
<td>4</td>
<td>Term</td>
<td>This clause confirms that the Delegation Agreement will take effect from the date set out in paragraph 10 of the Delegation (1 April 2017) and will remain in force unless terminated under clause 17 (Termination).</td>
</tr>
<tr>
<td>5</td>
<td>Principles</td>
<td>This clause describes certain overarching principles which NHS England and the CCG must adhere to in their dealings with each other under the Delegation Agreement. For example, NHS England and the CCG must at all times act in good faith, share information and best practice, eliminate duplication of effort, mitigate risk and reduce costs.</td>
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<tr>
<td>6</td>
<td>Performance of the</td>
<td>Clause 6 sets out the details of the primary medical care commissioning functions delegated to the CCG. Clause 6.1 confirms that the role of the CCG will be to exercise the Delegated Functions in the Area. Clause 6.2 sets out</td>
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<td>Clause</td>
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<td></td>
<td>Delegated Functions</td>
<td>the list of Delegated Functions – further detail on the functions is set out in Schedule 2 <em>(Delegated Functions)</em>. The CCG must perform the Delegated Functions in accordance with certain requirements, including the Delegation itself, the terms of the Delegation Agreement, all applicable Law, Guidance and Good Practice (clauses 6.4 and 6.4A). The CCG must also perform the Delegated Functions in such a manner as to ensure NHS England’s compliance with its statutory duties (clause 6.5), as NHS England remains liable for the functions delegated to the CCG. The CCG must not act outside of its delegated authority (clause 6.6) and the CCG’s decisions will be binding on the CCG and NHS England (clause 6.8).</td>
</tr>
<tr>
<td>7</td>
<td>Committee</td>
<td>The CCG must establish a committee to exercise its Delegated Functions. The structure and operation of the committee must take into account any Guidance issued by NHS England.</td>
</tr>
<tr>
<td>8</td>
<td>Performance of the Reserved Functions</td>
<td>Clause 8 sets out the details of the primary medical care commissioning functions that are reserved to NHS England (and so will not be performed by the CCG). The list of Reserved Functions is set out at clause 8.2 and includes management of the national performers list and the revalidation and appraisal process. The Delegation may be amended and additional functions may be delegated to the CCG in the future (clause 8.3). Any changes that need to be made to the Delegation Agreement following the delegation of additional functions will then be agreed with the CCG in accordance with clause 22 <em>(Variations)</em>. The CCG will provide some administrative and management services to NHS England in relation to certain Reserved Functions (as set out in clauses 8.8 and 8.9, in particular in relation to the Section 7A Functions). These arrangements are described in detail in clause 13.</td>
</tr>
<tr>
<td>9</td>
<td>Monitoring and Reporting</td>
<td>Clause 9 sets out the CCG’s reporting requirements under the Delegation Agreement and confirms that the CCG...</td>
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<td>Clause</td>
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<td></td>
<td>Reporting – General Requirements</td>
<td>must comply with its reporting obligations in the CCG Assurance Framework and its constitution (clause 9.1). The CCG must provide copies of the agenda and minutes from its primary medical services commissioning committee meetings to NHS England and must also provide NHS England with a monthly report (clause 9.2). The CCG must give NHS England 7 days’ notice of all committee meetings and NHS England has the right to attend the committee meetings (clause 9.3).</td>
</tr>
<tr>
<td>10</td>
<td>Information Sharing and Information Governance</td>
<td>NHS England and the CCG will enter into a Personal Data Agreement (to govern the processing of Relevant Information under the Delegation Agreement). A template Personal Data Agreement is set out at Schedule 4 (Further Information Sharing Provisions). NHS England and the CCG agree that, when sharing information under the Delegation Agreement, they will comply with relevant Information Law requirements, Good Practice and relevant guidance (clause 10.5).</td>
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<tr>
<td>11</td>
<td>IT interoperability</td>
<td>NHS England and the CCG will work together to ensure that IT systems are inter-operable and that data may be transferred between systems securely, easily and efficiently.</td>
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<td>12</td>
<td>Public Information and Access Targets</td>
<td>The CCG will provide such information to NHS England as is required in respect of the Delegated Functions to ensure NHS England’s discharge of its statutory duties (clause 12.1).</td>
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<tr>
<td>13</td>
<td>Financial Provisions and Liability</td>
<td>Notification of the Delegated Funds and Adjustments to the Delegated Funds (clauses 13.1 to 13.8) – NHS England will notify the CCG of the proportion of funds that will be allocated to the CCG for the purpose of meeting expenditure in respect of the Delegated Functions in each financial year (clause 13.1). Except in relation to pooled funds (see below) and subject to the CCG’s compliance with its statutory financial duties, the CCG must use these allocated funds to carry out the Delegated Functions (clause 13.2). NHS England may make adjustments to the Delegated Funds, for example to take into account monthly adjustments and/or any Losses that NHS England suffers as a result of the CCG’s negligence, fraud,</td>
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<tr>
<td>13.3</td>
<td>recklessness or deliberate breach of the Delegation Agreement</td>
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Schedule 5 *(Financial Provisions and Decision Making Limits)* sets out financial and decision-making limits that apply in relation to the exercise of the Delegated Functions (clause 13.8).

**Payment and Transfer (clauses 13.9 to 13.12)** – The Delegated Funds cannot form part of the funds used for the provision of the CCG’s own functions (clause 13.9). NHS England will pay the Delegated Funds to the CCG on a monthly basis, using the same revenue transfer process that NHS England uses to transfer funds to the CCG annually (or using such other process as notified to the CCG from time to time) (clause 13.10).

The CCG must comply with the requirements set out in clause 13.11 when dealing with the Delegated Funds (for example, the CCG must comply with any business rules set out in NHS England’s planning guidance and the HM Treasury guidance *Managing Public Money*).

**Administrative and/or Management Services and Funds in relation to certain Reserved Functions (clauses 13.13 to 13.23)** – the CCG will provide administrative services to NHS England in relation to the Section 7A Functions (i.e. the CCG will administrate payments made under section 7A of the NHS Act 2006 and will provide any other support or administrative assistance to NHS England that NHS England may reasonably request (clauses 13.17 to 13.19)). NHS England may also require the CCG to provide similar administrative services in relation the Capital Expenditure Functions (clauses 13.13 to 13.16), complaints management and other Reserved Functions (clauses 13.21 to 13.23).

**Pooled Funds (clauses 13.24 to 13.25)** – the CCG has the flexibility to use any part of the Delegated Funds to establish and maintain a pooled fund with NHS England (under section 13V of the NHS Act 2006) (clause 13.24). NHS England must consent in writing to the establishment of the pooled fund and the details of any pooled fund (at the date of the Delegation Agreement) must be set out in Schedule 7 *(Local Terms)* (clause 13.25).

**Business Plan, Commissioning Plan and Annual Report (clauses 13.26 to 13.33)** – the CCG is required to
Clause | Clause Name | Description
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 | | provide NHS England with a business plan and annual report in relation to the Delegated Functions, to ensure that NHS England is able to comply with its financial reporting obligations under the NHS Act 2006.
|Risk Sharing (clauses 13.34 to 13.36) – NHS England retains liability in relation to the exercise of the Delegated Functions (section 13Z(6) of the NHS Act 2006) (clause 13.34). NHS England has a right to claim back from the CCG for any Losses that it suffers as a result of the CCG’s negligence, fraud, recklessness or deliberate breach of the Delegation or the Delegation Agreement (clause 13.35). NHS England can either require payment from the CCG for any Losses, or NHS England can make adjustments to the Delegated Funds to reclaim the Losses under clause 13.3. |
14 | Claims and Litigation | The CCG is responsible for any Claims under the Primary Medical Services Contracts and will retain conduct of any Claims (clause 14.3). The CCG must comply with the requirements set out in clause 14.4 when dealing with any Claim or potential Claim (for example, the CCG must comply with any policies issued by NHS England from time to time about the conduct or avoidance of Claims and the pro-active management of Claims and must provide copies of any correspondence and claim documents to NHS England).

Subject to Schedule 5 (Financial Provisions and Decision Making Limits) and clause 14.4, the CCG is entitled to conduct a Claim in the manner it considers appropriate and may pay or settle any Claim on such terms as it thinks fit (clause 14.6). Please note that, under Schedule 5, NHS England is required to authorise the settlement of any Claim where the value of the settlement exceeds £100,000.

NHS England has a right to step-in and take over the conduct of any Claim (clause 14.7). If NHS England exercises this right, it can conduct the Claim in the manner it considers appropriate and is also entitled to pay or settle the Claim. NHS England also has the right to “step-out” of any Claim after it has exercised its step-in rights and so transfer conduct of the Claim back to the CCG (clause 14.8).
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<th>Clause</th>
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<tr>
<td>10</td>
<td></td>
<td>T. NHS England can either require payment from the CCG for any Claim Losses, or NHS England can make adjustments to the Delegated Funds to take account of such Claim Losses (clause 14.11).</td>
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<tr>
<td>15</td>
<td>Breach</td>
<td>Clause 15 sets out NHS England’s rights where the CCG does not comply with the Delegation or the Delegation Agreement. If the CCG breaches the Delegation or the Delegation Agreement, NHS England can exercise its escalation and termination rights under the Delegation Agreement and/or take steps (as it considers appropriate) under the CCG Assurance Framework (clause 15.1). NHS England can also choose to waive any non-compliance by the CCG, ratify any decision by the CCG, revoke the Delegation and terminate the Delegation agreement, exercise the Escalation Rights set out in clause 16 (see below) and/or exercise its rights under common law (clause 15.2). NHS England may only waive non-compliance by the CCG if the CCG provides a written report to NHS England setting out the reasons for its non-compliance and a plan for how the CCG proposes to remedy the non-compliance (clauses 15.3 and 15.4).</td>
</tr>
<tr>
<td>16</td>
<td>Escalation Rights</td>
<td>Clause 16 sets out further courses of action available to NHS England in the event of breach by the CCG – NHS England may require a suitably senior representative of the CCG to attend a review meeting with NHS England and may require the CCG to prepare an action plan and report (to include details of how the CCG proposes to remedy the non-compliance) (clause 16.1).</td>
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<tr>
<td>17</td>
<td>Termination</td>
<td>This clause describes how and when the CCG and NHS England can terminate the Delegation and the Delegation Agreement. The CCG may notify NHS England that it requires NHS England to revoke the Delegation and terminate the Delegation Agreement with effect from midnight on 31 March in any calendar year, provided that (i) on or before 30 September of the previous calendar year, the CCG sends written notice to NHS England of its requirement that NHS England revoke the Delegation and terminate the Delegation Agreement, and (ii) NHS England and the CCG meet to discuss arrangements for termination and transition of the Delegated Functions (clause 17.1).</td>
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<td><strong>NHS England may revoke the Delegation at midnight on 31 March in any calendar year, provided that it gives notice to the CCG by 30 September of the previous calendar year (clause 17.2). The Delegation Agreement will terminate immediately if the Delegation is revoked or terminated (clause 17.4).</strong></td>
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<td>NHS England may terminate the Delegation and the Delegation Agreement at any time under clause 17.3 (including if the CCG acts outside of its delegated authority or fails to perform a material obligation under the Delegation Agreement).</td>
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<td>Clause 17.5 sets out arrangements following revocation and termination of the Delegation and the Delegation Agreement. The Parties must agree a plan for transition of the Delegated Functions from the CCG to a successor commissioner and must comply with their obligations under the transition plan.</td>
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<tr>
<td>18</td>
<td>Staffing</td>
<td><strong>Clause 18 sets out basic information on the three Staffing Models under which the CCG may engage staff to undertake the Delegated Functions. The CCG may only engage staff to undertake the Delegated Functions under one of these three models (assignment, secondment and employment) (clause 18.1).</strong></td>
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<td>Within 6 months of the date of the Delegation Agreement, the CCG and NHS England must agree which Staffing Model the CCG will adopt (clause 18.2). Until NHS England and the CCG agree on a Staffing Model to be adopted, Model 1 (assignment – where the staff of NHS England remain in their current roles and locations and provide services to the CCG under a service level agreement) will apply (clause 18.3). Schedule 8 <em>(Assignment of NHS England Staff to the CCG)</em> sets out the terms that will apply under Model 1.</td>
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<td>The CCG must comply with any Guidance issued by NHS England in relation to the Staffing Models (clause 18.4).</td>
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<td>The Delegation Agreement confirms the understanding of the parties that TUPE will not operate to transfer the...</td>
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<td>Clause</td>
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<tr>
<td>18</td>
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<td>employment of NHS England staff to the CCG on commencement of the delegated co-commissioning arrangements, but if TUPE does apply (by operation of law), NHS England and the CCG will cooperate and comply with their obligations under TUPE (clauses 18.6 and 18.7).</td>
</tr>
<tr>
<td>19</td>
<td>Disputes</td>
<td>Clause 19 sets out a mechanism for resolving any disputes that arise between the CCG and NHS England under the Delegation Agreement. The parties must first try to resolve any dispute between their two nominated representatives. The dispute will then be escalated to the CCG’s Accountable Officer and a director or other person nominated by NHS England. The parties may then attempt to settle the matter by mediation in accordance with the CEDR model mediation procedure. If the dispute still cannot be resolved, it must be referred to the Secretary of State for Health, whose decision will be binding on NHS England and the CCG.</td>
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<tr>
<td>20</td>
<td>Freedom of Information</td>
<td>Under clause 20.1, NHS England and the CCG acknowledge that the other party is a public authority for the purposes of the Freedom of Information Act 2000 (FOIA) and the Environmental Information Regulations 2004 (EIR). Each party must provide the other with all reasonable assistance and co-operation to enable them to comply with their obligations under the FOIA and the EIR (clause 20.2). NHS England may issue a protocol on dealing with and responding to FOIA or EIR requests in relation to the Delegated Functions (clause 20.3).</td>
</tr>
<tr>
<td>21</td>
<td>Conflicts of Interest</td>
<td>The CCG must have regard to all relevant guidance published by NHS England in relation to conflicts of interest in the co-commissioning context (clause 21.2). In addition, the CCG must comply with its statutory duties in relation to conflicts of interest and must perform its obligations under the Delegation Agreement in such a way as to ensure NHS England’s compliance with its statutory duties (clause 21.1).</td>
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<tr>
<td>22</td>
<td>Variations</td>
<td>Clause 22 sets out the process for varying the Delegation Agreement. A variation of the Delegation Agreement is only effective if it is in the form of the template variation agreement set out at Schedule 6 (Template Variation Agreement) and is signed by NHS England and the CCG (clause 22.3). A variation must not contradict or conflict with the Delegation (clause 22.4).</td>
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</table>
NHS England has a general right (set out in clauses 22.5 to 22.10) to implement National Variations to the Delegation Agreement, for example to reflect any changes to the Delegation or changes in policy. NHS England must notify the CCG of a proposed National Variation (clause 22.5). The CCG must then confirm to NHS England whether it either accepts or refuses to accept the National Variation within 30 days (clause 22.8). If the CCG refuses to accept the National Variation, then NHS England has the right to terminate the Delegation Agreement and also revoke the Delegation (clause 22.10).

Clause 23 states that the Delegation Agreement may be executed in counterparts. This means that NHS England and the CCG can sign separate copies of the Delegation Agreement – each of these copies will be an original and together they will form one binding agreement.

Clauses 24.1 and 24.2 set out requirements for the delivery of notices under the Delegation Agreement. Notices must be in writing and may be sent by hand, post or email.

NHS England may issue Contractual Notices and Guidance from time to time in relation to the Delegated Functions and how these should be exercised by the CCG (clauses 24.3 and 24.4).

Schedule 1 sets out the meaning of all of the defined terms used in the Delegation Agreement.

Schedule 2 sets out further detail and obligations on the CCG in relation to the Delegated Functions. Part 1 sets out specific obligations and Part 2 sets out more general obligations relating to the Delegated Functions.

Part 1 paragraph 2 sets out the CCG’s obligations in relation to **Primary Medical Services Contract management**. For example, the CCG must manage the Primary Medical Services Contracts on behalf of NHS England and must perform NHS England’s obligations under the contracts.
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<thead>
<tr>
<th>Clause</th>
<th>Clause Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part 1 paragraph 3 sets out the CCG’s obligations in relation to <strong>planning the provider landscape</strong>, including establishing new GP practices in the Area, managing GP practices providing inadequate standards of patient care and agreeing variations to the boundaries of GP practices. Under paragraph 3.2, when the CCG is considering the form of contract (i.e. PMS, GMS or APMS) to use in relation to a new Primary Medical Services Contract, it must use the form of contract that will ensure compliance with NHS England’s legal obligations (including procurement law obligations). Please note that, under Schedule 5 (<em>Financial Provisions and Decision Making Limits</em>), NHS England’s sign off is required before the CCG can enter into a new Primary Medical Services Contract with a term exceeding 5 years.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Part 1 paragraph 4 sets out the CCG’s obligations in relation to <strong>approving GP practice mergers and closures</strong>. The CCG must undertake the necessary consultation when making these decisions and must fully consider the impact of any decision on the GP practice’s registered population and the population of surrounding practices.</td>
<td></td>
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</tr>
<tr>
<td>Part 1 paragraph 5 sets out the CCG’s obligations in relation to <strong>information sharing with NHS England in relation to the Delegated Functions</strong>. The CCG must provide NHS England with information relating to GP practices in the Area so that NHS England can continue to gather national data about the performance of GP practices.</td>
<td></td>
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<tr>
<td>Part 1 paragraph 6 sets out the CCG’s obligations in relation to <strong>making decisions in relation to management of poorly performing GP practices</strong>, including decisions and liaison with the CQC where appropriate.</td>
<td></td>
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</tr>
<tr>
<td>Part 1 paragraph 7 sets out the CCG’s obligations in relation to <strong>Premises Costs Directions Functions</strong>. The CCG must comply with the Premises Costs Directions and is responsible for making decisions in relation to the Premises Costs Directions. This includes applications for new payments and revisions to existing payments.</td>
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<tr>
<td>Clause</td>
<td>Clause Name</td>
<td>Description</td>
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<td></td>
<td>Part 2 sets out the CCG’s more general obligations in relation to the Delegated Functions, for example planning and reviews (paragraph 2), procurement and new contracts (paragraph 3), integrated working (paragraph 4) and resourcing (paragraph 5).</td>
</tr>
<tr>
<td>3</td>
<td>Reserved Functions</td>
<td>Schedule 3 sets out further detail in relation to the Reserved Functions. The CCG will work collaboratively with NHS England and will support and assist NHS England to carry out the Reserved Functions (paragraph 1.2). Paragraph 2 sets out further details in relation to management of the national performers list. NHS England will continue to perform its functions in relation to the national performers list, including considering applications and managing concerns, suspension, conditions and removal. NHS England may require a representative from the CCG to attend local Performance Advisory Group meetings to discuss complaints or concerns about a particular performer. The CCG must ensure that all complaints regarding a named performer are escalated to NHS England. Paragraph 3 sets out further details in relation to the management of the revalidation and appraisal process. NHS England will continue to perform these functions (including the funding of GP appraisers and quality assurance of the GP appraisal process). The CCG must not remove or restrict the payments made to GP practices in respect of GP appraisal. Paragraph 4 sets out further details in relation to the administration of payments and related performers list management activities. NHS England will continue to perform these functions and will continue to pay GPs who are suspended from the national performers list. Paragraph 5 sets out further details in relation to the Section 7A Functions. NHS England will continue to</td>
</tr>
<tr>
<td>Clause</td>
<td>Clause Name</td>
<td>Description</td>
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<tr>
<td></td>
<td></td>
<td>perform the Section 7A Functions – however, the CCG will provide certain administrative services to NHS England.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Paragraph 6 sets out further details in relation to the <strong>Capital Expenditure Functions</strong>. NHS England will retain and continue to be responsible for these functions.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Paragraph 7 sets out further details in relation to <strong>complaints management</strong>. NHS England will continue to be responsible for complaints management (including complaints about GP practices and individual named performers, controlled drugs and whistleblowing). The CCG must notify NHS England of any complaints it receives and must co-operate with NHS England when responding to complaints. NHS England may ask the CCG to provide certain administrative services to NHS England in relation to complaints management.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Paragraph 8 confirms that NHS England will carry out other ancillary activities that are necessary in order for NHS England to exercise the Reserved Functions.</td>
</tr>
<tr>
<td>4</td>
<td>Further Information Sharing Provisions</td>
<td>Schedule 4, together with the associated Personal Data Agreement, sets out the scope for the secure and confidential sharing of information between NHS England and the CCG under the Delegation and the Delegation Agreement.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Paragraph 2.1 confirms that the Specified Purpose (for which the Relevant Information is shared and processed) is to facilitate the exercise of the CCG’s Delegated Functions and NHS England’s Reserved Functions. Details of the Relevant Information to be shared and the lawful basis for sharing this information will be set out in the accompanying Personal Data Agreement (paragraphs 4 and 5).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NHS England and the CCG agree to only to process the Relevant Information as necessary to achieve the</td>
</tr>
<tr>
<td>Clause</td>
<td>Clause Name</td>
<td>Description</td>
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<td>--------</td>
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<tr>
<td>5</td>
<td>Financial Provisions and Decision Making Limits</td>
<td>The table in Schedule 5 sets out financial limits for decisions that the CCG takes in respect of the Delegated Functions – where a decision needs to be made which exceeds one of these limits, the CCG must obtain approval from the individuals at NHS England listed in the table. NHS England may update the table from time to time by sending a notice to the CCG. The relevant decisions, where the CCG must obtain NHS England approval are: • settlement of a Primary Care Contract Claim where the value of the settlement exceeds £100,000; • any matter in relation to the Delegated Functions which is novel, contentious or repercussive; and • entering into any Primary Medical Services Contract which has or is capable of having a term which exceeds 5 years.</td>
</tr>
<tr>
<td>6</td>
<td>Template</td>
<td>A template variation agreement is set out at Schedule 6 – NHS England and the CCG should use this template</td>
</tr>
<tr>
<td>Clause</td>
<td>Clause Name</td>
<td>Description</td>
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<tr>
<td>Variation Agreement</td>
<td>when agreeing variations to the Delegation Agreement. This is intended to be used for variations that may be required in future years once the delegation has occurred.</td>
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</tbody>
</table>
| 7      | Local Terms                          | Schedule 7 is where NHS England and the CCG will set out any locally agreed terms. Local Terms may only be agreed between the CCG and NHS England on an exceptional basis, must be approved prior to the signing of the agreement and must not derogate from the terms and conditions of the Delegation Agreement. NHS England does not intend that there should be any locally agreed terms, other than in relation to:  
  - details of any pooled funds of NHS England and the CCG;  
  - resourcing arrangements between NHS England and the CCG; and  
  - details of any particular services that the Assigned Staff will provide to the CCG under Schedule 8. |
| 8      | Assignment of NHS England Staff to the CCG | Schedule 8 sets out the terms that apply between NHS England and the CCG in relation to staffing until NHS England and the CCG agree which Staffing Model will be adopted for the co-commissioning arrangements.  
  
  NHS England agrees to make NHS England staff available to the CCG to perform administrative and management support services, to assist the CCG to exercise the Delegated Functions (paragraph 3.1). NHS England will continue to employ and be responsible for the Assigned Staff (paragraph 4.1) and will continue to pay salaries and benefits (paragraph 4.2). The Assigned Staff will carry out their work from NHS England’s places of work (although may be required to attend the offices of the CCG from time to time) (paragraph 4.3). NHS England will have day-to-day control of the Assigned Staff and the CCG will provide reasonable assistance and co-operation (paragraph 5). |
<table>
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<tr>
<th>Clause</th>
<th>Clause Name</th>
<th>Description</th>
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<td></td>
<td></td>
<td>The CCG must let NHS England know if it becomes aware of any claim by or against a member of the Assigned Staff and the CCG will not settle a claim without NHS England’s consent (paragraph 6).</td>
</tr>
</tbody>
</table>
Delegation Agreement: Completion Instructions
This document provides a summary of the key elements that should be completed in the period leading up to the CCG and NHS England signing the Delegation Agreement. It should be read in conjunction with the NHS England’s Guide to the Delegation Agreement.

This document replaces the version issued January 2016 with revised dates.

As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the intranet.

Document Status

This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled. As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the intranet.
The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the National Health Service Commissioning Board has used the name NHS England for operational purposes.
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4 The Delegation and the Delegation Agreement ........................................ 5
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2 Purpose

This note provides a summary of the key elements that should be completed in the period leading up to the CCG and NHS England signing the Delegation Agreement. It should be read in conjunction with the NHS England’s *Guide to the Delegation Agreement*.

3 Background and context

In 2014/15, NHS England agreed with CCGs and NHS Clinical Commissioners a standardised set of primary medical functions for delegated arrangements, as set out in the Delegation and Delegation Agreement. The same primary medical services functions will be delegated to CCGs in 2017/18 as 2016/17 and the same documentation used. To keep the process as simple and easy as possible, and to avoid unnecessary legal fees, CCGs applying for delegation for 2017/18 should not seek local variations to the documents.

4 The Delegation and the Delegation Agreement

There are two separate documents: the Delegation and the Delegation Agreement. The Delegation document sets out the statutory delegation of primary care commissioning functions to the CCG. A copy can be found [here](#). NHS England will issue a signed copy of the Delegation once the Delegation Agreement has been signed by both parties. CCGs are not required to sign the Delegation.

The Delegation is supplemented by the Delegation Agreement, which sets out the detailed arrangements for how the CCG will exercise its delegated functions. To ensure a consistency of approach, there is one standard form Delegation Agreement that NHS England and each relevant CCG are required to sign.

5 Definition of Terms

Where a term in the Delegation Agreement is capitalised, this means that the term is defined. Definitions are set out in Schedule 1 to the Delegation Agreement.

6 Local Terms of the Delegation Agreement

The *Particulars* and *Schedule 7 (Local Terms)* contain all the elements of the Delegation Agreement that are for local completion.

It is not intended that there will be any provisions to be inserted in Schedule 7 other than in relation to and pooled budgets with NHS England and specific workforce matters not covered by the provisions of the Delegation Agreement. These must be discussed and agreed with the Regional Office and national co-commissioning team of NHS England prior to completion and signing of the Delegation Agreement.

7 Sections for Completion
<table>
<thead>
<tr>
<th>Delegation Agreement Clause</th>
<th>Description of Clause</th>
<th>Action for Completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>Area</td>
<td>Enter the details of the geographical area covered by the CCG.</td>
</tr>
<tr>
<td>1.1</td>
<td>Clinical Commissioning Group</td>
<td>Enter the name of the CCG.</td>
</tr>
<tr>
<td>1.1</td>
<td>CCG Representative</td>
<td>Enter the details of the name of the individual who will manage the Delegation Agreement on behalf of the CCG.</td>
</tr>
<tr>
<td>1.1</td>
<td>CCG Address for Notices</td>
<td>Enter the main address of the CCG (this is the address where the CCG will receive notices and other correspondence relating to the Delegation Agreement).</td>
</tr>
<tr>
<td>1.1</td>
<td>Date of Agreement</td>
<td>NHS England will enter the date that the Delegation Agreement is signed by the CCG and NHS England. Please do not complete this.</td>
</tr>
<tr>
<td>1.1</td>
<td>NHS England Representative</td>
<td>NHS England will enter the details of the name of the individual who will manage the Delegation Agreement on behalf of NHS England.</td>
</tr>
<tr>
<td>1.1</td>
<td>Local NHS England Team</td>
<td>Enter the name of the local NHS England team who will be involved in the day-to-day management of the Delegation Agreement.</td>
</tr>
<tr>
<td>1.1</td>
<td>NHS England Address for Notices</td>
<td>Enter the relevant address of NHS England (this is the address where NHS England will receive notices and other correspondence from the CCG relating to the Delegation Agreement i.e., the office of your local NHS England team).</td>
</tr>
<tr>
<td>Signatures</td>
<td>Signatures</td>
<td>NHS England and the CCG must sign the Delegation Agreement. The CCG signatory must be authorised to sign the Delegation Agreement on behalf of the CCG in accordance with the CCG’s internal governance procedures. No seal will be required and the process for signature should be in accordance with the CCG’s usual signing procedure.</td>
</tr>
<tr>
<td>Schedule 7</td>
<td>Local Terms</td>
<td></td>
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</table>
|            | Local Terms may only be agreed between the CCG and NHS England on an exceptional basis and must not derogate from the terms and conditions of the Delegation Agreement. Any such terms must have been agreed by the relevant NHS England Regional Director and the NHS England national co-commissioning team prior to the signing and submission of the Delegation Agreement. NHS England cannot accept any amendments other than those relating to:

- Details of any pooled funds of NHS England and the CCG;
- Resourcing arrangements between NHS England and the CCG; and
- Details of any particular services that staff assigned by NHS England to the CCG will provide.

If there are no Local Terms, state “There are no Local Terms” in Schedule 7.

### 8 Completion Timeline

In order to ensure that the Delegation Agreement can be signed by both the CCG and NHS England in time for budget transfers on 1 April 2017, CCGs are requested to submit completed and signed Delegation Agreements no later than:

- **Wednesday 8 March 2017**

These should be sent to [england.co-commissioning@nhs.net](mailto:england.co-commissioning@nhs.net).

Where previously agreed local terms have been inserted into Schedule 7, please copy in the relevant NHS England colleague(s) in the Region.
NHS England will review and return a signed copy of the Delegation and the Delegation Agreement to you as soon as possible after 31 March 2017.

9 Queries

Please refer to the Delegation Agreement Summary document circulated with this note for a clause-by-clause explanation of the agreement itself.

There are also a series of frequently asked questions available on NHS England’s website at: https://www.england.nhs.uk/commissioning/pc-co-comms/apply/faqs/

If you have further queries please email: england.co-commissioning@nhs.net or discuss these with your NHS England Region.
<table>
<thead>
<tr>
<th><strong>Author/s:</strong></th>
<th>NHS England and Lewisham CCG (localised)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Effective Date:</strong></td>
<td>1st April 2017</td>
</tr>
<tr>
<td><strong>Review Date:</strong></td>
<td>31st March 2018</td>
</tr>
</tbody>
</table>
| **Document owner/CCG Contact/s:** | Victoria Medhurst, Associate Director Integrated Governance  
Diana Braithwaite, Director of Commissioning & Primary Care |
| **Lewisham CCG Consultation:** | Lewisham CCG Primary Care Programme Board Workshop – 15th February 2017  
Ray Warburton OBE, Lay Member, Audit Chair and Col Champion – 22nd February 2017 |
| **Ratified:** | Governing Body |
Terms of reference – NHS Lewisham CCG Primary Care Commissioning Committee

Introduction
1. Simon Stevens, the Chief Executive of NHS England, announced on 1 May 2014 that NHS England was inviting CCGs to expand their role in primary care commissioning and to submit expressions of interest setting out the CCG’s preference for how it would like to exercise expanded primary medical care commissioning functions. One option available was that NHS England would delegate the exercise of certain specified primary care commissioning functions to a CCG.

2. In accordance with its statutory powers under section 13Z of the National Health Service Act 2006 (as amended), NHS England has delegated the exercise of the functions specified in Schedule 2 to these Terms of Reference to NHS Lewisham CCG. The delegation is set out in Schedule 1.

3. The CCG has established the NHS Lewisham CCG Primary Care Commissioning Committee (“Committee”). The Committee will function as a corporate decision-making body for the management of the delegated functions and the exercise of the delegated powers as set out in NHS Lewisham CCG’s Constitution and Scheme of Delegation.

4. It is a committee comprising representatives of the following organisations:
   - NHS Lewisham CCG;
   - In attendance:
     - Lewisham Council representative of the Health and Wellbeing Board;
     - Lewisham Local Medical Committee;
     - Lewisham Healthwatch;
     - Officers as required to undertake business of the committee, including South east London CCGs Primary Care Contracts Team.

Statutory Framework
5. NHS England has delegated to the CCG authority to exercise the primary care commissioning functions set out in Schedule 2 in accordance with section 13Z of the NHS Act.

6. Arrangements made under section 13Z may be on such terms and conditions (including terms as to payment) as may be agreed between the NHS England Board and the CCG.
7. Arrangements made under section 13Z do not affect the liability of NHS England for the exercise of any of its functions. However, the CCG acknowledges that in exercising its functions (including those delegated to it), it must comply with the statutory duties set out in Chapter A2 of the NHS Act and including:

a) Management of conflicts of interest (section 14O);
b) Duty to promote the NHS Constitution (section 14P);
c) Duty to exercise its functions effectively, efficiently and economically (section 14Q);
d) Duty as to improvement in quality of services (section 14R);
e) Duty in relation to quality of primary medical services (section 14S);
f) Duties as to reducing inequalities (section 14T);
g) Duty to promote the involvement of each patient (section 14U);
h) Duty as to patient choice (section 14V);
i) Duty as to promoting integration (section 14Z1);
j) Public involvement and consultation (section 14Z2).

8. The CCG will also need to specifically, in respect of the delegated functions from NHS England, exercise those in accordance with the relevant provisions of section 13 of the NHS Act;

   a. Duty to have regard to impact on services in certain areas (section 13O);
   b. Duty as respects variation in provision of health services (section 13P).

9. The Committee is established as a committee of the CCG Governing Body in accordance with Schedule 1A of the “NHS Act”.

10. The members acknowledge that the Committee is subject to any directions made by NHS England or by the Secretary of State.

Role of the Committee

11. The Committee has been established in accordance with the above statutory provisions to enable the membership of the committee to make collective decisions on the review, planning and procurement of primary care services in Lewisham, under delegated authority from NHS England.

12. In performing its role the Committee will exercise its management of the functions in accordance with the agreement entered into between NHS England and NHS Lewisham CCG, which will sit alongside the delegation and terms of reference.
13. The functions of the Committee are undertaken in the context of a desire to promote primary care co-commissioning to increase quality, efficiency, productivity and value for money and to remove administrative barriers.

14. The role of the Committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act.

15. The Committee has both a strategic and operational remit in relation to primary care, which includes:

a. GMS, PMS and APMS contracts (including the design of PMS and APMS contracts, monitoring of contracts, taking contractual action such as issuing breech/remedial notices and removing a contract);

b. Newly designed enhanced services;

c. Design of local incentives schemes as an alternative to Quality Outcomes Framework (QOF);

d. Decisions in relation to the establishment of new GP practices (including branch surgeries) and closure of GP practices;

e. Approving practice mergers;

f. Making decisions on ‘discretionary’ payments (e.g. returner/retainer schemes);

g. Decisions about commissioning urgent care (including home visits as required) for out of area registered patients;

h. Planning primary medical care services in the Lewisham including carrying out needs assessments;

i. Undertaking reviews of primary medical care services in the Lewisham;

j. Decisions in relation to the management of GP practice performance and including (and without limitation); decisions and liaison with the Clinical Quality Commission (CQC), where there is reported non-compliance with standards (excluding any decisions in relation to the performers list);

k. Management of the delegated funds in the Lewisham;

l. Premises Costs Directions functions;

m. Co-ordinating a common approach to the commissioning of primary care services with other commissioners in the area where appropriate; and

n. Such other ancillary activities as are necessary in order to exercise the Delegated Functions.

16. The CCG will also carry out other activities as detailed in Schedule 1 of the Delegation Agreement between NHS Lewisham CCG and NHS England.
17. In particular the Committee will support the Governing Body in fulfilling the following functions and duties to:

   a. Meet the public sector equality duty;
   b. Act effectively, efficiently and economically;
   c. Act with a view to securing continuous improvement to the quality of services;
   d. Have regard to the need to reduce inequalities;
   e. Promote the involvement of patients, their carers and representatives in decisions about their healthcare;
   f. Act with a view to enabling patients to make choices;
   g. Promote innovation; and
   h. Act with a view to promoting integration of both health services with other health services and health services with health-related and social care services where the CCG considers that this would improve the quality of services or reduce inequalities.

Geographical Coverage

18. The Committee will make decisions in respect of primary care in the London Borough of Lewisham population including GP registered population.

Membership

19. The Committee shall consist of:

19.1 Members with voting rights
   a. Lay Members (Chair: Third Lay Member and Vice Chair: Lay Member responsible for Patient Public Engagement)
   b. CCG Chair
   c. 2 Governing Body GP Members
   d. Registered Nurse or Secondary Care Specialist (single member)
   e. CCG Chief Officer
   f. CCG Chief Financial Officer
   g. Director of Commissioning & Primary Care

19.2 Non-Voting Members
   a. Local Medical Committee Representative
   b. Healthwatch Representative
c. Local Authority Representative of the Health and Wellbeing Board (Elected Member or Mandated Officer)
d. Officers as required to undertake business of the committee
e. NHS England Representative

20. The Chair of the Committee shall be a Lay Member of NHS Lewisham CCG. This will not be the Lay Member responsible for Audit.

21. The Vice Chair of the Committee shall be a Lay Member of NHS Lewisham CCG. This will not be the Lay Member responsible for Audit.

Meetings and Voting

22. As a committee of the Governing Body, the Committee will operate in accordance with the CCG’s Standing Orders (in line with NHS England Standard Operating Procedures). This includes the capacity to manage urgent matters outside the normal arrangements.

23. The aim of the Committee will be to achieve consensus decision-making wherever possible. In the event that a vote is required, each member of the Committee shall have one vote. The Committee shall reach decisions by a simple majority of members present, but with the Chair having a second and deciding vote, if necessary.

Quorum

24. The quorum shall be a minimum of 4 members, of which 2 must be Lay Members.

25. Where a quorum cannot be convened from the membership, owing to arrangements for the management of conflicts of interest or potential conflicts of interest; the Chair of the meeting will comply with the conflicts of interest policy.

26. This may result in;
a. The meeting being deferred
b. A discussion being undertaken but the decision deferred until the next meeting
c. Discussion being undertaken being deferred to the Governing Body

Frequency of meetings

27. The Committee will meet regularly 6 times per year. After 12 months the frequency will be reviewed.
28. Meetings of the Committee shall:
   a. be held in public, subject to the application of Error! Reference source not found. (b);
   b. the Committee may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time;
   c. the closed confidential part of the meeting (as provided for at Error! Reference source not found. (b) above) shall be referred to as Part 2 of the meeting and shall have a separate agenda and minutes;
   d. the Committee may invite the representatives of the local authority (Health and Wellbeing Board), Local Medical Committees and Healthwatch to Part 2 of any meeting where it considers it is appropriate for such representatives to attend all or part of Part 2 of the meeting.

29. The committee may meet in common with other CCGs in south east London (NHS CCG Bexley, NHS CCG Bromley, NHS CCG Greenwich, NHS CCG Lewisham and NHS CCG Southwark – or any combination of these CCGs) when there is common business to transact.

30. Members of the Committee have a collective responsibility for the operation of the Committee. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

31. The Committee may delegate tasks to such individuals, sub-committees or individual members as it shall see fit, provided that any such delegations are consistent with the parties’ relevant governance arrangements, are recorded in a scheme of delegation, are governed by terms of reference as appropriate and reflect appropriate arrangements for the management of conflicts of interest.

32. The Committee may call additional experts to attend meetings on an ad hoc basis to inform discussions.

33. Members of the Committee shall respect confidentiality in attending and undertaking the business of the committee.
34. The Committee will present an executive summary report and its minutes to the governing body of NHS Lewisham CCG and the London area team of NHS England following each meeting for information, including the minutes of any sub-committees to which responsibilities are delegated under paragraph Error! Reference source not found. above.

35. The CCG will also comply with any reporting requirements set out in its Constitution.

36. Terms of Reference will be reviewed on an annual basis.

**Accountability of the Committee**

37. The Committee will be accountable for the expenditure of the primary care budget delegated from NHS England to the Governing Body of Lewisham CCG. Responsibility for authorising expenditure against this budget may be further delegated only as set out in the Scheme of Reservation and Delegation ratified by the Governing Body.

38. For the avoidance of doubt, in the event of any conflict between the terms of the CCG’s Operational Scheme of Delegation, the Committee’s Terms of Reference and the CCG’s Prime Financial Policies, the Operational Scheme of Delegation will prevail.

39. The Committee may be required where appropriate to provide reports and information to other Committees of the CCG.

**Decisions**

40. The Committee will make decisions within the bounds of its remit as set out in clause 22.

41. The Committee will ensure that any conflicts of interest are dealt with in accordance with the CCG’s Constitution and Standards of Business Conduct Policies which for the avoidance of doubt may include members (voting or otherwise) being excluded from a decision and/or the discussions leading thereto.

42. The decisions of the Committee shall be binding on NHS Lewisham CCG and NHS England.
43. All attendees are required to declare their interests as a standing agenda item for every committee before the item is discussed, in line with the Lewisham CCG policy on Conflicts of Interest (http://www.lewishamccg.nhs.uk/news-publications/Policies/Documents/Lewisham%20CCG%20Conflicts%20of%20Interest%20Policy%20November%202020.pdf).

44. The chair of the meeting has ultimate responsibility for deciding whether there is a conflict of interest and for taking the appropriate course of action in order to manage the conflict of interest.

45. In the event that the chair of a meeting has a conflict of interest, the vice chair is responsible for deciding the appropriate course of action in order to manage the conflict of interest. If the vice chair is also conflicted then the remaining non-conflicted voting members of the meeting should agree between themselves how to manage the conflict(s).

46. In making such decisions, the chair (or vice chair or remaining non-conflicted members as above) may wish to consult with the Conflicts of Interest Guardian or another member of the governing body.

47. The chair should ask at the beginning of each meeting if anyone has any conflicts of interest to declare in relation to the business to be transacted at the meeting. Each member of the group should declare any interests which are relevant to the business of the meeting whether or not those interests have previously been declared. Any new interests which are declared at a meeting must be included on the CCG’s relevant register of interests to ensure it is up-to-date.

**Reporting**

48. The CCG will ensure a person shall act as Secretary to the Committee and will:

a. Circulate the minutes and actions to all members of the Committee within 7 working days of any meeting of the Committee;

b. Report the proceedings of each meeting of the Committee to the next Governing Body;

c. Produce an executive summary report which sets out any decisions made by the Committee to be presented at the next meeting of the Governing Body;
d. The Chair shall draw to the attention of the Governing Body any issues that require disclosure to the full Governing Body or require executive action.

[Signature provisions]

Signatures will be applied upon delegation

Schedule 1 – Delegation (will be included on submission to NHS England)
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