NHS
Lewisham
Clinical Commissioning Group

Chair's Report to the Governing Body
12 May 2016 meeting

I am sorry to have missed the last Governing Body in public and I am grateful for Ray chairing what I understand was an excellent meeting. I am also sorry not to have welcomed Charles Gostling to the Governing Body myself. Today I will be welcoming Mark Hamilton, who is Associate Medical Director in Clinical Transformation and Quality Improvement, and Consultant and Honorary Senior Lecturer in Anaesthesia & Intensive Care Medicine at St. George's Hospital and Medical School, who joins our Governing Body as our Secondary Care Doctor. I look forward to both their inputs and help as we keep evolving.

Lewisham is moving in a very positive direction. It sometimes feels as if nothing changes month on month until I review the progress made. We are working closely with Lewisham Council, including Public Health which is based with them now, local acute providers – Lewisham and Greenwich and South London and Maudsley NHS Trusts, and local GPs providers to see what we can do better together. This comes in many shapes and sizes from just common sense examples like sharing of IT development through Connect Care and better use of the GP EMIS system, Community Connections working in the four neighbourhoods to direct people to the support they need, community development and through to looking at how we can better work with housing in the Health and Wellbeing Board and formal integration work as in the Devolution Pilot and the Adult Integrated care board.

There is a lot going on and it is also happening at the South East London level with Our Healthier South East London work and across London with the Healthy London Partnership and other work. All are complementary, as each level will help the others although it can all feel a bit overwhelming at times. We need to avoid duplication and work to keep everything as simple as possible.

I hope the Junior Doctor's industrial action will end in agreement soon as it has affected patient's routine care in the longer term but, due to careful planning and hard work, I understand there were no particular problems nationally or locally with some A&Es being quieter than normal with the CCG putting in place a diversion scheme from A&E to primary care urgent slots.

There has been a lot of concern locally and across London about the pressure on primary care and especially general practice, as highlighted in a recent King's Fund report 'understanding pressures in general practice'. NHSE launched the 'General Practice Forward View' last month which is very clear about increasing support to GPs and redressing the shortfall in GP funding

that has occurred over the past years. I would recommend it to all of you who are interested in the development of the NHS.

We have established contracts with the four new GP federations, the underpinning Lewisham Federation is well on it's way and an increasing number of practices are looking at combining working in various ways to give flexibility and efficiency

Within the CCG we have submitted draft accounts subject to external audit to be signed later this month following a lot of hard work by the Finance Team. We are in contract negotiations with our acute providers and these are near to agreement. Tony will update on these points later. It is an uneasy position to be in when we are trying to work co-operatively with them at all other times!

Lewisham are now top in London for over 65s Pneumococcal vaccinations at 72.6% which is even better then Tower Hamlets! We also saw the biggest improvement across London for this over the last year with a 10.5% shift. This area was part of the 15/16 Lewisham Neighbourhood Primary Care Improvement Scheme (LNPCIS) where practices were incentivised to work collaborative to improve outcomes – I think this demonstrates what can be achieved through joint working and is testament to the hard work of our member practices in the context of challenging times. We will be looking to build further on this in 2016/17 through our formal contract with federations where Pneumococcal vaccinations will continue to be a focus area and hope this will continue to have a positive impact on our local population's health.

Congratulations to the Midwifery service at Lewisham and Greenwich NHS Trust who won the midwifery service of the year award and also the Active Mothers of Bexley programme won the public health award at the RCM award ceremony a couple of weeks ago.

Following the Committee in Common for Strategic Decision Making meeting held on 17 March, where CCG members commented on the draft evaluation criteria in relation to the proposed Elective Orthopaedic Centre, a revised proposal was developed for approval by Chair's action. The Briefing for CCG Governing Bodies; first meeting of the Committee in Common held on 17 March 2016 (appendix A) and Chair's action report (appendix B) are attached to my report for your information.

I look forward to a busy and productive summer with closer working resulting in better services for the population of Lewisham.

Marc Rowland
11 May 2016

Briefing for CCG Governing Bodies

First Meeting of Committee in Common, 17 March 2016

The first meeting of the committee in common (CiC) has been held. The meeting was quorate, with at least two representatives from each governing body. There were about six members of the public, one of whom expressed concern during public questions at the beginning of the meeting about the possibility of an orthopaedic centre, if developed, being an attractive option for privatisation. Sarah Blow as SRO for planned care, assured her the proposal was a collaborative NHS one.

The first item was discussion of the establishment agreement. It was noted that it had been through governing bodies some time ago. Mark Easton explained that the CiC was effectively six governing bodies meeting simultaneously rather than a joint committee. As such decisions had to be unanimous. For the committee to work governing bodies had to be well briefed on any items for decision before the meeting and had to have had the opportunity to comment to their representatives. This would be particularly important if contentious service decisions were being made. Mark said the programme team would be sending out a brief for governing bodies in advance of agendas being published, and would also debrief the proceedings of the meeting.

It was clarified the NHS England were not voting members of the committee, but were important partners in the programme so would be in attendance. The local authority representative was Barry Quirk, chief executive, Lewisham Council.

The main item of business was a consideration of possible changes to the model of planned orthopaedic care. This was taken in three sections:

Case for Change

Sarah Blow, SRO, described why orthopaedics had been selected for scrutiny:

- In the consolidated strategy orthopaedics had been identified as the specialty with the greatest potential for clinical and financial gain from a new model and would therefore be first to be considered, although other specialities may follow. The reasons for this were:
- Demand for EOC is increasing year on year
- As a result waiting times for EOC are often longer than other specialties and more people wait longer than 18 weeks for their treatment
- In South East London trauma and orthopaedics account for 6% of elective activity and 25% of tariff spend – 10% more than the next specialty.
- Complications following orthopaedic surgery are costly to the patient and the NHS
- Feedback from the public, patients and clinicians that experience and practice was variable across SEL
- Alignment with the national work “Getting it Right First Time”
- Availability of evidence and good practice in developing alternative models for orthopaedics such as the model in South West London

Members **agreed** that the case for change had been made although noted that where comparisons had been made between general hospitals and specialist orthopaedic hospitals in terms of infection

and re-admission rates, this was potentially a weak comparison which did not strengthen the argument. It was agreed to seek a more direct comparison.

Outputs from Working Group and New Model of Care

Sarah described the new model of care proposed, which had been developed with clinicians from our provider trusts. The key elements of the model were:

- Consolidation of elective inpatient services from the current eight sites to two sites while retaining outpatient, day case and trauma services available locally at base hospitals
- A higher quality and more efficient planned care pathway
- Exploring the case for consolidating specialist and complex cases between the two sites
- Creating an orthopaedic network approach for procurement and service design
- A business model which ensure the financial benefits of consolidation benefits all providers rather than creating "winners and losers"
- This new model to be evaluated against the status quo/ do minimum option.

A number of points came up in discussion. Workforce was seen as an important consideration and it was confirmed the impact on workforce would be assessed in the business case, and in so far as it gave opportunities to develop new roles. It was confirmed that nothing in developing this proposal was intended to destabilise local A&E departments or the sustainability of our local trusts. There was detailed discussion about the impact on A&E if elective orthopaedic beds were no longer available for over spill emergencies. It was noted that the proposal was unlikely to make the current situation worse, especially if, as planned, the introduction of the elective centres increased capacity, improved efficiency and separated the emergency and planned care rotas. The relationship with ortho- geriatrics was raised. Sarah explained that patients who were medically complex and requiring a lot of input from other specialities likely to retained at base hospitals. It was noted no view had yet been taken on whether there should be one specialist site or two, this was still to be determined by the clinicians, but it may be the two sites would have a slightly different caseload with the super-specialist work all going to one site.

It was agreed that the arguments for not consolidating to three sites should be more clearly set out, as described by Sarah at the meeting, and the programme team agreed to do that.

The process for developing options and then assessing them was discussed, including the need for NHSE assurance, sign off by the clinical senate and possible public consultation in the autumn.

It was noted that possible unintended financial consequences to trusts of not being chosen as the consolidated site would be picked up early in the process.

With these comments noted the CiC **agreed** the outputs recommended by the working group, including the two site consolidation option being developed as the comparator to the status quo. In addition CiC **agreed** that work should continue to develop options through the submission of proposals, evaluation process and pre-consultation business case as described above

Evaluation Criteria

Sarah described the process for developing the evaluation criteria, including input from the clinical working group, the clinical executive group, the clinical commissioning board, PPAG and the planned care reference group.

The importance of scaling up diagnostics was noted. In a collaborative model the importance of clear arrangements for accountability was stressed as were the different workforce issues that needed to be taken account of between inner and outer SEL. The question of assessing commissioner benefit was raised. It was noted that it was assumed that the financial benefit of greater efficiency would fall to the providers as part of their productivity and sustainability efforts. Commissioner benefit would come from reduced demand, fewer re-admissions and shorter length of stay.

It was agreed that equality duties could be presented more positively and this should be re-drafted, and that equality came into a number of other criteria, such as travel.

Sarah fed back the comments from the planned care reference group who stressed the importance of travel, links with social care and above all that finance should not trump quality. Sarah said that she was looking for agreement on the principles set out in the evaluation criteria which should include a pass mark on financial and non-financial criteria and a two stage process, separating the financial from the non-financial assessment.

It was **agreed** that the criteria should be amended as discussed, and a worked example of the scoring mechanism devised. This should be circulated to CCG chairs for final sign off.

John King as chair of PPAG supported the work that had been done on orthopaedics.

With thanks to the many people involved in developing the orthopaedic proposals the meeting concluded.

Mark Easton

Programme Director

17 March 2016

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CHAIR'S ACTION

The NHS Lewisham Clinical Commissioning Group's Constitution states: it is recognised that there will be times when urgent decisions are required. The Chair has the discretion to define urgent decisions. To ensure transparency, any urgent decisions will be recorded and notified in the minutes of the next meeting in public of the CCG Governing Body.

Title: Evaluation Criteria for Elective Orthopaedic Care Proposals

Recommendation proposed:

Following on from the Committee in Common for Strategic decision making held on 17 March, where CCG members commented on the draft evaluation criteria in relation to the proposed Elective Orthopaedic Centre, a revised proposal was developed for approval by Chair's action.

Following the development of the specification and the identification of possible host sites it will be possible to compare alternative options for the future delivery of elective orthopaedic services in SEL. To support this process a set of objective evaluation criteria have been developed. These can be applied to each option to assess whether they should continue to be considered at further stages of the process. The evaluation criteria will be used to assess the relative merits of the different options to identify a short-list from which options for a potential consultation will be confirmed. These will take into account non-financial and financial criteria. It has been recommended by the evaluation group and the Committee in Common, that in line with other assessment processes, that non-financial criteria are scored separately and weighted greater than financial.

Rationale for Chair's action: Delegated sign off by Chair's was agreed by Committee in Common three CCG members.

Approving Lay Member: Ray Warburton

I, (Chair), support and agree the action:

Signature:

Date: **5 May 2016**

I, (Chief Officer), support and agree the action:

Signature: 

Date: 5 May 2016

Date of Governing Body meeting: 12 May 2016