AGENDA

A meeting of the Governing Body in public

Date: 9 January 2020
Time: 10:00 – 12:30
Venue: Room 1, Civic Suite, Catford Road, London SE6 4RU
Chair: Dr Faruk Majid

Enquiries to: Charles Malcolm-Smith
Telephone: 020 7206 3246
Email: Charles.malcolm-smith@nhs.net

Voting Members

Dr Faruk Majid  Chair, Lewisham CCG
Dr Esther Appleby  Clinical Director, CCG
Mr Andrew Bland  Accountable Officer
Ms Alison Browne  Registered Nurse Member, Lewisham CCG
Ms Debbie Brown  Clinical Director, LCCG
Dr Charles Gostling  Senior Clinical Director, Lewisham CCG
Ms Anne Hooper  Lay Member, LCCG
Dr Sebastian Kalwij  Clinical Director, Lewisham CCG
Ms Shelagh Kirkland  Lay Member, LCCG
Prof Simon McKenzie  Secondary Care Doctor, Lewisham CCG
Dr Jacky McLeod  Senior Clinical Director, Lewisham CCG
Mr Usman Niazi  Chief Financial Officer
Mr Peter Ramrayka  Lay Member, Lewisham CCG
Dr Angelika Razzaque  Clinical Director, Lewisham CCG
Dr Ravi Sharma  Clinical Director, Lewisham CCG
Mr Martin Wilkinson  Managing Director, Lewisham CCG

Non-Voting Members

Dr Magna Aidoo  Representative, Healthwatch Lewisham
Mr Tom Brown  Executive Director, Community Services, Lewisham Council
Mr David Maloney  Director of Finance
Dr Catherine Mbema  Interim Public Health Director, Lewisham Council
Dr Simon Parton  Chair of Local Medical Council

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 either Lay Members or 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

<table>
<thead>
<tr>
<th>Time</th>
<th>Item</th>
<th>Papers (pages)</th>
<th>Presented by</th>
</tr>
</thead>
<tbody>
<tr>
<td>10:00</td>
<td><strong>Welcome and introductions</strong></td>
<td></td>
<td>Chair</td>
</tr>
<tr>
<td></td>
<td><strong>Apologies for absence</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Declarations of Interest</strong></td>
<td></td>
<td>Chair</td>
</tr>
</tbody>
</table>
|      | *Members should discuss any potential conflicts of interest with the Chair prior to the meeting*
<p>|      | Declarations made by the Governing Body are listed in the register.   |                |                       |
| 10:05| <strong>To agree minutes of previous meeting</strong>                              | 6-14           | Chair                 |
|      | <strong>To review the actions and matters arising</strong>                         |                |                       |
| 10:10| <strong>Chair's Report</strong>                                                    | 15             | Dr Faruk Majid        |
|      | <em>To receive and note for information</em>                                 |                |                       |
| 10:20| <strong>Managing Director’s Report</strong>                                        | 16-19          | Martin Wilkinson      |
|      | <em>To receive and note for information</em>                                 |                |                       |
|      | <strong>Audit Committee Chair’s Report</strong>                                    |                |                       |
|      | <em>No meeting held since the last Governing Body meeting</em>               |                |                       |
| 10:30| <strong>Primary Care Commissioning Committee Chair’s report</strong>               | 20-21          | Peter Ramrayka        |
|      | <em>To receive and note from the meeting held on 17 December 2019</em>       |                |                       |
| 10:35| <strong>Public Engagement and Equalities Forum Chair’s Report</strong>             | 22-27          | Anne Hooper           |
|      | <em>To receive and note from the meeting held on 10 December 2019</em>       |                |                       |
| 10:40| <strong>Questions in relation to agenda items from members of the public</strong>  |                |                       |
| 10:45| <strong>Finance Report M8 2019-20</strong>                                         | 28-51          | David Maloney         |
|      | <em>To receive and note for information</em>                                 |                |                       |
| 11:00| <strong>Integrated Governance Committee Chair’s Report</strong>                    | 52-56          | Martin Wilkinson      |
|      | <em>To receive and note from the meeting held on 28 November 2019</em>       |                |                       |</p>
<table>
<thead>
<tr>
<th></th>
<th>Time</th>
<th>Item</th>
<th>Details</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>14.</td>
<td>11.20</td>
<td><strong>South East London Integrated Governance &amp; Performance Committee</strong></td>
<td>To receive and note from the meeting held on 1 November 2019</td>
<td>57-142</td>
</tr>
<tr>
<td>15.</td>
<td>11.30</td>
<td><strong>Board Assurance Framework (BAF)</strong></td>
<td>To receive and agree the recommendations relating to the corporate objectives and BAF for 2019/20</td>
<td>143-168</td>
</tr>
<tr>
<td>16.</td>
<td>11.45</td>
<td><strong>Annual Report delegation to Audit Committee</strong></td>
<td>To approve delegation of authority to approve the 2019/20 Annual Report and Accounts to the Audit Committee</td>
<td>169-170</td>
</tr>
<tr>
<td>17.</td>
<td>11.50</td>
<td><strong>South East London Integrated Care System Long Term Plan Response</strong></td>
<td>To review the summary response to the Long Term Plan and Lewisham Local Care Partnership content</td>
<td>171-183</td>
</tr>
<tr>
<td>18.</td>
<td>12.00</td>
<td><strong>Strategy and Development Workshop Chair's Report</strong></td>
<td>To receive and note from the meeting held on 6 December 2018</td>
<td>184-185</td>
</tr>
<tr>
<td>19.</td>
<td>12.05</td>
<td><strong>Annual Equalities Report 2019</strong></td>
<td>To review the draft Lewisham CCG Annual Equality report for publication by 31 January 2020</td>
<td>186-266</td>
</tr>
<tr>
<td>20.</td>
<td>12.15</td>
<td><strong>Potential Audit and Risk Management Issues</strong></td>
<td>To identify any issues which the Governing Body consider would benefit further scrutiny by the Audit Committee</td>
<td>Chair</td>
</tr>
<tr>
<td>21.</td>
<td>12.20</td>
<td><strong>Any Other Business</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22.</td>
<td>12.25</td>
<td><strong>Questions from members of the public</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23.</td>
<td></td>
<td><strong>Public Forum notes for information</strong></td>
<td>(November 2019)</td>
<td>267</td>
</tr>
<tr>
<td>24.</td>
<td></td>
<td><strong>Approved Committee minutes for information only:</strong></td>
<td></td>
<td>268-286</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Audit Committee (July 2019)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Integrated Governance Committee (September 2019)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• SEL Integrated Governance &amp; Performance Committee (November 2019)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Strategy and Development Committee</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Date of next meeting: Governing Body 12 March 2020</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----</td>
<td>-----</td>
<td>------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25.</td>
<td>12:30</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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

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

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

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

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

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

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

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

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

21. These arrangements will be recorded in the minutes.
Governing Body Meeting

Minutes of the meeting of the NHS Lewisham Clinical Commissioning Group (LCCG) Governing Body held on Thursday 14 November 2019 at St. Laurence Centre, Catford

Present

Dr Faruk Majid Chair, LCCG (Chair)
Dr Esther Appleby Clinical Director, LCCG
Dr Magna Aidoo Representative, Healthwatch Lewisham
Mr Andrew Bland Accountable Officer, LCCG
Ms Debbie Brown Clinical Director, LCCG
Mr Tom Brown Executive Director, Community Services, LB Lewisham
Ms Alison Browne Registered Nurse, LCCG
Dr Charles Gostling Senior Clinical Director, LCCG
Ms Anne Hooper Lay Member, LCCG
Dr Sebastian Kalwij Clinical Director, LCCG
Ms Shelagh Kirkland Lay Member, LCCG
Prof. Simon Mackenzie Secondary Care Doctor, LCCG
Mr David Maloney Director of Finance, LCCG
Dr Catherine Mbema Interim Director of Public Health
Mr Usman Niazi Chief Financial Officer
Dr Simon Parton LMC Chair
Mr Peter Ramrayka Lay Member, LCCG
Dr Angelika Razzaque Clinical Director, LCCG
Dr Ravi Sharma Clinical Director, LCCG
Mr Martin Wilkinson Managing Director, LCCG

Attendance

From Lewisham CCG and Partners

Ms Lesley Aitken Interim Board Secretary, LCCG (minutes)
Mr Charles Malcolm-Smith Deputy Director (Strategy & Organisational Development)
Ms Hannah Reeves Business Manager, LCCG

There were 3 members of the public present for the meeting

Apologies

Dr Jacqueline McLeod Senior Clinical Director, LCCG

LEW 19/111 Welcome and Introductions

Dr Majid welcomed all to the meeting. It was noted that there was a period of purdah given the general election though the meeting would continue as usual.

LEW 19/112 Declaration of Interest
It was declared that from the 1 November 2019 Mr Bland took up the post of Accountable Officer for Lambeth CCG and Mr Niazi the post of Chief Financial Officer for Lambeth CCG. There were no other new declarations of interest or conflicts identified in relation to agenda items.

**LEW 19/113  Previous Minutes**

The minutes of the meeting held on 12 September 2019 were taken as a correct record of the meeting subject to the amendment:

19/100 Dr Majid had discussed with other CCG Chairs; that the population was not static; there was a need to provide opportunity across a variety of services

**LEW 19/114  Matters Arising and Action Log**

The actions on the log had been cleared at the previous meeting.

There were no matters arising at this stage of the meeting.

**LEW 19/115  Chair’s Report**

Dr Majid presented the Chair’s report which was taken as read and noted. The following Clinical Directors gave their reports:

**Dr Appleby:** The Big Health Day for People with Learning Disabilities for the boroughs of Lewisham, Bexley and Greenwich, had been well attended. The event was made possible by transformation funding and the work of Mr Ian Ross, the Associate Director for Planned Care and Cancer, and the SE London team. Attendees at the event were able to book in for health checks and received information on cancer screening. Ms Hooper added that it had been a vibrant event with those with learning disabilities voicing that they felt proud that the day was dedicated to them as it demonstrated that they were an important part of the community. Dr Razzaque hoped that learning from events such as the Big Health Day would inform future commissioning.

**Dr Gostling:** The Suicide Prevention Strategy had been launched in September; it had been a moving day hearing from a wide range of stakeholders. It was noted that suicides by males between 18 and 35 were a concern locally. It was acknowledged that healthcare professionals needed training on related issues including suicide prevention.

**Dr Kalwij:** The first Lewisham Workforce Race Equality (WRES) seminar held was well attended by representatives from the council, the main providers, partners, Public Health and Primary Care. Dr Kalwij has been invited to present his findings from the GP Survey to the National WRES team. This was the first primary care survey and could potentially lead to creating a new set of indicators for Primary Care. Dr Kalwij would roll out the survey to other primary care providers. His findings showed that 37% of BAME primary care staff were being exposed to racial abuse from patients and their relatives and also from colleagues. 22% of the abuse had been deemed bad enough for staff to change jobs. Ms Hooper added that it had been a powerful event which showed the level of the problem in Lewisham. Tangible work and planning were needed to act on the information and statistics provided. Dr Majid commended Dr Kalwij for the work on the survey.

The Governing Body NOTED the report
Managing Directors Report

Mr Wilkinson presented the Managing Directors report, which was taken as read, and confirmed that Lewisham CCG membership had approved the new constitution for the merger CCG and the dissolution of NHS Lewisham CCG. The application to merge the six south east London CCGs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark to NHS England and NHS Improvement (NHSE&I) had been made on time. Approval had now been given by NHSE&I for the merger from 1 April 2020.

The Governing Body NOTED the report

Audit Chairs report

Ms Kirkland presented the Audit Chair’s report from the meeting held 22 October 2019 which was taken as read, the following was highlighted:

- Even though there has been an overall increase on spending on mental health services the CCG would potentially receive an ‘Except For, opinion from KPMG, external auditors, on their review on compliance under the Mental Health Investment Standard (MHIS). It was explained that under MHIS requirements it was necessary to show that in 15 categories that spending has increased. Records for last year were not granular enough, this was primarily because the contracts were in the main block contracts and not separately identified. KPMG had suggested that only 10% of their clients would receive an acceptable opinion.
- RSM, Internal auditors, completed their deep dive report for QIPP and Financial Management and awarded the CCG a ‘Reasonable Assurance’ opinion. A benchmark report produced from internal assurance reports, which had been issued by RSM to all of their healthcare clients during the year 2018/19, was presented for which Lewisham CCG had achieved an above average achievement.

The Governing Body NOTED the report

Primary Care Commissioning Committee (PCCC) Chairs report

Mr Ramrayka presented the Primary Care Commissioning Committee Chair’s report from the meeting held on 15 October 2019. He reported that there had been an interesting discussion on the utilisation of GP Extended Access Service (GPEA). Also discussed was the support the primary care team were providing to eight GP practices to improve quality issues highlighted by the information received from CQC inspection reports, Friends and Family Test and the GP Patient Survey.

Ms Kirkland pointed out the 74% utilisation rate for the GPEA service which had allocated funding of £1.17m, which appeared that the public were not aware of the service. Dr Majid explained that not all appointments were available to primary care, there was provision for NHS 111 and the emergency departments. Dr Razzaque added that the appointment slots were often fully booked. In response to Dr Razzaque on whether the underspend on primary care would be invested elsewhere, Mr Maloney said that as indicated on the start budget for 2019/20 there was an underspend on primary care which was being used to support the overall financial position of the CCG.

Referring to the GPEA uptake rate, Dr Parton had concerns over how the appointment slots were being used and the high DNA rate. Ms Brown added that the nursing slots were always full with short appointment times.

ACTION: The comments made from the Governing Body meeting would be reported to the PCCC.
The Governing Body NOTED the report

**LEW 19/119  Public Engagement and Equalities Forum Chairs report**

Ms Hooper gave the report from the Public Engagement and Equalities Forum (PEEF) held on 15 October 2019. She described, how following the PEEF Governing Body/SMT workshop in August, it had been agreed that a rationale for a borough based Public Engagement Forum would be developed to ensure that public engagement and involvement continued in Lewisham. It was recognised that local people want assurance that public engagement would continue, to be involved in decision making and to retain a voice on local issues. Following earlier discussion, it was agreed that overseeing the Public Reference Group would be added to the rationale. The aim was for a borough-based committee to provide assurance across the Borough Based Board and the SEL Governing Body.

Mr Bland added that he supported the rationale.

Ms Hooper commended the work of the Communication and Engagement Team for their work towards the proposals.

The Governing Body ENDORSED the rationale and the formal Terms of Reference which would be developed for agreement by the new Borough Based Board once established and then SEL CCG Governing Body.

**LEW 19/120  Public questions**

Q. There is no mention in the report of the inequalities for patients with dementia and about supporting older adults and their carers.

A. Dr Gostling responded that there was a clear dementia strategy across Lewisham and services were commissioned from Mindcare. He agreed that it should be highlighted in the report. Dr Majid added that the level of dementia was increasing and that Lewisham had been recognised for their high level of detection. Mr Brown added that there were challenges including those with both dementia and physical health concerns, there needed to be a joined-up service between social care and mental health. Mr Wilkinson added that Ms Karin Barthel, Senior Joint Commissioning Manager for Adult Mental Health, was working with lead clinicians on pathways. There would be further detail on diagnosis and support in the January Governing Body Managing Director’s report.

Q. Was staggered by the information from the WRES seminar and GP survey on that 37% of BAME staff were subject to racial abuse, especially on abuse from colleagues, should this not be a failure of management.

A. Dr Majid responded that the seminar came about after discussing results of the Lewisham and Greenwich Trust’s WRES data at a Clinical Director’s meeting. The abuse received by BAME staff was a daily occurrence in the acute sector. There is a zero tolerance policy to abuse in the CCG and primary care. Following the conference there was more interest in tackling problems, this could be potentially included in the Primary Care Strategy.

**LEW 19/121  Finance Report M6 2019-20**

Mr Niazi reported that all the SE London CCGs were on plan to date. He highlighted:

- There would be risks associated with winter.
• QIPP schemes were making progress
• There was a need to deliver a forecast outturn across SE London

Mr Maloney gave a report on the Lewisham position. The M6 finance report had been discussed at the Finance and Investment Committee (FIC) on 24 October 2019. It was highlighted:

• Lewisham was reporting on plan for M6
• The overall position for acute services was a £400k overspend, this was for the block 2019/20 contracts on LGT, GSTT and King’s.
• The key areas of financial pressure were Continuing Health Care (CHC) and the Prescribing budgets. The CCG was mitigating the risks.
• Pressures regarding prescribing was faced by all CCGs nationally due to price increase and supply issues for certain drugs.
• The forecast was to achieve the control total at year end.
• There would be increased pressures for Lewisham across winter.

Ms Kirkland added that there was a need to focus on the underlying activity data. It was noted that there was an underspend on the LGT contract and overspends on GSTT and Kings. Mr Maloney reported that the overall position for Lewisham across the three contracts for the first half of the year was on plan.

Mr Maloney added that the Long Term Financial Plan was to be submitted on 15 November 2019. Mr Usman explained that across SE London a response to the LTP was being worked on, work had just started on the 2020/21 investments working with primary care and acute services partners. There would continue to be QIPP across SE London with local input. There would be three areas of QIPP likely for focus on by Borough Based Boards next year:

• CHC
• Prescribing
• Demand Management work by primary care

Mr Wilkinson said that there was a need to look at system cost rather than CCG QIPP. Work would be ongoing with the council on efficiency savings across the CCG and council, along with other local system partners.

Mr Bland continued that there was work happening including conversations with OHSEL on what should be the appropriate marginal rate of activity, how to improve quality and manage demand.

Dr Majid asked if there was future funding to supporting the community on WRES issues to improve the lives of Lewisham residents and across the sector. This would yield better health benefits. Mr Bland responded that the Governing Body would look at the prioritisation process for investment and spending. There has been investment in the SE London WRES team. Any future investment doesn’t have to be financial.

The Governing Body NOTED the Finance Report for Month 6 2019/2020

LEW 19/122 Integrated Governance Committee (IGC) Chair’s Report

Mr Wilkinson gave the report from the non-acute areas discussed at the IGC meeting held on 26 September 2019. The key non acute area exceptions had not changed since the last report.
• Children and Young People (CYP) Mental Health Transformation. SLaM’s data capture highlighted concerns about meeting the 34% CYP Mental Health Transformation standard. This should improve when there are rolling numbers.
• Personal Health Budgets; there has been an increased uptake with the appointment of a new project worker.
• CHC – has slipped back but staffing capacity has now improved. The commissioning opportunity for bedded and community provision was being looked at.
• Mental Health Out of Area placements – the concern was patients being in emergency departments for too long, with long stays within the acute beds and none being available when needing resulting in placements out of area. An improvement was being seen though the demand was still high. There was now increased mental health triage provision at UHL A&E.

The Governing Body NOTED the report

LEW 19/123 South East London Integrated Governance and Performance (IG&P Committee)

Mr Wilkinson reminded the Governing Body that Prof Mackenzie, Dr McLeod and himself represented Lewisham at the SE London IG&P meeting. At the meeting held on 1 November 2019 there had been full discussion on the Constitutional Standards:

• Refer to Treatment (RTT)
• Cancer
• Accident and Emergency
• Diagnostics
• Transforming Care Programme

The Committee had been assured that there was improvement on cancer, that the plans were robust with a commitment to deliver plans. There was not assurance though on the providers ability to implement the plans. There had been a deep dive on diagnostic waiting times.

Prof Mackenzie asked the Governing Body note that there was no assurance to the GB on provider’s ability to recover the standards or agreed recovery targets. He added that some risks were foreseeable and having the appendix of the SPC charts included with the papers would have been useful.

Mr Bland felt more should be reflected on;

• Regarding flu vaccinations, what were providers and staff doing?
• SE London emergency department planning; what was happening as this was away from plan
• Were there plans to use other providers

Referring to the flu vaccination, Ms Browne reported that the vaccination was being refused by high risk groups because of a misconception of the effects of the vaccination. These issues would be taken back to the Pensioners Forum. Dr Parton added that there needed to be more information advertised on the effectiveness of the vaccination. Dr Razzaque explained that there had been a presentation to the Unplanned Care Group on the engagement programme on demystifying message regarding flu vaccinations. Dr Parton added that LGT should encourage midwives to vaccinate.
ACTION: Dr Mbema to bring the borough flu action plan back to the Governing Body for information.

It was noted that there had been a delay in the nasal spray for children.

In response to Mr Ramrayka on concerns regarding PHBs in Q1, Mr Wilkinson said that PHB were tailored to cohorts, mainly CHC. There was a wider issue of personalisation and care planning.

Dr Gostling informed the Governing Body that primary care services had access to the mental health rapid response team and to the crisis café.

The Governing Body NOTED the report

LEW 19/124  Board Assurance Framework (BAF)

Mr Wilkinson informed the meeting that there were twelve risks with a rating of twelve and above, five local and seven SE London risks. The highest risk being CHC which was being looked at locally. An Internal Audit review was being undertaken on risk processes which would be presented at the Audit Committee. One of the recommendations from this report, was how we are integrating the SE London risk work into local systems.

Referring to the risk on Financial Targets 2019/20, Mr Maloney said that the impact of this should decrease next month. Mr Niazi added that all financial risks would be discussed before the next IG&P meeting. Ms Kirkland pointed out that of the five major local risks, two had deteriorated; CHC which additional staffing should help to improve and CAMHS.

In response to Dr Majid on whether the local BAF would feed into the merged CCG BAF, Mr Wilkinson explained that the BAF stood whilst the Governing Body was a sovereign body, the Borough Based Board (BBB) would manage and consider local risks. Providers would be scrutinised through the Lewisham Health & Care Partners with joint agendas including risk and performance conversations. Mr Bland added that the Health & Care Partners would potentially have an system assurance framework.

The Governing Body AGREED that the appropriate risks had been identified against the achievement of the Corporate Objectives, AGREED the current risk scores and the target risk scores for the risks contained within the BAF, AGREED that there were adequate controls in place to mitigate the risks to be Corporate Objectives and where existing controls had not reduced the current risk score to the target risk score there are credible action plans, noting that further work was required to ensure they capture the breadth of work on each risk adequately

LEW 19/125  Strategy and Development Workshop Chair’s report

Dr Gostling reported from the Strategy and Development Workshop held on 3 October 2019. The following was highlighted:

- CCG System Reform and Borough Based Development – discussion included the interface between providers and commissioners, that Community Based Care would meet the needs of the population and the interface with the SE London CCG.
- Workforce Race Equality Standard (WRES) update – the report submitted to NHSE on the CCG’s performance against the WRES was discussed. Positive areas of performance were reported in BAME representation in senior grades, recruitment, access to non-mandatory training and workforce representation of the local population. Improvement was required on experience of bullying and harassment,
equality of opportunity, experience of discrimination and representation on the Governing Body.

The Governing Body NOTED the report

**LEW 19/126 Proposed Amendment to IVF Treatment Policy**

Dr Razzaque presented the report on the proposed amendment to the current SE London IVF Treatment Policy. The Governing Body were reminded that the Treatment Access Policy (TAP) had been approved by them at the March 2019 meeting where the issue on the IVF for single women was highlighted. To take forward, as it had been shown that this decision was not in line with neighbouring CCGs and did not follow NICE guidelines, a task and finish group had been set up. Once all six governing bodies had reached a decision, a communication plan would be implemented to ensure all key stakeholders were formed, including hospitals and general practices in SE London.

In response to a comment from Dr Sharma on whether the decision to amend the policy was an emotional rather than inequality and whether subsequent children would be put at an advantage, Dr Razzaque said that the current policy was an inequality as it excludes certain groups of patients from access to the service, there was some evidence that children from single parent families were at a disadvantage, but that this evidence was outdated. Dr Mbema added that the SE London policy was to be amended to align with neighbouring CCGs. This would now be in line with NICE guidance.

The Governing Body AGREED:

- The rapid amendment to the SE London Treatment to Access Policy for IVF for single women, to enable them to have access to IVF on the same basis as same sex female couples.
- As for same sex couples, eligible single women would have confirmed infertility, evidenced by unsuccessful cycles of artificial insemination within the 12 past months. This would indicate for further assessment to take place, following which IVF may be offered if the woman is eligible
- To review and update the whole Section 2.26 Fertility treatments in the SE London Treatment Access Policy 2019/20 by the end of the financial year, in time for the next iteration of the Policy.

**LEW 19/127 Potential Audit and Risk Management Issues**

No audit or risk management issues were raised.

**LEW 19/128 Any other business**

Dr Majid, pointing out that this was the last meeting to the Governing Body in 2019, thanked all the members for support throughout the year and would appreciate feedback on his chairing of the meeting.

**LEW 19/129 Questions from Members of the Public**

There were no further questions at this point from members of the public.

**LEW 19/130 Public Forum Notes**

The notes from the public forum meeting held in September 2019 were noted.
LEW 19/131  Approved Committee minutes

The approved minutes of the Integrated Governance Committee, SEL Integrated Governance and Performance Committee and Strategy and Development Workshop meetings were taken for information.

LEW 19/132  Date of the next meeting

Thursday 9 January 2020 at 10am
CCG Chair’s Report

Governing Body meeting – 9 January 2020

Happy New Year to all!

The end of 2019 presented several challenges for our staff. They have maintained the normal business functions of the CCG whilst the process of employment change and organisational development activity for the new CCG progressed. They have also needed to manage significant emergency activity pressures at our local hospital although winter has been relatively mild so far.

January is the first anniversary of the publication of the Long Term Plan which has been a driver of change and many of the plans developed during 2019. We now have an opportunity to build on those and helping our local providers by creating an environment for them to jointly develop better services for our population. The new Borough Based Board will be central to this local process and I look forward to working with you in the coming weeks.

Clinical Directors Update

Dr Charles Gostling, Senior Clinical Director

The results for the national Diabetes Audit 2019-20 were published in late December. I am very pleased to note that the attainment for the combined three diabetes targets, population of people with diabetes achieving all three targets, has now climbed to 46.2%. Lewisham is now the 5th ranking CCG in London and ahead of illustrious neighbours such as Bexley, Tower Hamlets and Lambeth. It is only a few years ago that Lewisham was propping up the tables. Better outcomes here mean less future risk of cardiovascular disease and other complications of diabetes for the people of Lewisham. Well done to One Health Lewisham and Dr Sanjay Das in particular who has been the driving clinical force. Well done also to all our practices who have upped the collective game superbly.

Dr F Majid 01.01.2020
Managing Director’s Report

Governing Body meeting – 9 January 2020

1. Appointments to the SEL CCG Governing Body

Since the approval of our merger, with the exception of appointing the chair, we have now completed appointments to the new South East London CCG Governing Body. The process to appoint our Chair will be completed in January.

The GB appointments are:

- Bexley GP leads: Dr Sid Deshmukh and Dr Clive Anggiansah
- Bromley GP leads: Dr Andrew Parson and Dr Ruchira Paranjabe
- Greenwich GP leads: Dr Krishna Subbarayan and Dr Sabah Salman
- Lambeth GP leads: Dr Adrian McLachlan and Dr Diane Aitken
- Lewisham GP leads: Dr Faruk Majid and Dr Jacky McLeod
- Southwark GP leads: Dr Jonty Heaversedge and Dr Nancy Kuchemann

Secondary Care Doctor: Dr Simon Mackenzie

Registered Nurse: Mary Currie

Lay Member Audit & Governance: Shelagh Kirkland

Lay Member PPI: Joy Ellery

Lay Member Primary Care & Commissioning: Peter Ramrayka

In addition to the Governing Body lay member appointments; there is a lay member post on the Borough Based Board for each borough. To date, five of the six lay members have been confirmed in post: Bexley - Keith Wood; Greenwich - Richard Rice; Lambeth - Sue Gallagher; Lewisham – Anne Hooper and Southwark – Richard Gibbs. Bromley’s appointment will be confirmed in the near future.

Interviews were also held before Christmas for the CCG’s new Chief Nurse post and we are pleased to announce that Kate Moriarty-Baker, the current Director of Quality and Chief Nurse with Southwark CCG, was successful at interview and has been appointed.
2. Progress on Lewisham Borough based Board

Lewisham’s approach to joint commissioning between health and care locally has been long standing and built on a shared commitment across agencies that all money is public money and that all staff work for the benefit of our residents. Through strengthened joint and increasingly integrated commissioning, we aim to ensure that we maximise value, reduce duplication between services and agencies and we address the needs of our residents across their lives, helping people to optimise their independence, reducing health inequalities, improving health and wellbeing, care, support and educational outcomes for all our residents.

Draft terms of reference for the Borough based board have been developed and will be considered by the new SEL Governing Body in due course. The Council’s Mayor and Cabinet will also consider LBL’s formal participation, though they agreed the direction of travel at its meeting in December 2019.

For the CCG, the Borough Based Board will have delegated responsibility for local commissioning, include delivery of the annual plan, the associated budget and service performance for the areas in scope, ensuring the best value and optimal outcomes are delivered in these areas:

- Primary care (making recommendations to the SEL Primary Care Committee as appropriate)
- Community health services
- Client groups (learning disabilities, physical disabilities, mental health, children and young people and maternity services), including existing s75 agreements
- Medicines optimisation related to community based care
- Continuing Healthcare

For LBL, the Borough Board is expected to advise and make recommendations to Mayor and Cabinet for the following areas

- Client groups (as above), including existing s75 agreements
- Public Health
- Other areas - reablement, community development, and substance misuse

The main responsibilities of the Lewisham Borough Based Board are expected to be:

- Agreement and delivery of a near-term plan to support Health and Wellbeing Board and Children and Young People’s strategies including agreement of Better Care Fund and Improved Better Care Fund, and production of an annual delivery plan.
• Shaping and implementing detailed strategies and approaches (both commissioning and providers) for the integrated community based health and care in-scope responsibilities
• Support and oversee the statutory market shaping responsibilities for adult social care ensuring quality, accessibility and sustainability
• Establish and maintain appropriate partnership governance arrangements for both and between CCG and LBL to effectively discharge responsibilities in line with CCG governance arrangements, policies and procedures and membership constitution and LBLs constitution
• Ensure S75s arrangements are in place for agreed areas and are effectively discharged and monitored
• Performance of delegated budgets and responsibilities including financial, quality and key performance metrics, reporting progress against delivery objectives, risk and mitigation plans
• Provide oversight of local contract registers and align procurement plans acting as ‘gateway’ approvers on behalf of LBL’s Procurement Board prior to recommendation to Mayor and Cabinet and decisions on CCG in-scope services
• Engaging with and responding to local population, clinicians and staff to use their insights to shape local services, taking advice from the local Patient Engagement and Equalities Forum
• Implementation of strategies and service plans
• Assessing impact on local residents in particular on health inequalities
• Secure a coordinated borough contribution and response to SEL work on annual commissioning intentions and delivery plans across the totality of CCG commissioned services
• Produce regular report on progress and activities reporting to CCG Governing Board and Health and Wellbeing Board, including the provision of an annual report and a self-assessment on effectiveness of the Borough Based Board for the CCG.

Membership of the Borough Based Board is expected to be:

<table>
<thead>
<tr>
<th>CCG Members (Voting)</th>
<th>Local Authority attendees (non-voting)</th>
<th>Other non-voting attendees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Borough Based Director</td>
<td>Executive Director of Community Services</td>
<td>Local LMC representative</td>
</tr>
<tr>
<td>Borough CCG lead (chair)</td>
<td>Executive Director of Children and Young People’s Services</td>
<td>Local Healthwatch representative</td>
</tr>
<tr>
<td>Borough CCG lead (vice chair)</td>
<td>Director of Public Health</td>
<td></td>
</tr>
<tr>
<td>Borough lay member</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The Borough Based Board will meet in public as well as conduct some business privately.

It is also envisaged that the Borough Based Board will meet jointly with Lewisham Health and Care Partners with additional representatives from local providers to provide shared system wide leadership, strategic direction and a collective view on the transformational change required in health and care across Lewisham, especially focused on local integrated community based care and services.

Subject to agreement of the terms of reference by the CCG, it is expected the Borough Based Board will begin to meet in shadow form before March ahead of establishment in April 2020.

3. New Chair announced at South London & Maudsley NHS Foundation Trust

Sir Norman Lamb has been announced as the new Chair of South London & Maudsley following a competitive recruitment process. He is a long-standing and active campaigner for mental health, has worked to challenge stigma around mental health and to ensure people with mental health issues are treated with the same priority as patients with physical health needs. A former Health Minister from 2012-2015, Sir Norman introduced the first access and waiting time standards in mental health care for the treatment of mental health problems like depression and anxiety, and for patients experiencing a first episode of psychosis. In 2019, Sir Norman received a knighthood for his public and political service, notably his contribution to mental health. Sir Norman takes up the position in March 2020.

Martin Wilkinson
January 2020
Governing Body meeting on Thursday 9th January 2020

Primary Care Commissioning Committee (PCCC): Chairs Report

Report from: Peter Ramrayka, CCG Lay Member and Chair of the PCCC
PCCC date: Tuesday 17th December 2019
Managerial Lead: Diana Braithwaite, Director of Commissioning & Primary Care
Author: Ashley O’Shaughnessy, Deputy Director of Primary Care


1.1 Overall there is a small year to date overspend of £14k and a forecast outturn overspend of £20k. The Committee was advised that the overspends are not material to the budget and do not present a current concern.

1.2 A breakdown of PCN funding for 2019/20 was also presented which totals £1.6M.

2. GP Forward View (GPFV)

2.1 The committee received a high level update on new developments in the local implementation of the GPFV in Lewisham; highlights include:

- a 78% utilisation rate for the GP Extended Access Service in October 2019 (this % includes appointments where patients did not attend (DNA’d))
- 21,568 patients registered to use the Ask NHS GP symptom checker APP (as of the 30th November 2019)
- GPFV Resilience funding: The CCG received a total of 12 applications covering 17 GP practices and allocations have now been confirmed following peer review by the London-wide Medical Committee and a CCG lay member

2.2 The Committee was satisfied that the updates indicated good progress and that appropriate actions were being taken where needed.

3. Primary Care Operational Group Chairs Report

3.1 As raised at the November 2019 Integrated Governance Committee, the Group discussed specific CCG priority actions which could help support and strengthen primary care.

3.2 Five identified actions are:

- To support community services to use the EMIS clinical system which will help address delays, inefficiencies and risks to care of complex patients. This will also support the CCG integrated working strategy.
- To improve the level of business as usual ICT support services delivered to GP practices.
- To move at least one community service area (e.g. dermatology or diabetes) into primary care.
- To revive the ‘making time in general practice’ work stream, which considers the impact others in the system have on primary care and how to better manage this.
- To ensure primary care is visibly celebrated and recognised for its good work.

3.3 The Committee endorsed the actions identified and recommended that work should continue to progress these items.
4. **Practice Merger - Brockley Road Medical Centre and Hilly Fields Medical Centre**

4.1 The committee approved the merging of the contracts for Hilly Fields Medical Centre and Brockley Road Medical Centre as of the 1st April 2020 and the closure of the Brockley Road Medical Centre site on the 13th March 2020.

4.2 To mitigate conflict of interest Dr. Faruk Majid, a partner at the Brockley Road Medical Centre and the Hilly Fields Medical Centre, was not present during the discussion and decision on this item.

5. **Minor Ailments (Pharmacy First) Scheme**

5.1 The committee received an update on the local Pharmacy First scheme which provides advice and support to people on the management of a defined list of common conditions from community pharmacists at local pharmacies. The scheme has been in existence for over 15 years and aims to reduce avoidable pressure on GP practices and provide patients with more flexible access to care.

5.2 To date 45 out of 55 pharmacies in Lewisham provide the scheme.

5.3 In the period between April 2018 and March 2019 the scheme has had 17,546 interactions from 11,397 patients. Of these audited interactions, had the scheme not been available:

- 15,480 (88.2%) would have gone to the GP
- 63 (0.4%) would have gone to A and E
- 196 (1.1%) would have gone to a Walk-in Centre

5.4 The scheme is currently undergoing a refresh and will be re-launched in February 2020.

6. **CQC Update Reports**

6.1 An update was provided in regard to the Contractual Remedial Notices issued to Wells Park Practice and the Queens Road Partnership following the publication of their CQC inspection reports.

7. **Discretionary funding - Inclusion of the SE London Special Allocation Scheme APMS registered list as part of the Sevenfields PCN**

7.1 The Committee was advised that officers had approved a Discretionary payment adjustment of £220.21 to the Network Contract DES payments (‘the Payment’) in favour of Sevenfields PCN, which has agreed to incorporate the new SE London wide Special Allocation Scheme (SAS) APMS contract provider (One Health Lewisham) as a member of its PCN Network.

8. **Date of next meeting**

8.1 The next scheduled meeting of the Primary Care Commissioning Committee held in public is at 9.45am on Tuesday 18th February 2020 at the Civic Suite, Lewisham Town Hall, Catford, London SE6 4RU.

9. **Further information**

9.1 Full meeting papers for the Primary Care Commissioning Committee held on Tuesday 17th December 2019 are available at: [https://www.lewishamccg.nhs.uk/about-us/how-we-work/Meeting%20papers/Lewisham%20PCCC%20combined%20papers%2017.12.19.pdf](https://www.lewishamccg.nhs.uk/about-us/how-we-work/Meeting%20papers/Lewisham%20PCCC%20combined%20papers%2017.12.19.pdf)
Main issues discussed

At the PEEF meeting in December 2019 we discussed progress against three of our Public Engagement priorities (respiratory, diabetes and primary care support and development); we reviewed feedback and actions from our engagement around the NHS Long Term Plan; we had an update on progress from our Public Reference Group and from Healthwatch Lewisham on engagement they have carried out on our behalf and with our providers; we heard about the innovative winter communications and public engagement campaign; and we discussed the NHSE&I Oversight Framework 19/20 which has replaced the Improvement Assessment Framework.

We also discussed work to reduce health inequalities including engagement and involvement in our Equality Delivery Scheme (EDS2) exercise; and engagement case studies for our Annual Equality Report.

Other updates

This report also covers partnership events (including the Big Health Day event for people with a learning disability, Falls event, mental health event); plans to develop a Lewisham Public Engagement Forum following the merger and establishment of the South East London CCG; actions following the review of the Lambeth, Southwark and Lewisham interpreting and translation service; handing over to the new organisation and structures.

Progress against the priorities in the Public Engagement Plan 2019/20

Respiratory

Objective: Engage with and involve local people in developing a new respiratory model of care in Lewisham which better supports and meets their needs.

We received a progress update on the review of the Lung Exercise and Education Programme (LEEP) that we have commissioned Healthwatch Lewisham to carry out on our behalf. The report will be completed early in 2020 and the forum will discuss it further when finalised.

The forum also heard how Public Reference Group members and members of the Breatheeasy group have been involved in activities such as developing plans to pilot the MyCOPD App. Members requested further information on the development of community respiratory hubs.
Diabetes

Objective: To involve local people and community organisations in plans to transform care for people with diabetes.

Plans to transform care for people with diabetes across Bexley, Greenwich and Lewisham include a local public and patient engagement programme to co-develop a new model of care in 2020/21. The forum were pleased to note the excellent pre-engagement work that has already been carried out. This has included the commissioner and senior clinical director presenting and discussing plans with the Public Reference Group (PRG). They have also engaged several times with a subgroup of the PRG for more detailed discussions, to develop PRG members’ knowledge and understanding of the subject and to jointly develop patient outcome measures for Lewisham patients.

An engagement plan for 20/21 is in development. It was noted that equalities should underpin the plan as it is important that the new model helps to reduce inequalities, particularly around access to diagnostics and treatments. The forum requested that the plan is brought to PEEF at either the January or March 2020 meetings.

Primary care support and development

Objective: Support Primary Care Networks (PCNs) to map out their community connections and to engage their communities in ongoing dialogue; Support practices with guidance around public engagement relating to mergers; Engage with the public around primary care developments such as online consultations.

Forum members heard that currently there is variability across SE London with regards to the different CCGs’ roles in supporting primary care to engage with their patients (including involvement with Patient Participation Groups and around changes such as mergers). Different levels of support have also been provided to the new Primary Care Networks to help them engage with patients. A public engagement framework for SE London is being developed which should bring some consistency to this. The framework will be discussed at PEEF in either January or March 2020. Opportunities have been identified for the Lewisham CCG engagement team to support primary care eg through training, sharing knowledge and contacts and commissioners will be discussing these with primary care network leads.

NHS Long Term Plan

Following up on the discussion at the previous PEEF meeting members discussed the main findings from the portfolio of activities and how these can be transferred into a ‘you said, we did/are doing’ summary. This will be discussed with PRG members and will help to ensure that the feedback and actions are fed back in a meaningful way to participants. It will also enable us to ensure that this valuable input from Lewisham residents can be handed over to the new structures within the SE London CCG and the Lewisham Borough Based Board to ensure that our residents’ views are taken forward and not forgotten about.
Healthwatch Lewisham update

Forum members received an overview of recent Healthwatch engagement activities. This is an important way in which we monitor the performance of our providers when it comes to engagement and involvement. We received overviews of an ‘Enter and View’ at the GP Extended Access Service, a review of Lung Exercise and Education Programme (LEEP) and a review of primary care services for people who are homeless. The full reports into each of these will be shared with PEEP members when they are available.

Public Reference Group report

The Forum received a report from the Chairs of the Public Reference Group, summarising their activity since June 2019 (including meetings, events, training and feedback). Members were particularly impressed to note the depth of their work and thanked members for their valuable and meaningful contributions.

Each PRG activity is listed against the engagement ladder and it was pleasing to see that the majority of activities were either classed as ‘involving’, ‘collaborating’, ‘consulting’ or ‘devolving’. Highlights included members who have been actively participating in the development of the Mental Health Provider Alliance, diabetes and equalities work.

It was also pleasing to note that many members attended the Deaf Awareness and introduction to British Sign Language training that we organised to help improve communication with our deaf PRG member.

Their meaningful input was illustrated further by some excellent feedback from commissioners and other people who have held discussions with the PRG.

Forum members agreed the report was an excellent way of demonstrating the impact and influence of the PRG.

Winter campaign

Forum members received an overview of the innovative winter communications and public engagement campaign being led by the Lewisham team across Bexley, Greenwich and Lewisham. We have commissioned one of the UK’s leading specialists in behaviour change communications and nudge theory and the campaign is underway and will run until the end of February 2020. The aim is to:

- Increase the numbers of people aged over 65 who have vaccinations for flu, pneumococcal and shingles (over 70s)
- Increase the numbers of people with long term conditions who have flu vaccinations
- Increase the numbers of children under 11 who have flu vaccinations
• Promote to residents and health and care staff the different ways people can access appropriate care across Bexley, Greenwich and Lewisham
The approach is very evidence-based and so far there has been a great deal of activity to develop and test the materials. This has included:

• A kick off meeting with input from A&E staff, public health, medicines management, commissioning and a practice nurse where we developed a behavioural audit
• A focus group with older people in residential housing
• Two focus groups with local parents
• Qualitative one to one interviews
• COM-B questionnaires (completed by over 200 local residents)
• Google surveys testing the creative concepts

Following these the artwork and messaging for outreach engagement has been developed, tested and tweaked in response to the feedback.

**NHSE&I Oversight Framework 19/20**

The deadline for submission of evidence for the patient and public participation element of the Oversight Framework is 10 February 2020. The engagement team and commissioners are working to ensure that our work is evidenced effectively on our website and we are confident that we can improve on 18/19 where we were rated ‘good’.

**Reducing inequalities**

One of the ways that we monitor the public engagement and involvement of our providers and work with them to reduce inequalities is through the Equality Delivery System, a tool to measure equality performance of NHS organisations.

The forum noted that our Public Reference Group were involved in three stages of this work: selecting the services to be assessed and graded, reviewing the evidence before the grading, and taking part in the grading workshop (with other residents and service users).

The forum were informed of the provisional grades for the three services reviewed:

• Community Specialist Palliative Care (provided by St Christopher’s)
• Core24 Mental Health Liaison Service (provided by Lewisham and Greenwich NHS Trust)
• High Intensity Users Services and Interventions (provided by One Health Lewisham)

We also discussed public engagement case studies to be included in the Public Sector Equality Duty Annual Report. These will include our summer engagement
Other updates

**Lewisham Public Engagement Forum**

In November the Governing Body endorsed the rationale for a Lewisham Public Engagement Forum following the creation of the South East London CCG on 1 April 2020. We have continued to develop plans for the forum and the Governing Body will be asked to approve the Terms of Reference. The new forum will ensure that Lewisham residents retain a voice in the new SE London CCG Governance structures, and equalities continue to be a focus of the engagement activities carried out at all levels (Primary Care Networks, Lewisham, Bexley/Greenwich/Lewisham, SE London). It will also enable more coordination of public engagement and involvement activities across commissioners and the main health and care providers in the borough.

**Partnership events**

I attended the excellent [Big Health Day event](#) for people with a learning disability in October which was led by Lewisham CCG staff in partnership with colleagues from Bexley and Greenwich. The aim was to reduce inequalities for people with a learning disability by providing helpful information about staying healthy and active. It was attended by more than 340 people. I spoke to several participants and feedback was overwhelmingly positive and people were appreciative that such a large scale event had been organised to help meet their health needs. There were a wide range of activities including theatre, dance, a choir, exercise classes, an inflatable colon and 27 different health information stalls.

Also in October we held a successful [Me and my community mental health event](#) in partnership with Lewisham Council, community organisations and our providers. The event was well attended and there were a number of excellent workshops and a marketplace of stalls.

We also participated in a very successful Falls Awareness Day in November which was organised by Lewisham Council and the Falls Service which is run by Lewisham and Greenwich Trust and jointly commissioned by the CCG and the Council. This was attended by over 250 local residents.

**Lambeth, Southwark and Lewisham interpreting and translation service**

The public engagement carried out during the [interpreting and translation service review](#) informed the specification for a new service. A procurement exercise has been completed. I have requested the communications plan for the mobilisation of the new service includes feeding back creatively to the people engaged with (eg by producing information in a range of formats such as a video in British Sign Language).
Handing over PEEF work to the new SE London CCG and the Lewisham Borough Based Board

The Lewisham Public Engagement Forum mentioned above will help to ensure that there is a good handover of public engagement and equalities work to both the SE London CCG and the Lewisham Borough Based Board. To facilitate continuity we will produce a final PEEF report in March 2020 that will include progress against the public engagement objectives 2019/20 and the findings from the activities.
Finance Report M8 2019-20

RESPONSIBLE LEAD: David Maloney, Director of Finance

AUTHOR: Michael Cunningham, Head of Finance

RECOMMENDATIONS:
The Governing Body is asked to note the Finance Report for Month 8 2019/20. The financial position has previously been scrutinised by the Finance & Investment Committee (FIC) on 20th December 2019.

SUMMARY:
The Finance report for Month 8 2019-20 is attached in this report. The headlines are:

- The CCG has profiled a planned ‘technical’ surplus of £1,684k YTD at month 8. This reflects that although the plan for the year is to breakeven, NHSE guidance requires the 0.5% (£2,526k) contingency to be profiled in month 12, and as a consequence a ‘technical’ surplus has been profiled in earlier months, in order to show a breakeven plan for the whole year. This profiling is consistent with the operating plan submission. The CCG is reporting achievement of this ‘technical’ surplus YTD at month 8, and as such is reporting an ‘on plan’ financial position. This position is achieved on a forecast outturn basis by use of balance sheet flexibilities from the previous year of £580k and full use of the contingency £2,526k. This utilisation includes coverage of future NCSO drugs costs risk.

- The CCG is forecasting to meet the annual breakeven target against its control total.

- In relation to acute contracts, an 'actual' position is reported at month 8, based on information received from providers. Since for 2019/20 aligned incentive contracts are in place with the CCGs three main providers, although the reported position is 'on plan,' it will be crucially important during the year to retain sight of the underlying contract position, in order to manage activity and inform future years planning. The CCG is reviewing this underlying position on a monthly basis. The overall acute forecast over spend of £865k (slide 3) relates to non contracted activity and other contracts, the main element relating to London Ambulance Service (LAS).

- Commitments information pertaining to Continuing Healthcare is showing significant cost pressures. At month 8 a forecast outturn over spend of £293k is being reported in relation to adults commissioning, and £300k in relation to children’s commissioning expenditure. Budget review meetings are taking place with the services on a monthly basis. These have resulted in the net risk position on Continuing Healthcare reducing to £250k at month 8 (month 7 £1,000k). In relation to mental health the forecast outturn is an over spend of £237k and this is reported within the Joint Commissioning Adults position shown in the budget summary on slide 3. This reflects an assessment of forecast non contractual activity to the year end and an increase in the forecast cost of complex mental health treatments anticipated to be conducted during quarter 4.

- Running cost budgets are showing a forecast under spend of £719k, and this indicates
that the running cost reduction target of £685k is expected to be achieved. There is a small forecast overspend of £20k relating to corporate programme costs.

- Other reserves and financing shows a forecast under spend of £2,088k (month 7 forecast under spend 1,370k). The movement between months reflects a movement in assumed prescribing No Cheaper Stock Option (NCSO) drugs costs £612k, the equivalent cost of which is now reported in the prescribing outturn, and an immaterial movement in other reserves of £106k. The reserves position continues to include a credit of £580k pertaining to balance sheet flexibilities carried forward from the previous financial year, and full use of contingency £2,526k.

- The use of £2,526k contingency has been approved by the CFO, and similar approval has been given to other CCGs across SEL. It is forecast to be used to support offset of the main forecast over spends which are on acute contracts of £865k, primary care £1,103k, and other Joint Commissioning forecast over spends. The CCG has identified further non recurrent flexibilities of £915k in order to offset remaining risks.

- The CCG is forecasting a small net mitigation position of £28k (month 7 net risk of £324k). This means that the CCG’s assessment of risks and mitigations is in financial balance, and the Governing Body can be assured that the CCG will meet it’s year end control total. This improvement from month 7 to month 8 reflects some risks now becoming part of the forecast outturn and others having been mitigated. This is consistent with a common approach agreed for the 6 SEL CCGs.

- The CCG is continuing to work with other SEL CCGs to collectively manage the financial risks across the SEL Alliance.

**CONSULTATION HISTORY:**
Finance & Investment Committee 20th December 2019.

**PUBLIC ENGAGEMENT**
A report setting out the financial position of the CCG is a standing item for Governing Body meetings.

**HEALTH INEQUALITY DUTY & PUBLIC SECTOR EQUALITY DUTIES:**
The CCG’s financial position supports the delivery of strategic and operational commissioning plans and objectives which include delivering the health inequality and the public sector general equality duties.

**RESPONSIBLE LEAD CONTACT:**
Name: David Maloney
E-Mail: d.maloney@nhs.net

**AUTHOR/S CONTACT:**
Name: Michael Cunningham
Email: mikecunningham@nhs.net
## Financial Performance Duties

<table>
<thead>
<tr>
<th>Duty</th>
<th>YTD Target</th>
<th>YTD Performance</th>
<th>RAG</th>
<th>Annual Target</th>
<th>Forecast Performance</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achieve planned surplus (Expenditure not to exceed income)</td>
<td>£1,684k</td>
<td>£1,684k</td>
<td>✔</td>
<td>£0k</td>
<td>£0k</td>
<td>✔</td>
</tr>
<tr>
<td>Capital resource does not exceed the allowance</td>
<td>£0k</td>
<td>£0k</td>
<td>✔</td>
<td>£0k</td>
<td>£0k</td>
<td>✔</td>
</tr>
<tr>
<td>Revenue resource does not exceed the allowance</td>
<td>£337,598k</td>
<td>£335,914k</td>
<td>✔</td>
<td>£515,429k</td>
<td>£515,429k</td>
<td>✔</td>
</tr>
<tr>
<td>Capital Resource use on specified matters does not exceed the allowance</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Revenue resource use on specified matters does not exceed the allowance</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Revenue administration resource use does not exceed the allowance</td>
<td>£4,463k</td>
<td>£3,984k</td>
<td>✔</td>
<td>£6,696k</td>
<td>£5,977k</td>
<td>✔</td>
</tr>
</tbody>
</table>

**Note:** a red bracket indicates budget overspend
Summary of Financial Position at Month 08

- The CCG has profiled a planned ‘technical’ surplus of £1,684k YTD at month 8. This reflects that although the plan for the year is to breakeven, NHSE guidance requires the 0.5% (£2,526k) contingency to be profiled in month 12, and as a consequence a ‘technical’ surplus has been profiled in earlier months, in order to show a breakeven plan for the whole year. This profiling is consistent with the operating plan submission. The CCG is reporting achievement of this ‘technical’ surplus YTD at month 8, and as such is reporting an ‘on plan’ financial position. This position is achieved on a forecast outturn basis by use of balance sheet flexibilities from the previous year of £580k and full use of the contingency £2,526k. This utilisation includes coverage of future NCSO drugs costs risk.

- The CCG is forecasting to meet the annual breakeven target against its control total.

- In relation to acute contracts, an ‘actual’ position is reported at month 8, based on information received from providers. Since for 2019/20 aligned incentive contracts are in place with the CCGs three main providers, although the reported position is ‘on plan,’ it will be crucially important during the year to retain sight of the underlying contract position, in order to manage activity and inform future years planning. The CCG is reviewing this underlying position on a monthly basis. The overall acute forecast over spend of £865k (slide 3) relates to non contracted activity and other contracts, the main element relating to London Ambulance Service (LAS).

- Commitments information pertaining to Continuing Healthcare is showing significant cost pressures. At month 8 a forecast outturn over spend of £293k is being reported in relation to adults commissioning, and £300k in relation to children’s commissioning expenditure. Budget review meetings are taking place with the services on a monthly basis. These have resulted in the net risk position on Continuing Healthcare reducing to £250k at month 8 (month 7 £1,000k). In relation to mental health the forecast outturn is an over spend of £237k and this is reported within the Joint Commissioning Adults position shown in the budget summary on slide 3. This reflects an assessment of forecast non contractual activity to the year end and an increase in the forecast cost of complex mental health treatments anticipated to be conducted during quarter 4.

- Running cost budgets are showing a forecast under spend of £719k, and this indicates that the running cost reduction target of £685k is expected to be achieved. There is a small forecast overspend of £20k relating to corporate programme costs.

- Other reserves and financing shows a forecast under spend of £2,088k (month 7 forecast under spend 1,370k). The movement between months reflects a movement in assumed prescribing No Cheaper Stock Option (NCSO) drugs costs £612k, the equivalent cost of which is now reported in the prescribing outturn, and an immaterial movement in other reserves of £106k. The reserves position continues to include a credit of £580k pertaining to balance sheet flexibilities carried forward from the previous financial year, and full use of contingency £2,526k.

- The use of £2,526k contingency has been approved by the CFO, and similar approval has been given to other CCGs across SEL. It is forecast to be used to support offset of the main forecast over spends which are on acute contracts of £865k, primary care £1,103k, and other Joint Commissioning forecast over spends. The CCG has identified further non recurrent flexibilities of £915k in order to offset remaining risks.

- The CCG is forecasting a small net mitigation position of £28k (month 7 net risk of £324k). This means that the CCG’s assessment of risks and mitigations is in financial balance, and the Governing Body can be assured that the CCG will meet it’s year end control total. This improvement from month 7 to month 8 reflects some risks now becoming part of the forecast outturn and others having been mitigated. This is consistent with a common approach agreed for the 6 SEL CCGs.

- The CCG is continuing to work with other SEL CCGs to collectively manage the financial risks across the SEL Alliance.
## CCG Budget Summary 2019/20 - Month 08

<table>
<thead>
<tr>
<th>Programme Budget</th>
<th>Annual Budget (£000s)</th>
<th>Variance to Month 08 (£000s)</th>
<th>Forecast Variance (£000s)</th>
<th>End of Year Risk Assessment Variance (£000s)</th>
<th>Slides</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Contracts</td>
<td>262,899</td>
<td>(631)</td>
<td>(865)</td>
<td>(1,173)</td>
<td></td>
</tr>
<tr>
<td>Community Services</td>
<td>35,596</td>
<td>6</td>
<td>11</td>
<td>11</td>
<td>7-8</td>
</tr>
<tr>
<td>Joint Commissioning Adults</td>
<td>89,643</td>
<td>(273)</td>
<td>(530)</td>
<td>(655)</td>
<td>5-6</td>
</tr>
<tr>
<td>Joint Commissioning Children</td>
<td>3,799</td>
<td>(245)</td>
<td>(300)</td>
<td>(425)</td>
<td>5-6</td>
</tr>
<tr>
<td>Primary Care Budgets</td>
<td>83,840</td>
<td>(603)</td>
<td>(1,103)</td>
<td>(1,390)</td>
<td>9-10</td>
</tr>
<tr>
<td>Corporate Budgets - Running Cost</td>
<td>6,696</td>
<td>479</td>
<td>719</td>
<td>719</td>
<td>4, 13</td>
</tr>
<tr>
<td>Corporate Budgets - Programme Costs</td>
<td>1,829</td>
<td>(14)</td>
<td>(20)</td>
<td>(20)</td>
<td>14</td>
</tr>
<tr>
<td>Other, Reserves and Financing</td>
<td>31,127</td>
<td>1,281</td>
<td>2,088</td>
<td>2,961</td>
<td>11-12</td>
</tr>
<tr>
<td><strong>Total Expenditure</strong></td>
<td><strong>515,429</strong></td>
<td>0</td>
<td>0</td>
<td>28</td>
<td></td>
</tr>
<tr>
<td>Planned Surplus</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>Revenue Resource Allocation</strong></td>
<td><strong>515,429</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

*Note: a red bracket indicates budget overspend*
### CCG Running Costs Summary 2019/20 – Month 08

<table>
<thead>
<tr>
<th>Running Costs</th>
<th>Annual Budget (£000s)</th>
<th>Variance to Month 08 (£000s)</th>
<th>Forecast Variance (£000s)</th>
<th>End of Year Risk Assessment Variance (£000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Running costs</td>
<td>6,696</td>
<td>479</td>
<td>719</td>
<td>719</td>
</tr>
<tr>
<td>Month 07 (for comparison)</td>
<td>6,696</td>
<td>421</td>
<td>719</td>
<td>719</td>
</tr>
</tbody>
</table>

**Notes:**
1. The running costs allocation is separate from the Programme budget and should be monitored separately.
2. The CCG has a running cost reduction target of £685k, and the table above shows this target is forecast to be achieved.
3. Further breakdown is provided on slide 13.

*Note: a red bracket indicates budget overspend*
## Client Group Financial Position 2019/20

<table>
<thead>
<tr>
<th>Programme Budget</th>
<th>Annual Budget (£000s)</th>
<th>Variance to Month 08 (£000s)</th>
<th>Forecast Variance (£000s)</th>
<th>End of Year Risk Assessment Variance (£000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Contracts</td>
<td>58,393</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mental Heath - NCAs</td>
<td>3,481</td>
<td>(201)</td>
<td>(302)</td>
<td>0</td>
</tr>
<tr>
<td>Mental Heath - Dementia</td>
<td>1,461</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>IAPT</td>
<td>3,702</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Learning Disabilities</td>
<td>1,368</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Continuing Care - Learning Disabilities</td>
<td>2,855</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Continuing Care - Mental Health</td>
<td>475</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Continuing Care - YPD</td>
<td>5,966</td>
<td>(195)</td>
<td>(293)</td>
<td>(655)</td>
</tr>
<tr>
<td>Continuing Care - Older Adults</td>
<td>4,089</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Continuing Care – Palliative Care</td>
<td>1,097</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Continuing Care - FNC</td>
<td>2,074</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other Adult Client Groups</td>
<td>4,682</td>
<td>43</td>
<td>65</td>
<td>0</td>
</tr>
<tr>
<td>Children Services</td>
<td>3,799</td>
<td>(165)</td>
<td>(300)</td>
<td>(425)</td>
</tr>
<tr>
<td><strong>Total Client Groups</strong></td>
<td><strong>93,442</strong></td>
<td><strong>(518)</strong></td>
<td><strong>(830)</strong></td>
<td><strong>(1,080)</strong></td>
</tr>
<tr>
<td><strong>Month 07 (for comparison)</strong></td>
<td><strong>93,442</strong></td>
<td><strong>(343)</strong></td>
<td><strong>(593)</strong></td>
<td><strong>(1,593)</strong></td>
</tr>
</tbody>
</table>

**Note:** a red bracket indicates budget overspend
Notes on Client Groups Budgets

• The Month 8 position has been based on the latest available data in terms of invoices received and the present patient databases held by the services. The majority of budgets are in line with plan but there is a FOT over spend relating to mental health NCAs £302k, adults joint commissioning of £293k, and £300k relating to children’s joint commissioning, offset by a £65k forecast underspend relating to other adult client groups.

• The end of year risk assessment is currently a FOT overspend of £1,080k. This reflects a forecast over spend of £830k and net risk of £250k (month 7 £1,000k). This improvement in the risk position reflects the outcomes of meetings which are held with the adult and children’s service on a monthly basis to maximise mitigations to the risk position.
## Community 2019-20

<table>
<thead>
<tr>
<th>Programme Budget</th>
<th>Annual Budget (£000s)</th>
<th>Variance to Month 08 (£000s)</th>
<th>Forecast Variance (£000s)</th>
<th>End of Year Risk Assessment Variance (£000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Contract</td>
<td>27,109</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>111/Out of Hours</td>
<td>2,014</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other Community</td>
<td>6,473</td>
<td>6</td>
<td>11</td>
<td>9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>35,596</strong></td>
<td><strong>6</strong></td>
<td><strong>11</strong></td>
<td><strong>9</strong></td>
</tr>
<tr>
<td><strong>Month 07 (for comparison)</strong></td>
<td><strong>35,650</strong></td>
<td><strong>5</strong></td>
<td><strong>9</strong></td>
<td><strong>9</strong></td>
</tr>
</tbody>
</table>

*Note: a red bracket sign indicates budget overspend*
Notes on Community 2019-20

- The Month 8 position has been based on the latest available data in terms of activity and invoices received and other information held by the services. Overall the month 8 YTD and FOT position shows a small underspend against these budgets.

Note: a red bracket indicates budget overspend
### Primary Care Health Services 2019-20

<table>
<thead>
<tr>
<th>Programme Budget</th>
<th>Annual Budget (£000s)</th>
<th>Variance to Month 08 (£000s)</th>
<th>Forecast Variance (£000s)</th>
<th>End of Year Risk Assessment Variance (£000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescribing</td>
<td>35,516</td>
<td>(431)</td>
<td>(838)</td>
<td>(885)</td>
</tr>
<tr>
<td>Primary Care</td>
<td>48,324</td>
<td>(172)</td>
<td>(265)</td>
<td>(505)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>83,840</strong></td>
<td><strong>(603)</strong></td>
<td><strong>(1,103)</strong></td>
<td><strong>(1,390)</strong></td>
</tr>
<tr>
<td><strong>Month 07 (for comparison)</strong></td>
<td><strong>82,233</strong></td>
<td><strong>(482)</strong></td>
<td><strong>(608)</strong></td>
<td><strong>(962)</strong></td>
</tr>
</tbody>
</table>

**Note:** A red bracket indicates budget overspend.
Notes on Primary Care Health Services 2019-20

• The primary care position overall is showing an overspend of £603k YTD and £1,103k FOT. The main drivers of this overspend are prescribing costs derived from the NHS Business Services Authority prescribing data, and the impact of GP at Hand. In relation to prescribing this includes coverage of national cost pressures totalling £1,350k relating to No Cheaper Stock Option drugs and category M drugs.

• There is considerable risk attached to primary care totalling £287k across the whole of primary care.

Note: a red bracket indicates budget overspend
Other Reserves and Financing 2019/20 (1 of 2)

<table>
<thead>
<tr>
<th>Programme Budget</th>
<th>Annual Budget (£000s)</th>
<th>Variance to Month 08 (£000s)</th>
<th>Forecast Variance (£000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Reserve</td>
<td>0</td>
<td>580</td>
<td>(438)</td>
</tr>
<tr>
<td>Contingency (0.5%)</td>
<td>2,526</td>
<td>701</td>
<td>2,526</td>
</tr>
<tr>
<td>Total Uncommitted Reserves</td>
<td>2,526</td>
<td>1,281</td>
<td>2,088</td>
</tr>
<tr>
<td>Committed Reserves</td>
<td>28,601</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total All Reserves</td>
<td>31,127</td>
<td>1,281</td>
<td>2,088</td>
</tr>
<tr>
<td>Month 07 (for comparison)</td>
<td>29,363</td>
<td>956</td>
<td>1,370</td>
</tr>
</tbody>
</table>

*Note: a red bracket indicates budget overspend*
As referenced on slide 2 in the Summary of the Financial Position, Other Reserves and financing shows a forecast under spend of £2,088k (month 7 £1,370k). The movement between months reflects a movement in assumed prescribing No Cheaper Stock Option (NCSO) drugs costs £612k, the equivalent cost of which is now reported in the prescribing outturn, and an immaterial movement in other reserves of £106k. Contingency of £2,526k is forecast to be fully committed as well as £580k of balance sheet flexibilities carried forward from the previous financial year, to offset financial pressures.

- The utilisation of the contingency within the CCGs YTD and forecast outturn position has been approved by the CFO.

- Committed Reserves of £28,601k are largely committed and there is minimal expected favourable variance against these reserves to support programme budgets. The main element of these Committed Reserves relates to the Better Care Fund (BCF) allocations, and a number of other central budget reserves which have not been devolved to programme budgets, or yet utilised to support other CCGs through the SEL risk share arrangements. This is reviewed in detail on a monthly basis.

- Work is continuing as planned to de-risk QIPP and to continue to exert tight budgetary control, in order to restore available mitigations to financial risks.
Corporate Running Costs 2019/20 (Separate Allocation)

- The YTD & FOT position at Month 8 shows under spends of £479k and £719k. The main drivers of these under spends are unfilled staff vacancies, and a number of other uncommitted corporate budgets as planned.

<table>
<thead>
<tr>
<th>Budgets</th>
<th>Annual Budget (£000s)</th>
<th>Variance to Month 08 (£000s)</th>
<th>Forecast Variance (£000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Costs</td>
<td>3,989</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>CSU Recharge</td>
<td>1,444</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>1,263</td>
<td>479</td>
<td>719</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>6,696</strong></td>
<td><strong>479</strong></td>
<td><strong>719</strong></td>
</tr>
<tr>
<td><em>Month 07 (for comparison)</em></td>
<td><strong>6,696</strong></td>
<td><strong>421</strong></td>
<td><strong>719</strong></td>
</tr>
</tbody>
</table>

**Note:** A red bracket indicates budget overspend.
Corporate Programme Costs 2019/20

The YTD position at Month 08 shows an overspend of £14k which is forecast to be an overspend of £20k for the full year. This mainly reflects CHC staffing costs.

<table>
<thead>
<tr>
<th>Budgets</th>
<th>Annual Budget (£000s)</th>
<th>Variance to Month 08 (£000s)</th>
<th>Forecast Variance (£000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Costs</td>
<td>1,478</td>
<td>(112)</td>
<td>(167)</td>
</tr>
<tr>
<td>CSU Recharge</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>351</td>
<td>98</td>
<td>147</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,829</strong></td>
<td><strong>(14)</strong></td>
<td><strong>(20)</strong></td>
</tr>
<tr>
<td><strong>Month 07 (for comparison)</strong></td>
<td><strong>1,829</strong></td>
<td><strong>(12)</strong></td>
<td><strong>(20)</strong></td>
</tr>
</tbody>
</table>

Note: a red bracket indicates budget overspend
As outlined on slide 2 regarding risk, the CCG is reporting a net mitigation position of £28k (month 7 net risk of £324k). This means that the CCG’s assessment of risks and mitigations is in financial balance, and the Governing Body can be assured that the CCG will meet it’s year end control total. This position is achieved through applying the contingency of £2,526k, and identified further non recurrent flexibilities of £915k. The gross risk position before applying these mitigations, is £887k and this is driven by the following key risks;

- Acute Contract Performance: Whilst the CCG has agreed aligned incentive contracts with its three main providers, there remains risk assessed as £308k in relation to other acute contract activity.
- Primary Care £287k, relating to general primary care pressures.
- Continuing Healthcare is also identified as a key risk area with risk assessed as £250k.
- System reform cost risk is £42k.
- The risk assessed position will be reviewed each month. The CCG continues to play a full part in the work to understand and de-risk the overall SEL position.
- The CCG will continue to apply tight budgetary control in order to de-risk the overall financial position.
- The CCG will continue to hold budget meetings with budget holders in order to maintain robust financial disciplines.
The CCGs external auditors recommended inclusion of a Statement of Comprehensive Net Expenditure, and a Statement of Financial Position in its management accounts. The following two tables provide these statements at Nov-19. The Statement of Comprehensive Net Expenditure shows the total income, pay and non-pay costs, as categorised by administrative and programme revenue and costs.

<table>
<thead>
<tr>
<th></th>
<th>2019</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Nov-19</td>
<td>Oct-19</td>
</tr>
<tr>
<td>Other Operating Revenue</td>
<td>(401,000)</td>
<td>(350,875)</td>
</tr>
<tr>
<td>Gross Employee Benefits</td>
<td>2,304,455</td>
<td>1,993,667</td>
</tr>
<tr>
<td>Other Costs</td>
<td>2,081,021</td>
<td>1,841,376</td>
</tr>
<tr>
<td><strong>Administrative Costs Total</strong></td>
<td><strong>3,984,476</strong></td>
<td><strong>3,484,169</strong></td>
</tr>
<tr>
<td>Other Operating Revenue</td>
<td>(2,560,723)</td>
<td>(2,295,569)</td>
</tr>
<tr>
<td>Gross Employee Benefits</td>
<td>938,619</td>
<td>850,389</td>
</tr>
<tr>
<td>Other Costs</td>
<td>333,551,948</td>
<td>287,356,254</td>
</tr>
<tr>
<td><strong>Programme Costs Total</strong></td>
<td><strong>331,929,844</strong></td>
<td><strong>285,911,074</strong></td>
</tr>
<tr>
<td>Other Operating Revenue</td>
<td>(2,961,723)</td>
<td>(2,646,444)</td>
</tr>
<tr>
<td>Gross Employee Benefits</td>
<td>3,243,073</td>
<td>2,844,056</td>
</tr>
<tr>
<td>Other Costs</td>
<td>335,632,969</td>
<td>289,197,630</td>
</tr>
<tr>
<td><strong>Net Operating Costs for the Financial Period Total</strong></td>
<td><strong>335,914,320</strong></td>
<td><strong>289,395,243</strong></td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>335,914,320</strong></td>
<td><strong>289,395,243</strong></td>
</tr>
</tbody>
</table>
## Statement of Financial Position 2019/20

<table>
<thead>
<tr>
<th></th>
<th>Closing Balance</th>
<th></th>
<th>Closing Balance</th>
<th></th>
<th>Closing Balance</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Nov-19</td>
<td>Oct-19</td>
<td>ADJ-19</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intangible Assets</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Property, Plant And Equipment</td>
<td>118,761</td>
<td>122,747</td>
<td>150,643</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-current Assets Total</td>
<td>118,761</td>
<td>122,747</td>
<td>150,643</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cash And Cash Equivalents</td>
<td>77,160</td>
<td>-439,643</td>
<td>5,090</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current Trade And Other Receivables</td>
<td>7,292,019</td>
<td>7,395,237</td>
<td>9,631,550</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current Assets Total</td>
<td>7,369,180</td>
<td>6,955,395</td>
<td>9,636,640</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current Other Liabilities</td>
<td>-9,414,040</td>
<td>-3,969,331</td>
<td>-3,571,419</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current Trade And Other Payables</td>
<td>-42,442,342</td>
<td>-43,405,299</td>
<td>-37,249,261</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provisions</td>
<td>0</td>
<td>56,961</td>
<td>56,961</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current Liabilities Total</td>
<td>-51,856,382</td>
<td>-47,431,591</td>
<td>-40,877,641</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NC Provisions</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Current Liabilities: Total</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grand Total</td>
<td>-44,368,440</td>
<td>-40,353,250</td>
<td>-31,090,358</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### General Fund

<table>
<thead>
<tr>
<th></th>
<th>Closing Balance</th>
<th></th>
<th>Closing Balance</th>
<th></th>
<th>Closing Balance</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>General Fund</td>
<td>44,368,440</td>
<td>40,353,250</td>
<td>31,090,358</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Financed by Taxpayers Equity: Total

<table>
<thead>
<tr>
<th></th>
<th>Closing Balance</th>
<th></th>
<th>Closing Balance</th>
<th></th>
<th>Closing Balance</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Financed by Taxpayers Equity: Total</td>
<td>44,368,440</td>
<td>40,353,250</td>
<td>31,090,358</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Grand Total

<table>
<thead>
<tr>
<th></th>
<th>Closing Balance</th>
<th></th>
<th>Closing Balance</th>
<th></th>
<th>Closing Balance</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Grand Total</td>
<td>44,368,440</td>
<td>40,353,250</td>
<td>31,090,358</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Statement of Financial Position 2019/20

The Net Book value of Property, Plant and Equipment (PPE) is £119k net book value and consists of Information Technology equipment.

Month 08 closing GL balance was £77k. The NHSE cash target (<1.25% of initial cash drawdown/CFF1) was met. The closing bank balance was £169k.

The Current Trade and Other Receivables at the end of November was £7.3 million a decrease of £0.1m compared to October.

The ‘Current Trade and Other Payables’ was £42.4 million, a decrease of £1.0 million compared to October, and ‘Current Other Liabilities’ was £9.4 million an increase of £4.4m compared to October. This increase reflects month 8 allocations received and accrued for, but for which payment has not been made yet to providers.
Under the Better Payments Practice Code (BPPC), CCGs are expected to pay 95% of all creditors within 30 days of the receipt of invoices. This is measured both in terms of the total value of invoices and the number of invoices by count. The CCG continues to show high performance against target.
Aged Debtors (Receivables) 2019/20

<table>
<thead>
<tr>
<th>Customer Account Group</th>
<th>Outstanding Debt 1-30 Days £</th>
<th>Outstanding Debt 31-60 Days £</th>
<th>Outstanding Debt 61-90 Days £</th>
<th>Outstanding Debt 91-120 Days £</th>
<th>Outstanding Debt 121-180 Days £</th>
<th>Outstanding Debt 181+ Days £</th>
<th>Total Outstanding Debt £</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS</td>
<td>105,470.34</td>
<td>79,750.00</td>
<td>140,000.00</td>
<td>57,938.50</td>
<td>-</td>
<td>91,750.68</td>
<td>474,909.52</td>
</tr>
<tr>
<td>Non-NHS</td>
<td>162,162.44</td>
<td>4,231.08</td>
<td>70,000.00</td>
<td>-</td>
<td>570.00</td>
<td>25,189.17</td>
<td>262,152.69</td>
</tr>
<tr>
<td>Total</td>
<td>267,632.78</td>
<td>83,981.08</td>
<td>210,000.00</td>
<td>57,938.50</td>
<td>570.00</td>
<td>116,939.85</td>
<td>737,062.21</td>
</tr>
<tr>
<td></td>
<td>36%</td>
<td>11%</td>
<td>20%</td>
<td>8%</td>
<td>0%</td>
<td>16%</td>
<td>100%</td>
</tr>
</tbody>
</table>

- The value of the non-NHS 181+ relates to invoices outstanding from Lewisham Council. The value of the NHS 181+ invoices relates to a number of NHS organisations. The remaining outstanding debt is not considered to be at material risk.
Recommendations

1. To note the financial position against budgets for the ‘Programme Budgets’ and the ‘Running Costs’ as at end of November 2019.

2. To note the main forecast over spends in relation to acute services £865k, primary care £1,103k, joint commissioning £830k, and the CFO approved forecast use of contingency £2,526k to offset these forecast overspends. Also to note is the need to utilise balance sheet flexibilities of £580k from the previous year to support a forecast on plan position for the year.

3. To note specifically the net risk assessed forecast position for the CCG’s overall financial position which shows a net mitigation of £28k (previous month net risk of £324k). This is after applying identified further non recurrent mitigations of £915k. This means that the CCG’s assessment of risks and mitigations is in financial balance, and therefore the Governing Body is asked to note, and be assured that the CCG will meet it’s year end control total.

4. To note the drivers to the risk assessment mentioned above. To note the reported position reflects a need to continue to apply robust budgetary control and fully deliver QIPP.

5. To note the collaborative approach being implemented across SEL CCGs to applying budgetary control and de-risking the financial position.

David Maloney
Director of Finance
NHS Lewisham CCG
9 January 2020
Governing Body meeting on 9th January 2020

Report from the Chair of the Integrated Governance Committee (IGC)
Date of Meeting Reported: 28th November 2019

Author: Martin Wilkinson, Chair

1. Quality
The Quality reports at the November meeting were focused on mental health.

IGC heard that the CQRG at SLaM had received strong assurance of the quality of care provided by the Home Treatment Team. The team has been accredited by the Royal College of Psychiatrists and supports a number of patients in the community who would otherwise need to be in hospital. The team has recently implemented a rapid response service and is operational 24/7.

SLaM has implemented Perfect Ward software to enhance its clinical audit programme. There is a wide range of clinical audits carried out across the Trust using the new software package and the CCG can be assured that members of staff across SLaM are clinical audit quality improvement processes.

SLaM continues to be challenged in meeting its own targets to reduce the levels of aggression and violence in its acute wards. There are some known issues driving an increase including the provision of new services such as Peak Ward and the new CAMHS PICU. The Trust and CCGs will review violence and aggression in depth at the January CQRG. It is thought that the Trust has been successful in reducing levels of violence but because violence and aggression incidents are counted together it is difficult to show this. Work is underway to disaggregate the data.

There have been marked reductions across the Trust in the use of restraint. This is particularly notable in Lambeth where strong leadership and collective values are thought to have driven a culture change. The Trust is using collaborative approaches to share the learning from Lambeth to other Boroughs.

2. NHS Constitutional Standards and Plan Requirements for Non Acute Areas
The key exceptions are:

- **Children and Young People Mental Health Transformation**
  Children and Young People’s Mental Health Transformation standard has been provided by NHS Digital Data based on the Mental Health Minimum Data Set (MHSDS) and a local collection for providers. The forecast for the full 19/20, based on previous year patterns. As at August 19-20 MHSDS only reporting resulted in a 19-20 forecast of 24.4% of likely prevalence and
with the local data collection to September 19 this was 29.0%. Both of these are a short of the 34% standard. South East London’s local data forecast is close to the standard at 33.9%.

Lewisham has made use of the CYP MH Intensive Support Team in January 2019 and is working through the recommendations. There are improvements to data quality of providers required.

Lewisham has been awarded funding to be a Mental Health in Schools Trailblazer Site for Children and Young People early support and this will enable them to access appropriate services when required. While funding begins in Q4, this is going to be largely training and setting up relationships with schools rather than delivering substantial new treatments.

- **Personal Health Budgets**, although increasing, have not met the plan set. This has been identified as an Issue for 19-20 for the CCG. Q1 and Q2 plans for 19-20 have been set close to the Q4 outturn. A post across South East London CCGs has been recruited to identify further cohorts of patients to increase Personal Health Budgets to the Quarter 4 requirement of three times the current level. Q2 19-20 just submitted is still under the Q2 plan and NHS Lewisham CCG is now in the lowest quartile of all CCGs for this indicator for Personal Health Bugets per 100,000 Registered Population.

The Interim CHC Manager has recruited two assessors to begin in November 19 and the two assessors have been appointed for start in November 19. This will enable packages of care at home is "re-launched". Discussions continue with Imosphere (Resource Allocation Provider) and the new Version of the Referral Advice Service full functionality will be initiated with the new assessors.

The Mental Health Commissioning team has met twice with the Croydon CCG PHB Lead to discuss the development of a cross borough protocol and plan to be used across SLaM areas.

Discussions continue with parents of children in receipt of CHC regarding PHB.

A South East London Lead for Personal Health Budgets has been appointed to expand PHBs with an initial focus on wheelchairs users and mental health Section 117 patients. A report on the process and impact of wheelchair users being included will be made at the January 2020 Integrated Governance Committee.

- **Continuing Healthcare**
  In Quarter 2 19-20 the proportion of Assessments in Acute Settings decreased to 27% which is still above the less than 15% requirement. Furthermore, the timeliness of assessments at 65% percentage of assessments in 28 days against the 80% standard.
The acute settings relates to the closure of sapphire ward and given the focus on reducing Long Length of Stay (see later in this report) this may struggle to recover this year.

However, with the two new assessors beginning in November 19, they will focus on reducing any over 28 day backlog and re-establishing the 28 day standard. Given the backlog, recovery may take until the end of the financial year with performance being delivered in Q1 20/21.

Indicators with more positive assurance are:

- Improving Access to Psychological Therapies Indicators are all being met except just being under the quarterly access rate of 4.7% against the required rate of 4.75% for the quarter running to August 19.
- Similarly, the level of dementia diagnosis has met the required rate in every month of 18-19.
- Out of Area Placements for Lewisham people have already halved from the December baseline at 350 for the quarter finishing in August 19.
- Both Eating Disorders for Children have been met for the rolling year Q318-19 to Q2 19-20. The breach on Urgent Referrals have dropped out of the rolling annual numbers.
- The e referral assessment is running at 92% of referrals for 19-20 year to August 19. This is better than the NHS England & Improvement standard of 80% and is better than the England and London performance who were at 82.5% and 85.2% respectively for August 19.

The CCG dashboard has been supplemented with the 19-20 Primary Care Requirements

- The CCG is meeting both the number of practices signed up to the online appointment system and the plan for percentage of extended access appointments booked by patients. The extended access stands at 76% in September 19, which delivers the 75% standard against the standard.
- There is more work to get all 6 tests (e.g. BMI, blood glucose) completed for those people on Serious Mental Illness Registers. The CCG is at 30.3% for Q2 19-20 against a plan for 19-20 of 60% (50% from primary care and 10% from acute care). There is an incentive to improve this in 19-20, but it may improve towards the end of 19-20 as the indicator is for a rolling year.

3. CCG National Oversight Framework – Previously CCG Improvement and Assurance Framework

The IGC considered a presentation on National Oversight Framework for Q1 19-20 published in October 19 (Previously the CCG Improvement and Assurance Framework).

Overall the CCG has 10 indicators in the top quartile of all CCGs and 14 indicators in the bottom quartile, 11 of which are from Better Care Indicators.
In terms of improvements they are focused on mental health with the Psychological Therapies Recovery Rate returning to the middle quartile from lowest quartile last time and Out of Area Placements which has returned to middle quartile from the lowest quartile last time. With no indicators in the lowest quartile for mental health, it is likely that mental health will be rated Good as it was in 18-19.

However, there are a series of declines in the quartiles viz:

- Personal Health Budgets per 100000 population – while the CCG numbers are stable, other CCGs are improving quickly. For recovery see Section 2 above.
- Provision of High Quality Primary Care has dropped into the lowest quartile. This indicator which relates to CQC ratings for practices. This drop is due to the inadequate rating for two practices in Q1. Since then one practice has merged and the other is being CQC reviewed soon.
- Delayed Transfers of Care, which has moved from top quartile to middle quartile as it has risen recently.

There are two new 18 weeks measures – the size of the incomplete waiting list and 52 week waiting patients on the incomplete list. In addition to 18 weeks Incomplete Standard, Lewisham patients are consistently in the lowest quartile of all CCGs for all three indicators.

In terms of indicators that are Red Amber Green rated, there have been no changes for Q1 19-20. Finance and Leadership continued to be Green Rated. However, a new indicator for Primary Care prescribing of low value drugs identified by NHS England has been rated as Amber. Medicines management is aware of this new rating and is working with practices and patients to reduce prescribing of these items.

**4. A&E and Urgent Care CCG and Local Authority plans and issues.**

While these issues are managed via the South East London IB&P, there is a deep dive planned for the next South East London IB&P. The IGC considered the issues locally. The performance at Lewisham and Greenwich Trust – Q1 and Q2 19-20 have been the lowest Quarters over the last 5 years, including winter. However, the performance is not very different to the national picture, which is similarly challenged.

Emergency (non-elective) admissions have increased by 5.3% year on year, but non elective bed days have reduced by 5.8%, which has led to SLA Monitoring costs being very close to plan. However, A&E attendances are up 14.7% year on year and more work to understand the reason for this increase is planned.

The major QIPP reductions for non-elective admissions for 19-20 are

- UTIs
- Respiratory
- Care homes.
There is an incentive scheme for winter to reduce over 21 day LOS patients. While these are slightly down year on year, Lewisham is higher than benchmarks for this cohort, so this will require continued focus.

Following Committee discussion it was agreed to request that the deep dive consider:

- how could front door screening at Emergency Departmets EDs be improved and how can best practice be implemented across SEL
- have all alternatives been considered to improve patient flow and the way EDs work for patients who have already been seen by a GP
- can Coordinate My Care (CMC) be provided in EDs to enable front door streamers and clinicians further down the pathway to access patient records for complex patients.

The SEL IBP discussion led by the Director of the ICDT agreed there is a need to implement a standardised service based on best practice and highlighted that the A&E delivery board is being re-launched and one of its areas of focus will be to consider and share best practice. All providers acknowledge that streaming needs to improve and agreed there is a need to provide clinicians with easier access to patient records.

5. Corporate Objectives

Also reported to the committee was the CCG’s progress against its corporate objectives for quarters 1 and 2. The committee was assured on the progress being made on most of the objectives, though with further action required for end of life care.
1. Principal role of the committee

SEL CCGs agreed that a pan-SEL Committee should be established to monitor the delivery of provider organisations' statutory and delivery responsibilities to ensure agreed actions / mitigations are followed through; to discuss and agree appropriate remediation; and to pro-actively identify and address declining performance indicators, ensuring deterioration is managed rapidly. The current scope of the SEL Committee includes oversight of and coordination of the SEL CCGs’ response to:

- The delivery of the SEL CCG control total and as such the individual annual CCG control totals and both individual and collective mitigations where this is off plan.
- The sustainable delivery of all acute NHS Constitution standards and Transforming Care performance.
- Matters of clinical quality and safety related to the areas of business within the SEL Committee’s scope.

The committee will additionally act to identify and pro-actively manage key strategic and operational risks relating to the areas deemed as in-scope. The committee approves the SEL BAF for all areas within its scope.

2. Report Enclosures

Annex 1 South East London Board Assurance Framework – November / December 2019


Annex 3 SEL Finance Report – M7 2019

Final approved minutes of the SEL IG&P Committee 1st November 2019 are contained in the items for information.
3. Recommendations to the Governing Body for decision / approval / action

The Governing Body should formally note the recommendation made by the committee and undertake the proposed action(s):

<table>
<thead>
<tr>
<th>No.</th>
<th>Agenda item</th>
<th>Recommendation for decision / approval / action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>South East London BAF; Assurance and Finance Reports</td>
<td>CCGs should use this month’s SEL BAF; performance assurance and finance reports for January 2020 Governing Body meetings. These were shared with CCG governance leads on 29 November 2019. These reports are appended to this report. CCGs should ensure there was no duplication of acute or SEL-wide financial risks on local CCG BAFs.</td>
</tr>
</tbody>
</table>

4. Action taken under delegation: Governing Body to note for assurance

The Governing Body should note the below items, where a prime committee undertook an action under the authority delegated to it by the CCG Governing Body:

<table>
<thead>
<tr>
<th>No.</th>
<th>Agenda item</th>
<th>Action taken under delegation by the committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>SEL CCG Performance Assurance Report</td>
<td>The committee received the monthly Assurance Performance report and focused assurance discussions on the current position on RTT (18 and 52 weeks and PTL size); cancer pathways and waiting times and diagnostic waiting times. The committee noted that the number of 52-week waiters at both LGT and GSTT were below or in-line with trajectory. KCH remains the most challenged provider and the trust continues to report a large and static number of over 40-week waiters. On diagnostics waiting times, the committee welcomed the improved performance and noted that local providers are meeting their recovery trajectories and are expected to be compliant with the national target by year-end. The committee was provided with an update on the winter assurance process and noted that SEL had achieved a green or amber rating on all indicators except length of stay, which was a particular challenge at LGT. The committee heard that a significant number of funding bids had been submitted with the aim of supporting improvement in diagnostics, elective care and A&amp;E performance. The committee then discussed and agreed the following levels of assurance in respect of acute performance and performance against transforming care targets:</td>
</tr>
<tr>
<td>No.</td>
<td>Agenda item</td>
<td>Action taken under delegation by the committee</td>
</tr>
<tr>
<td>-----</td>
<td>------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Notwithstanding the plans in place to recover performance ahead of year end, the committee is not fully assured on the feasibility in achieving the performance standards or recovery trajectories by year-end for all acute performance standards.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• The committee is assured that existing recovery actions along with the actions suggested by the committee are appropriate and comprehensive.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• The committee is assured that SEL CCGs are delivering the recovery actions / contributions asked of them.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• The committee noted the trusts’ commitment to deliver their action plans but registered a position of not being assured given their recent track-record and future ability to successfully achieve the planned impact from these actions.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• The committee is assured that processes and controls are in place to mitigate the risks to the quality and safety of patient care due to the current performance position and delivery of agreed recovery actions and this will be re-visited next month based on the outcome of the quality and safety deep-dive.</td>
</tr>
<tr>
<td></td>
<td>ii.  Deep dive: urgent and emergency care</td>
<td>Members of the ICDT team presented a deep-dive paper and responded to questions and comments raised by committee members before and during the meeting. The paper looked at the current performance position, challenges and issues and the winter planning process related to acute services, 111 and LAS.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The committee learned that a national clinical review was being undertaken on the constitutional standards which is considering the introduction of new performance measures for A&amp;E, 111 and ambulance services.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The committee heard that the difficulty in accurately predicting demand and supply and securing sufficient workforce were the major issues. They discussed approaches to improving performance which included enhancing front door streaming at EDs and upgrading IT and patient record systems. The committee also discussed ways of balancing the demand and capacity of acute services by improving the use of GP hub capacity at weekends and increasing the use of community pharmacies.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The committee noted the report and the responses to questions asked by committee members before the meeting.</td>
</tr>
</tbody>
</table>
### iii. SEL CCGs Finance Update – M7 19/20

- The committee noted that SEL CCGs are currently forecasting delivery of plans at year end across the board and at present this plays-in contingency to cover unexpected cost-pressures associated with category M drugs; non-local contracts and primary care allocation adjustments.

- The committee noted that SEL CCGs are currently forecasting achievement of their control totals at year end. The committee discussed the detail of the forecast position and considered necessary actions planned in Q4 to achieve a balance. They examined the implications of different scenarios on the use of CCG reserves and risk-sharing arrangements.

- The committee noted that financial performance year-to-date; the net risk position YTD; and the delivery of QIPP were all better this year when compared to the same period in 18/19.

- The committee noted the current financial position and registered its assurance that an adequate approach to remediation is in place to mitigate identified risks. It agreed to receive a further update on risk mitigation at its next meeting.


- The committee endorsed the BAF for November 2019 and accepted the proposed risk scores for each risk included.

---

### Further items of business highlighted by the committee for the Governing Body to discuss

In addition to the above actions and items of business concluded under delegation, the Governing Body should note and discuss the following:

<table>
<thead>
<tr>
<th>No.</th>
<th>Agenda item</th>
<th>Item to note or discuss further</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No further items arising at the committee meeting.</td>
<td></td>
</tr>
</tbody>
</table>
Introduction and recommendations to the committee

- This SEL Integrated Governance & Performance Committee Board Assurance Framework is designed to support the SEL IG&P committee to provide oversight of the strategic risks that relate to all areas deemed to be within the committee’s scope as defined in the terms of reference endorsed by CCG governing bodies in November 2018 and revised in May 2019.

- The over-arching purpose of the BAF is to enable the SEL IG&P committee, CCG governing bodies and any delegated local committees to be kept suitably informed of significant risks or issues and their associated mitigation plans.

- The SEL IG&P should use this document to ensure that all risks and issues related to in-scope areas are included in the BAF; that the risk-score is accurate for each; that mitigation actions are robust and achievable; that gaps are clearly identified and that assurances are noted for the purpose of verification.

- In undertaking these activities, the committee should follow the South East London CCGs Integrated Governance & Performance Committee Risk Management Framework, which sets out in detail the agreed approach to the management of risk.

- This BAF will be made available to CCGs on a monthly basis and it is proposed that this document is made available together with the CCG BAF as part of CCG Governing Body papers.

The SEL IG&P Committee is asked to undertake the following:

1. Agree that each risk / issue is accurately described.

2. Review and agree the risk / issue score for each risk included in the BAF.

3. Review the mitigations in place and confirm that these represent a comprehensive approach to taking action to reduce both the likelihood and potential impact of each risk. Note any gaps in risk mitigations.

4. Note any additional oversight arrangements to be set-up to provide additional levels of assurance for particular risks / issues.
### Summary of SEL IG&P Committee BAF risks

The below table presents a summary of the risks related to all SEL IG&P in-scope areas. The current risk rating the is headline risk-rating post mitigations being applied. Full details of the status of each risk are provided on the following pages.

<table>
<thead>
<tr>
<th>Risk / issue reference</th>
<th>Risk / issue description</th>
<th>Current rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>SEL-01</td>
<td>STP for the 62 day referral-to-treatment cancer standard</td>
<td>16</td>
</tr>
<tr>
<td>SEL-02</td>
<td>STP trusts are not able to achieve their trajectories for timely access to emergency services as measured by the 4 hour A&amp;E target</td>
<td>16</td>
</tr>
<tr>
<td>SEL-03</td>
<td>STP acute trusts do not meet their monthly improvement trajectories to clear long waiters by the end of Q3</td>
<td>12</td>
</tr>
<tr>
<td>SEL-04</td>
<td>STP acute trusts are not able to achieve their trajectories for the number of patients on elective waiting lists</td>
<td>9</td>
</tr>
<tr>
<td>SEL-05</td>
<td>STP acute trusts are not able to achieve their improvement trajectories for the access to planned care as measured by the 18 week standard</td>
<td>12</td>
</tr>
<tr>
<td>SEL-06</td>
<td>STP acute trusts do not achieve the monthly improvement trajectories for the access to timely diagnostics as measured by the standard for diagnostic access</td>
<td>12</td>
</tr>
<tr>
<td>SEL-07</td>
<td>Financial risk around LAS contract for 2019/20</td>
<td>6</td>
</tr>
<tr>
<td>SEL-08</td>
<td>The TCP will not achieve the BRS target by March 2020.</td>
<td>9</td>
</tr>
<tr>
<td>SEL-10</td>
<td>Ability to reduce running costs to target by 31 March 2020.</td>
<td>8</td>
</tr>
<tr>
<td>SEL-11</td>
<td>Activity related expenditure is greater than budget leading to inability to deliver the SEL and CCG control totals and financial duties.</td>
<td>12</td>
</tr>
</tbody>
</table>

**Note:** risk SEL-09 was closed at the SEL IG&P Committee in May 2019

**Note:** risks relate to period April 2019 to March 2020 unless otherwise stated
## Risk 1: Cancer 62-day pathways

<table>
<thead>
<tr>
<th>Ref</th>
<th>Description and key drivers</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Initial Risk Score</th>
<th>On-going controls (pan-SEL) and frequency</th>
<th>Residual Score</th>
<th>Assurances</th>
</tr>
</thead>
</table>
| SEL-01 | The risk that the STP acute trusts do not achieve the monthly improvement trajectory for the access to cancer treatment as measured by the standard for 62 days from GP referral to treatment. | 5          | 4      | 20                | - Trusts have developed actions plans to deliver their 62 day trajectory including a SEL Recovery Plan specifically focusing on shared pathway actions and performance.  
- Monthly performance meetings with acute trusts – focus on internal trust performance and actions relating to them. This covers areas not picked up by the 62 day Leadership Group (see below)  
- Monthly System Leadership Group – 62 day leadership meeting with a focus on the shared pathway actions and performance. Performance has been under trajectory year to date with the majority of breaches in Prostate cancer pathways. Because of this the system is changing the 62 day leadership group format to have a continued deep dive on Prostate as well as Lung cancer pathways to help mitigate the risk.  
- The SCCD (Shared Care Cancer Delivery Team) the operational arm of the ACN – virtual team including commissioners to progress actions on a day to day basis.  
- Monthly ACN Steering group.  
- Monthly Members Board – a trust CEO, COO board which will facilitate trust level escalation where plans are not being progressed. | 4 x 4 = 16 | - The SEL recovery plan with SMART actions and senior level action owners, KPIs to measure delivery of the actions, and a risk and issues log, all of which will be updated monthly.  
- Trust performance reports for performance meetings; monthly performance against trajectory by trust and CCG; minutes of performance meetings.  
- Trust performance report to 62 day leadership group showing progress updates for actions by trust and tumour type; minutes and action log from 62 day leadership meeting.  
- SEL sector dashboards showing information such as median wait to first outpatient, diagnostic turnaround time.  
- Project summary highlight reports with RAG ratings.  
- Papers and minutes of the monthly Members Board  
- Deep dive template for urology, lung and gynaecology which monitors performance against the timed pathways. |

### Forward-view on this risk / issue:

- Employment of additional staff to create a specialist cancer management sector workforce, including senior operational management, junior operational management and patient navigator roles for relevant trusts sites. The aim of this recruitment is to deliver sector commitments in relation to improving performance and delivering timed pathways, and also provide support and buddying/mentoring for trust staff in more general roles involving cancer. £1.2million of transformation funding has been assigned to this new team.
- 360 degree review of ACN Members Board to assure that the governance is fit for purpose. / Governance review with ICDT and Cancer Alliance Director.
- Additional SEL diagnostic fund agreed for CT and MRI across SEL.
- Expansion of RADC agreed through transformation funding.

### Baseline risk scores: April 2019

- Initial risk score 3 x 4 = 12; Residual risk score 3 x 4 = 12

### Last month’s scores: Oct 2019

- Initial risk score 5 x 4 = 20; Residual risk score 4 x 4 = 16

### Change in risk scores

- No change in risk score
**Risk 2: A&E 4-hour target**

<table>
<thead>
<tr>
<th>Ref</th>
<th>Description and key drivers</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Initial Risk Score</th>
<th>On-going controls (pan-SEL) and frequency</th>
<th>Residual Score</th>
<th>Assurances</th>
</tr>
</thead>
</table>
| SEL-02 | The risk that the STP acute trusts are not able to achieve their trajectories for timely access to emergency services as measured by the 4 hour target. In 2019/20, trust trajectories are to deliver improvements in the timeliness of access rather than achieve the national standard of 95%, which is reflective of the challenges faced by all acute providers in SEL. | 5 | 4 | 20 | • Trusts have developed action plans to deliver their trajectory for improving performance against the 4 hour standard. These plans are linked to the SEL strategy for improvement in non-elective services and have been updated to reflect plans to reduce ambulance handover delays.  
• Monthly performance meeting with acute trusts reviews progress against the trust specific trajectories.  
• ICDT team members attend internal trust meetings relating to A&E performance delivery.  
• Monthly A&E delivery boards at both local and SEL-level provide oversight on system delivery for non-elective services.  
• UEC System meeting with each site and respective CCG, community and primary care colleagues to assess current performance against plan and establish if any further system-wide support or external support is required to ensure delivery of the trajectory.  
• A key theme arising from the UEC system meetings, was the ability to affect cultural and therefore operational changes in limited timescales | 4 x 4 = 16 | • The individual trusts recovery plans with SMART actions and senior level action owners; KPIs to measure delivery of the actions; risk and issues log – all of which will be updated monthly.  
• Trust performance reports for performance meetings; monthly performance against trajectory by trust; monthly reports against KPIs and risk and issues; minutes of performance meetings.  
• Trust reports to their internal A&E delivery meetings.  
• Monthly reports, papers and minutes of A&E delivery boards.  
• AEDB Winter Assurance assessment and AEDB winter plans |

**Baseline risk scores: April 2019**  
Initial risk score 3 x 4 = 12; Residual risk score 3 x 4 = 12

**Last month’s scores: Oct 2019**  
Initial risk score 5 x 4 = 20; Residual risk score 4 x 4 = 16

**Change in risk scores**  
No change in risk score

**Forward-view on this risk / issue:**

**Further comments and additional planned mitigations to be enacted:**

- Discussions are planned at the ABC Board and SEL UEC Board about actions that can be taken to address cultural change.
- LGT and KCH are now part of the national escalation programme and are reporting against their immediate recovery actions as part of this process.
## Risk 3: 52-week waiters

<table>
<thead>
<tr>
<th>Ref</th>
<th>Risk description and key drivers</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Initial Risk Score</th>
<th>On-going risk controls (pan-SEL) and frequency</th>
<th>Residual Risk Score</th>
<th>Assurances</th>
</tr>
</thead>
</table>
| SEL-03 | The risk that the STP acute trusts do not meet their monthly improvement trajectories to clear long waiters by the end of Q3.  
Long waiters are defined as any patient referred by a GP who has been waiting more than 52 weeks and is still waiting at month end.  
The count of long waiters is a monthly census.                                                                 | 5          | 4      | 20                 | • Trusts have developed actions plans to deliver their reduction trajectory for long waiters.  
• Monthly performance meeting with acute trusts will review progress against the trust specific trajectories.  
• ICDT team members attend additional internal RTT meetings at GSTT and KCH.  
• A ‘Star Chamber’ process has been implemented at GSTT for the GMS directorate which has an emerging and increasing number of long waiters over the last few months. Feedback on this process is shared through the monthly performance meeting. | 3 x 4 = 12   | • GSTT and KCH recovery plans with SMART actions and senior level action owners; KPIs to measure delivery of the actions; and a risk and issues log, all of which will be updated monthly.  
• Trust performance reports for performance meetings; monthly performance against trajectory by trust; monthly reports against KPIs and risk and issues; minutes of performance meetings.  
• Detailed monthly report on current and prospective long waiters at KCH.  
• Clinical Harm Reviews are undertaken for long waiting patients and updates are given at the relevant CQRG meetings.  
• Daily reporting on long waiters has been introduced at GSTT, and is already in place for KCH, to be able to provide a real time assessment of performance, |

### Forward-view on this risk / issue:

- In light of unsuccessful outsourcing attempts, KCH are expanding the offer of choice to patients waiting more than 26 weeks for orthopaedic cases
- GSTT are exploring insourcing as well as current plans for outsourcing patients to reduce waits in challenged specialties.

### Baseline risk scores: April 2019

- Initial risk score: 3 x 4 = 12
- Residual risk score: 3 x 4 = 12

### Last month’s scores: Oct 2019

- Initial risk score: 5 x 4 = 20
- Residual risk score: 3 x 4 = 12

### Change in risk scores

- No change in risk score
### Risk 4: RTT waiting list (PTL) size

**Ref** | **Risk description and key drivers** | **Likelihood** | **Impact** | **Initial Risk Score** | **On-going risk controls (pan-SEL) and frequency** | **Residual Risk Score** | **Assurances** |
---|---|---|---|---|---|---|---|
SEL-04 | The risk that the STP acute trusts are not able to achieve their trajectories for the number of patients on the waiting list (patient tracking list or ‘PTL’ size). | 3 | 4 | 12 | • Trusts have developed actions plans to deliver their trajectory for managing their RTT performance and RTT 18 week performance. • Monthly performance meeting with acute trusts will review progress against the trust specific trajectories. | 3 x 3 | • The individual trusts recovery plans with SMART actions and senior level action owners, KPIs to measure delivery of the actions, and a risk and issues log, all of which will be updated monthly. However, the ICDT have requested LGT to further develop their performance improvement plans, to ensure that key challenges are fully addressed. • Trust performance reports for performance meetings; monthly performance against trajectory by trust; monthly reports against KPIs and risks and issues; minutes of performance meetings. • Further refinement for the KCH and LGT performance improvement plans |

**Baseline risk scores: April 2019** | Initial risk score \(3 \times 4 = 12\); Residual risk score \(3 \times 4 = 12\) |

**Last month’s scores: Oct 2019** | Initial risk score \(3 \times 4 = 12\); Residual risk score \(3 \times 3 = 9\) |

**Change in risk scores** | No change in risk score |

**Forward-view on this risk / issue:**

*No further comments or planned mitigations*
## Risk 5: Achievement of 18-week RTT standard

### Baseline risk scores: April 2019
Initial risk score 3 x 3 = 9; Residual risk score 3 x 3 = 9

### Last month’s scores: Oct 2019
Initial risk score 4 x 3 = 12; Residual risk score 4 x 3 = 12

### Change in risk scores
No change in risk score

<table>
<thead>
<tr>
<th>Ref</th>
<th>Description and key drivers</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Initial Score</th>
<th>On-going controls (pan-SEL) and frequency</th>
<th>Residual Score</th>
<th>Assurances</th>
</tr>
</thead>
</table>
| SEL-05 | The risk that the STP acute trusts are not able to achieve their improvement trajectories for the access to planned care as measured by the 18 week standard for patients being referred by a GP for treatment. | 4 | 3 | 12 | • Trusts have developed actions plans to deliver their trajectory for managing their RTT performance.  
• Monthly performance meeting with acute trusts will review progress against the trust specific trajectories.  
• ICDT team members attend additional internal RTT meetings at GSTT and KCH. | 4 x 3 = 12 | • The individual trusts recovery plans with SMART actions and senior level action owners, KPIs to measure delivery of the actions, and a risk and issues log, all of which will be updated monthly.  
• Trust performance reports for performance meetings; monthly performance against trajectory by trust; monthly reports against KPIs and risk and issues; minutes of performance meetings.  
• Further refinement for the LGT performance improvement plan. |

### Forward-view on this risk / issue:

**Further comments and additional planned mitigations to be enacted:**

No further comments or planned mitigations
Risk 6: Access to diagnostics

<table>
<thead>
<tr>
<th>Ref</th>
<th>Description and key drivers</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Initial Score</th>
<th>On-going controls (pan-SEL) and frequency</th>
<th>Residual Score</th>
<th>Assurances</th>
</tr>
</thead>
</table>
| SEL-06 | The risk that the STP acute trusts do not achieve the monthly improvement trajectories for the access to timely diagnostics as measured by the standard for diagnostic access. The diagnostic standard assesses a basket of diagnostic tests against the requirement that collectively no more than 1% of patients should be waiting more than 6 weeks at the end of each month. | 5          | 4      | 20            | • Trusts have developed actions plans to deliver their diagnostic trajectory.  
• Monthly performance meeting with acute trusts will review progress against the trust specific trajectories.  
• Additional meetings are being held with PRUH site lead to oversee the delivery of the PRUH trajectory.  
• A Star Chamber process has been implemented at GSTT for the GMS directorate which has an emerging and increasing number of long waiters in endoscopy over the last few months. Feedback on this process is shared through the monthly performance meeting. | 3 x 4 = 12   | • The individual trusts recovery plans with SMART actions and senior level action owners, KPIs to measure delivery of the actions, and a risk and issues log, all of which will be updated monthly.  
• Trust performance reports for performance meetings; monthly performance against trajectory by trust; monthly reports against KPIs and risk and issues; minutes of performance meetings.  
• ICDT now takes part in the weekly endoscopy oversight meetings at KCH and are meeting with KCH to review demand and capacity model. |

Forward-view on this risk / issue:

• GSTT have identified additional clinical and physical capacity for a number of diagnostic services including non-obstetric ultrasound, MRI (outsourcing to Queen Mary’s Sidcup) and echocardiography. Additional capacity has also been identified for endoscopy including options for insourcing, outsourcing and new clinical pathways for challenged areas.

• KCH are undergoing a thorough retrospective and prospective clinical harm review process for patients awaiting endoscopy, or those have received a cancer diagnosis in the last 12 months. To note that KCH delivered and continue to deliver the 2ww target for endoscopy referrals, and their non compliant diagnostic position is driven by non-2ww referrals.

• SEL Endoscopy Task and Finish group established.

Further comments and additional planned mitigations to be enacted:
## Risk 7: Financial risk around LAS contract for 19/20

### Description and key drivers

The Pan-London LAS 999 contract remains unsigned, but is in the final stages of completion and anticipated to be signed shortly.

The financial impact of this revised contract agreement is £2.791m more than budget, which was set in line with the original heads of terms agreement. The agreement is now set on the basis of a block with no reopener.

This agreement, across London, is based on in-year activity variation against plan. SEL activity variation is 4.2% over plan which is in line with the London average.

Within SEL this cost pressure is being split evenly across all CCGs, as agreed, and is factored into the latest reported position. The pressure is being funded from CCG contingency reserves.

### Change in risk scores

<table>
<thead>
<tr>
<th>Ref</th>
<th>Description and key drivers</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Initial Risk Score</th>
<th>On-going controls (pan-SEL) and frequency</th>
<th>Residual Score</th>
<th>Assurances</th>
</tr>
</thead>
<tbody>
<tr>
<td>SEL-07</td>
<td>The Pan-London LAS 999 contract remains unsigned, but is in the final stages of completion and anticipated to be signed shortly. The financial impact of this revised contract agreement is £2.791m more than budget, which was set in line with the original heads of terms agreement. The agreement is now set on the basis of a block with no reopener. This agreement, across London, is based on in-year activity variation against plan. SEL activity variation is 4.2% over plan which is in line with the London average. Within SEL this cost pressure is being split evenly across all CCGs, as agreed, and is factored into the latest reported position. The pressure is being funded from CCG contingency reserves.</td>
<td>3</td>
<td>2</td>
<td>6</td>
<td>• Pan-London CFOs have been in continual contact with NWL LAS Commissioning team to negotiate the new offer to LAS. All STPs fully aware of the financial risks associated with the new potential contract. • Proposed that POMs are implemented on a bimonthly basis to ensure that there is sufficient oversight of the deliverables at a CEO/AO/regulator level. LAS have requested NEL and SEL join the POM to have one commissioning/regulator meeting which will ensure further system wide ownership of the IUC 111/999 agenda. The first POM to be held on the 28th of November.</td>
<td>3 x 2 = 6</td>
<td>SEL Exec has been kept appraised of the contract and on-going discussions by the SEL ICDT. Updates have also been provided via the SEL Finance Planning and Delivery Committee; as well as the SEL LAS Demand Management Group. Updates also provided to CFOs and Heads of Finance via the monthly financial reporting process and associated meetings.</td>
</tr>
</tbody>
</table>

### Baseline risk scores: April 2019

- Initial risk score 4 x 3 = 12
- Residual risk score 3 x 4 = 12

### Last month’s scores: Oct 2019

- Initial risk score 5 x 4 = 20
- Residual risk score 4 x 4 = 16

### Change in risk scores

Risk score has reduced from October as the cost pressure associated with the year-end settlement has been factored in to CCG financial positions. Therefore the ‘impact’ level has been reduced given it’s already realised. Residual risk relates to the contract not yet being formally signed but it is anticipated to be completed shortly.

### Forward-view on this risk / issue:

Further comments and additional planned mitigations to be enacted:

20/21 planning will need to be set in line with Pan-London discussions and approach set by the NWL LAS commissioning team. Given the additional financial risk in 19/20 and the significant level of investment made, this needs increased focus going forward.
## Risk 8: SEL Transforming Care BRS target 2019/20

<table>
<thead>
<tr>
<th>Ref</th>
<th>Risk description and key drivers</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Initial Risk Score</th>
<th>On-going risk controls (pan-SEL) and frequency</th>
<th>Residual Risk Score</th>
<th>Risk Assurances</th>
</tr>
</thead>
<tbody>
<tr>
<td>SEL-08</td>
<td>The risk is that the TCP will not achieve the agreed revised a target of 64 agreed by NHSE/I based on local demographics and complexities with the current inpatients.</td>
<td>4</td>
<td>4</td>
<td>16</td>
<td>Weekly Programme meeting with SROs (Neil Kennett-Brown and Fiona Connolly) for risk and issues escalations. TCP PMO fortnightly risk and issue review and actions Monthly inpatient surgery to review case management and ensuring that patients can return to the community as soon as clinically appropriate. Monthly TCP Operational and Strategy board meetings with health and social care stakeholders including the forum and specialised commissioning. CCG governing bodies, SEL Executives and DASS to be updated regularly throughout 2019-20.</td>
<td>3x3 = 9</td>
<td>Monthly assurance meetings with NHS England. Monthly reporting to SEL IG&amp;P</td>
</tr>
</tbody>
</table>

### Forward-view on this risk / issue:

- Established additional programme management and case management resource with a focus on actions to improve discharge processes, admissions management and building capacity in the community to reduce of length of stay.
- Building capacity in the community by the establishment of Autism Support Services across South East London and new intensive community support for Lewisham, Bexley, Bromley and Greenwich and expansion of Lambeth Without Walls services to ensure that more people are cared for in the community.
- Mobilising additional positive behavioural support training offered to family carers of people with learning disabilities and autism who exhibit behaviours that challenge to prevent admissions.
- Established enhanced data analysis to inform decision making, with regard to patient care and required targeted support to understand the current service provision locally for the transforming care cohort.
- Development of accommodation models for the cohort in collaboration with DASS, to support complex cases.
- **NEW** - Deep dive review of patients by expected discharges dates to identify opportunities for discharge planning.
- **NEW** - Implementation of a standardised Dynamic Support Registers (DSR) template and operational process in each borough.

### Change in risk scores

In August the team reviewed and revised the current likelihood and impact of this risk:

**Baseline risk scores: April 2019**
- Initial risk score $4 \times 4 = 16$; Residual risk score $2 \times 5 = 10$

**Last month’s scores: Oct 2019**
- Initial risk score $4 \times 4 = 16$; Residual risk score $3 \times 3 = 9$
### Risk 10: Delivery of CCG running cost reduction

<table>
<thead>
<tr>
<th>Ref</th>
<th>Risk description and key drivers</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Initial Risk Score</th>
<th>On-going risk controls (pan-SEL) and frequency</th>
<th>Residual Risk Score</th>
<th>Risk Assurances</th>
</tr>
</thead>
</table>
| SEL-10 | Risk that CCGs will not achieve the running costs reduction target by 31 March 2020. Actions include the review of CCG functions, structures, governance and future model. | 3 | 4 | 12 | • Budgets have been set net of the required running cost reduction and all CCGs are in the process of finalising plans to deliver this saving in 2019-20.  
• CCG financial governance in place and overseen by governing bodies and delegated committees (where relevant), SELCA Executive and SEL IG&P.  
• Recruitment controls are in place across SEL CCGs panel made up of AO, CFO and Director of System Reform | 2 x 4 = 8 | Monthly reporting to SEL IG&P. CCG governing bodies to be updated by CFO / SELCA finance team / DoFs in April and regularly throughout 2019-20. |

### Further CCG-specific risk controls in place:

#### Further CCG-specific actions

- All CCGs are reporting FOT that is either on or under plan.

### Forward-view on this risk / issue:

#### Further comments and additional planned mitigations to be enacted:

No further comments or planned mitigations
## Risk 11: Delivery of SEL and individual CCG control totals in 2019/20

### Baseline risk scores: April 2019
- Initial risk score: $3 \times 5 = 15$
- Residual risk score: $3 \times 5 = 15$

### Last month’s scores: Oct 2019
- Initial risk score: $3 \times 5 = 15$
- Residual risk score: $3 \times 5 = 15$

### Change in risk scores
- No change since April 2019

<table>
<thead>
<tr>
<th>Ref</th>
<th>Risk description and key drivers</th>
<th>Likelihood</th>
<th>Impact</th>
<th>Initial Risk Score</th>
<th>On-going risk controls (pan-SEL) and frequency</th>
<th>Residual Risk Score</th>
<th>Risk Assurances</th>
</tr>
</thead>
<tbody>
<tr>
<td>SEL-11</td>
<td>Risk that expenditure in 19/20 is greater than plan/budget leading to: 1. inability to deliver the SEL CCG collective and/or individual CCG control totals in 2019/20. 2. inability to deliver Individual CCG CTs and financial duties</td>
<td>3</td>
<td>4</td>
<td>12</td>
<td>• CCG financial governance in place and overseen by governing bodies and committees, SELCA Executive and SEL IG&amp;P. • SEL risk-share arrangement refreshed for 2019-20 and approved through required CCG governance in early autumn. • CFO/AO led CCG specific and SEL-wide monthly finance &amp; QIPP assurance meetings in place for improved scrutiny assurance.</td>
<td>$3 \times 4 = 12$</td>
<td>Monthly financial review meetings with NHS England Monthly reporting to SEL IG&amp;P CCG governing bodies updated by CFO / SELCA finance team / DoFs in April and regularly throughout 2019-20. Block contract agreed for SEL providers 0.5% general contingency in CCG plans</td>
</tr>
</tbody>
</table>

### Further CCG-specific risk controls in place:

### Further CCG-led actions

**Bexley:** The CCG continues to be the highest risk CCG within SEL due to the £0.7m of unidentified savings. This is an improvement of £0.9m compared to M06 and following assurance meetings during October the CCG is developing plans to reduce the level of Unidentified savings and will provide an update through the M08 Finance reporting.

### Forward-view on this risk / issue:

**Further comments and additional planned mitigations to be enacted:**
- At this point in the year we are still forecasting to achieve the control total positions across SEL CCGs. However the finance report sets out in more detail a gross financial risk of £16.2m to the control total across SEL and a net risk of £8.1m. Additional mitigations are being implemented over the course of M07 and M08 to reduce the run rate and mitigate the net risk position.
South East London CCGs
Integrated Governance & Performance Committee
Performance Assurance Report
November 2019
This pack summarises the south east London performance position for all areas agreed as in-scope for the SEL Integrated Governance and Performance Committee:

- **Summary: Updates on work with CCGs to deliver ICDT recommendations**  
  Page 3

- **Referral-to-treatment waiting time standard (PTL; 52 and 18 week waits)**  
  Page 5

- **A&E 4 hour standard**  
  Page 12

- **London Ambulance Service performance**  
  Page 15

- **NHS 111 performance**  
  Page 17

- **Cancer waiting time standards**  
  Page 21

- **Diagnostic waiting time standard**  
  Page 24

- **Transforming Care Programme**  
  Page 27

Please note: the RAG rating of monthly performance positions are **against the national standard** rather than local recovery planned trajectories.
RTT PTL

- CCGs will need to fully engage in the planned care transformation agenda, including use of RAS’s, Advice & Guidance and Consultant Connect, to ensure referrals to secondary care are optimised and the improvements experienced in 18/19 are sustained into 19/20. A resource pack has been circulated to CCG leads for Planned and Primary Care which contains a range of materials they can use to promote services such as VisualDx, Consultant Connect and PhotSAF to primary care.

- CCGs should ensure that referrers are aware of the challenged specialties at local trusts, particularly at KCH and that at the point of referral this is taken into account. To continue to be highlighted in GP newsletters and on practice visits.

- Within the resource packs, example Primary Care dashboards have been included. CCGs should ensure that practice packs include key metrics including referral rates, use of A&G/Consultant Connect and the proportion of referrals bypassing mandated pathways (e.g. Ophthalmology referrals bypassing the optometrist triage service). Consideration should be given to how to present this information to practices and through which forums (PCNs, Locality meetings, practice visits etc).

- Joint work with BGL CCGs on promotional material for RASs including patient leaflets, practice packs and guideline preparation.

RTT 52 week wait

- The ICDT hold a monthly briefing with CCGs covering key performance issues to ensure that CCGs are aware of challenged specialties. CCGs should consequently ensure that referrers are aware of the challenged specialties at local trusts, and that at the point of referral this is taken into account and continue to highlight in their respective GP newsletters and on practice visits.

RTT 18 week

- CCGs should ensure that referrers are aware of the challenged specialties at local trusts, and at the point of referral this is taken into account. To continue to be highlighted in GP newsletters and on practice visits.

- CCGs will need to fully engage in the planned care transformation agenda, including use of RAS’s, Advice & Guidance and Consultant Connect, to ensure referrals to secondary care are optimised and the improvements experienced in 18/19 are sustained into 19/20.

A&E and urgent care

- The ICDT along with the STP support the SEL UEC Board and local AEDBs. The need for the following areas to be taken forward have been highlighted in these fora:
  - Ensure equitable access to out of hospital services, including for patients not in the host hospital site
  - Provision of admission prevention services / appropriate referrals to ED
  - Support for timely discharge and associated reduction in LLOS (>21 days)
### Summary: Updates on work with CCGs to deliver ICDT recommendations (2 of 2)

#### LAS
- SEL CCGs to continue to develop ACPs to allow for direct referrals from the 999 Clinical Hub and 999 crews.

#### 111
- The ICDT has confirmed with CCGs the need to work with GP Federations to provide more appointments slots Monday through Friday for the 111 IUC service.

#### Cancer waiting times – 62 day
CCGs should be leading cancer locality meetings (with support from the SEL Cancer Alliance), with particular focus on:
- stratified follow-up – to facilitate appropriate patients being managed in a non acute setting,
- ensuring 2ww referrals are in line with agreed process e.g. full patient workup, appropriate documentation with referral, patients aware they are on a 2ww pathway etc,
- working with providers to ensure that eRS is fit for purpose and support their referrals.
- Improving uptake and roll out of FIT
- Improve uptake of cancer screening

#### Diagnostic waiting times
- CCGs to be aware of the prolonged waits for endoscopy services at PRUH & GSTT.
- CCGs should highlight to GPs that referrals to endoscopy services should be flagged as urgent only when appropriate to do so. This recommendation applies to referrals for specialties where endoscopy is a standard part of the pathway.
## RTT: performance headlines and month-on-month trend

### 18 weeks RTT Incomplete pathway - % of patients waiting for 18 weeks or less (92%) - September 2019

<table>
<thead>
<tr>
<th>Plan trajectory</th>
<th>Bexley</th>
<th>Bromley</th>
<th>Greenwich</th>
<th>Lambeth</th>
<th>Lewisham</th>
<th>Southwark</th>
<th>SEL CCGs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned</td>
<td>85.5</td>
<td>82.9</td>
<td>85.6</td>
<td>86.3</td>
<td>85.1</td>
<td>85.7</td>
<td>-</td>
</tr>
<tr>
<td>Current</td>
<td>81.8</td>
<td>83.4</td>
<td>83.1</td>
<td>84.1</td>
<td>82.0</td>
<td>82.7</td>
<td>82.9</td>
</tr>
<tr>
<td>SPC position</td>
<td>Below lower limits</td>
<td>Within limits</td>
<td>Below lower limits</td>
<td>Within limits</td>
<td>Below lower limits</td>
<td>Within limits</td>
<td>-</td>
</tr>
</tbody>
</table>

### Number of patients on waiting list (PTL) – September 2019

<table>
<thead>
<tr>
<th>Plan trajectory</th>
<th>Bexley</th>
<th>Bromley</th>
<th>Greenwich</th>
<th>Lambeth</th>
<th>Lewisham</th>
<th>Southwark</th>
<th>SEL CCGs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned</td>
<td>19,303</td>
<td>30,718</td>
<td>22,890</td>
<td>29,602</td>
<td>30,115</td>
<td>26,084</td>
<td>-</td>
</tr>
<tr>
<td>Current</td>
<td>20,824</td>
<td>30,679</td>
<td>24,673</td>
<td>28,013</td>
<td>30,918</td>
<td>24,803</td>
<td>159,910</td>
</tr>
</tbody>
</table>

### Number of patients on waiting list (PTL) over 52 weeks - September 2019

<table>
<thead>
<tr>
<th>Plan trajectory</th>
<th>Bexley</th>
<th>Bromley</th>
<th>Greenwich</th>
<th>Lambeth</th>
<th>Lewisham</th>
<th>Southwark</th>
<th>SEL CCGs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td>8</td>
<td>3</td>
<td>11</td>
<td>-</td>
</tr>
<tr>
<td>Current</td>
<td>39</td>
<td>19</td>
<td>21</td>
<td>50</td>
<td>29</td>
<td>62</td>
<td>220</td>
</tr>
</tbody>
</table>

### Key

- **Performance position**
  - Not achieving national standard
  - Achieving national standard
- **Current month SPC position**
  - Outside of SPC process limit (good performance)
  - Outside of SPC process limit (poor performance)
  - Within SPC limits (within expected levels of variation)

- **Worst performer**
- **Best performer**
### RTT PTL: summary of current position

<table>
<thead>
<tr>
<th>Summary of current south east London performance position</th>
<th>Main drivers of current performance position</th>
<th>High impact actions currently in place to address performance variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The LGT trajectory forecasts a reduction in PTL size in 2019/20. In September the Trust are above trajectory and therefore didn’t perform as well as expected.</td>
<td>• The extent to which trusts are able to achieve their PTL trajectory is linked to the success of CCGs in optimising referrals and implementing the planned care strategies for 19/20.</td>
<td>• All Trusts performance improvement plans have been agreed between commissioners and providers, with SMART actions and senior level action owners, KPIs to measure delivery of the actions, and a risk and issues log, all of which will be updated monthly.</td>
</tr>
<tr>
<td>• The KCH trajectory forecasts a reduction in PTL size in 2019/20. The Trust continue to perform better than trajectory with the September position below trajectory.</td>
<td>• GSTT: Focus of trust is on delivering the 18 week performance trajectory rather than reduction in PTL size.</td>
<td>• Monthly performance meetings are in place with acute trusts to review progress against the trust specific trajectories.</td>
</tr>
<tr>
<td>• The GSTT trajectory plans for an increase in overall PTL size, however, for September their PTL was lower than planned and therefore performed better than their September trajectory.</td>
<td>• For both KCH and LGT a reduction in their PTL size is forecast with a small improvement in performance against the 92% standard.</td>
<td>• All Trust plans include a significant element relating to strengthening governance and processes, supporting RTT delivery.</td>
</tr>
</tbody>
</table>

### Impact or potential impact of the current performance position on the quality of care and mitigation actions in place

- If the Trust PTLs increase it can become harder to manage from an operational perspective. The ICDT are attending KCH, GSTT & LGT internal RTT meetings to gain assurance of operation grip.

### Known equality or health inequality issues related to this standard

- No known equality issues known related to this standard. Trusts have measures in place to ensure that all the organisation’s obligations under equality, diversity and human rights legislation are complied with.
## RTT PTL: monthly update

### What has changed since last month?
- GSTT saw an increase in PTL size between August and September. KCH and LGT had a reduction in PTL size.
- LGT PTL size is larger than expected due to validation resources being diverted to a specific review of data quality.
- Both GSTT and KCH achieved the September trajectory.

### New actions taken in the last month
- ICDT undertook a review of the revised RTT performance improvement plan for LGT and agreed further developments for inclusion into the next iteration.
- LGT has commissioned an external agency to perform a detailed validation of their complete PTL.

### Proposed actions in the next quarter
- ICDT to review output of the LGT data quality report.

### SEL BAF risk

<table>
<thead>
<tr>
<th>Reference</th>
<th>Current risk rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>SEL-04</td>
<td>3 x 3 = 9 (medium risk)</td>
</tr>
</tbody>
</table>

### Update on work with CCGs to deliver ICDT recommendations

- CCGs will need to fully engage in the planned care transformation agenda, including use of RAS’s, Advice & Guidance and Consultant Connect, to ensure referrals to secondary care are optimised and the improvements experienced in 18/19 are sustained into 19/20. A resource pack has been circulated to CCG leads for Planned and Primary Care which contains a range of materials they can use to promote services such as VisualDx, Consultant Connect and PhotSAF to primary care.
- CCGs should ensure that referrers are aware of the challenged specialties at local trusts, particularly at KCH and that at the point of referral this is taken into account. To continue to be highlighted in GP newsletters and on practice visits.
- Within the resource packs, example Primary Care dashboards have been included. CCGs should ensure that practice packs include key metrics including referral rates, use of A&G/Consultant Connect and the proportion of referrals bypassing mandated pathways (e.g. Ophthalmology referrals bypassing the optometrist triage service). Consideration should be given to how to present this information to practices and through which forums (PCNs, Locality meetings, practice visits etc)
- Joint work with BGL CCGs on promotional material for RASs including patient leaflets, practice packs and guideline preparation.
Summary of current south east London performance position | Main drivers of current performance position | High impact actions currently in place to address performance variance
--- | --- | ---
- There are more long waiters than expected across the sector, none of the Trusts met their August trajectory. | - At KCH the main specialties with long waiters are trauma & orthopaedics (71% of long waiters) and general surgery. KCH long waiter specialties are likely to have a wide spread impact on SEL CCGs, with data for 19/20 showing Lambeth, Bexley and Southwark CCGs having more long waiting patients, and Bromley, Lewisham and Greenwich CCGs having long waiters at the trust but in slightly lower numbers.  
- For GSTT the main drivers remain Upper GI, Colorectal & Gastroenterology with some issues in tertiary services e.g. cleft.  
- LGT identified a small number of long waiting patients through their review of data quality and validation. These are present in a number of specialties (T&O, General Surgery and Paediatric Ophthalmology) which have been reported in the September position. | - All performance improvement plans agreed between commissioners and providers with SMART actions and senior level action owners, KPIs to measure delivery of the actions, and a risk and issues log, all of which will be updated monthly:  
- Monthly performance meetings are in place with acute trusts to review progress against the trust specific trajectories and ICDT team members attend additional internal RTT meetings at GSTT.  
- KCH continue to work in identify options for orthopaedic capacity including extending the date range of patients offered treatment at SWLEOC.  
- GSTT has put additional clinical and managerial support into the GMS directorate (Upper GI / Colorectal).  
- ICDT has established monthly meetings with KCH to review RTT performance improvement plans in detail prior to the monthly performance meetings.  
- Weekly updates on real time long waiter positions are shared with NHSI.  
- LGT clinical review of all long waiting patients following validation work.  

Impact or potential impact of the current performance position on the quality of care and mitigation actions in place

- Clinical Harm Reviews are undertaken for long waiting patients and updates are given at the relevant CQRG meetings.

Known equality or health inequality issues related to this standard

- No known equality issues known related to this standard. Trusts have measures in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.
### RTT 52 week wait: monthly update

<table>
<thead>
<tr>
<th>What has changed since last month?</th>
<th>New actions taken in the last month</th>
<th>Proposed actions in the next quarter</th>
<th>SEL BAF risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>• KCH are expecting an increase in the number of long waiters for October and will therefore continue to be above trajectory.</td>
<td>• ICDT undertook a review of the revised RTT performance improvement plan for LGT and agreed further developments for inclusion into the next iteration.</td>
<td>• ICDT continues working with regional office to ensure any external support is fully utilised.</td>
<td></td>
</tr>
<tr>
<td>• October pre-validated performance for GSTT reporting a decrease in the number of long waiters and will be below trajectory.</td>
<td></td>
<td>• ICDT working with GSTT as part of national review of long waiters.</td>
<td></td>
</tr>
<tr>
<td>• LGT are expecting to have 5/6 long waiters in October and will not meet trajectory which is zero.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SEL BAF Reference:**
- SEL-03

**Current risk rating:**
- $3 \times 4 = 12$ (medium risk)

### Update on work with CCGs to deliver ICDT recommendations

- The ICDT hold a monthly briefing with CCGs covering key performance issues to ensure that CCGS are aware of challenged specialties. CCGs should consequently ensure that referrers are aware of the challenged specialties at local trusts, and that at the point of referral this is taken into account and continue to highlight in their respective GP newsletters and on practice visits.
### RTT 18 week: summary of current position

<table>
<thead>
<tr>
<th>Summary of current south east London performance position</th>
<th>Main drivers of current performance position</th>
<th>High impact actions currently in place to address performance variance</th>
</tr>
</thead>
</table>
| • All three Trusts are below their September trajectories. GSTT and KCH saw a small improvement compared to last month and LGT saw a slight deterioration. | • The extent to which trusts are able to achieve their PTL trajectory is linked to the success of CCGs in optimising referrals and implementing the planned care strategies for 19/20.  
• GSTT: Focus of trust is on delivering the 18 week performance trajectory rather than reduction in PTL size.  
• For both KCH and LGT a reduction in their PTL size is forecast with a small improvement in performance against the 92% standard. | • All Trusts have recovery plans with SMART actions and senior level action owners, KPIs to measure delivery of the actions, and a risk and issues log, all of which will be updated monthly:  
• Monthly performance meeting with acute trusts are in place to review progress against the trust specific trajectories and ICDT team members attend additional internal RTT meetings at GSTT and KCH.  
• All Trust plans include a significant element relating to strengthening governance and processes, supporting RTT delivery.  
• All Trusts implementation of the acute trust aspects of the planned care strategy, including promoting Advice and Guidance, implementing Referral Assessment Services and enhanced clinical triage; transformation of outpatient processes and optimising on site theatre capacity and increasing off site capacity. |

### Impact or potential impact of the current performance position on the quality of care and mitigation actions in place

• Patients are potentially experiencing longer waits for routine treatment than would be expected, provider Trusts have identified actions to address challenged specialties within their RTT performance improvement plans. The plans will be monitored via the monthly performance meetings.

### Known equality or health inequality issues related to this standard

• No known equality issues known related to this standard. Trusts have measures in place to ensure that all the organisation’s obligations under equality, diversity and human rights legislation are complied with.
## RTT 18 week: monthly update

<table>
<thead>
<tr>
<th>What has changed since last month?</th>
<th>New actions taken in the last month</th>
<th>Proposed actions in the next quarter</th>
<th>SEL BAF risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>• GSTT and KCH saw a small improvement compared to last month and LGT saw a slight deterioration.</td>
<td>• ICDT undertook a review of the revised RTT performance improvement plan for LGT and agreed further developments for inclusion into the next iteration.</td>
<td>• ICDT continues working with regional office to ensure any external support is fully utilised.</td>
<td><strong>SEL BAF Reference:</strong>&lt;br&gt;• SEL-05&lt;br&gt;<strong>Current risk rating:</strong>&lt;br&gt;• $3 \times 4 = 12$ (medium risk)</td>
</tr>
</tbody>
</table>

### Update on work with CCGs to deliver ICDT recommendations

- CCGs should ensure that referrers are aware of the challenged specialties at local trusts, and at the point of referral this is taken into account. To continue to be highlighted in GP newsletters and on practice visits.
- CCGs will need to fully engage in the planned care transformation agenda, including use of RAS’s, Advice & Guidance and Consultant Connect, to ensure referrals to secondary care are optimised and the improvements experienced in 18/19 are sustained into 19/20.
# A&E and urgent care: performance headlines and month-on-month trend

<table>
<thead>
<tr>
<th></th>
<th>GSTT</th>
<th>KCH</th>
<th>LGT</th>
<th>SEL Acute*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A&amp;E 4 hour waits - 95% of patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&amp;E department – October 2019</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Planned trajectory</td>
<td>90.0</td>
<td>86.6</td>
<td>91.3</td>
<td>-</td>
</tr>
<tr>
<td>Current month</td>
<td>84.8%</td>
<td>72.2%</td>
<td>83.8%</td>
<td>83.2%</td>
</tr>
<tr>
<td>SPC position</td>
<td>Within limits</td>
<td>Within limits</td>
<td>Within limits</td>
<td>-</td>
</tr>
</tbody>
</table>

### Key

- **Performance position**
  - Not achieving national standard
  - Achieving national standard

- **Current month SPC position (compared to performance since April 2017)**
  - Outside of SPC process limit (good performance)
  - Outside of SPC process limit (poor performance)
  - Within SPC limits (within expected levels of variation)

*Includes activity at Beckenham Beacon UCC*
### A&E and urgent care: summary of current position

#### Summary of current south east London performance position

- GSTT, KCH and LGT’s trajectories show slight improvement during 19/20 but does not meet the national standard.
- Performance at each Trust has been below trajectory for each month this year.

#### Main drivers of current performance position

- A mismatch between demand and capacity in both physical and staffing resource:
  - Increases in acuity leading to increased rates of admission
  - Continuing pressure from patients presenting in ED with serious mental health issues
  - Challenges with patient flow, within the EDs, from EDs to ward areas and in timely discharge from hospital
  - The variability in SEL of available appropriate alternative pathways e.g. to support streaming at the front door, admission avoidance or in and out of hospital services.

#### High impact actions currently in place to address performance variance

- All trusts have developed performance improvement plans to deliver their trajectory for improving performance against the 4 hour standard and link to the SEL strategy for improvement in non-elective services:
  - KCH have established performance improvement work streams on both sites which are focused on improving flow in the emergency department and acute assessment, improving site management and improving length of stay and discharge processes on wards.
  - The LGT performance improvement plan focus on the end to end pathway and includes developing a new clinical model and site reconfiguration to drive improved flow and performance.
  - GSTT actions are focused on addressing three elements - LAS Handover and RAT, throughput, and discharge and transfer. In addition, there are projects related to the Urgent Care Centre, looking at assessment, capacity and the environment. The final focus is staffing demand, with both a clinical and administrative focus.
  - In addition to their performance improvement plans both LGT and KCH have produced immediate recovery actions as part of the national process in response to enhanced scrutiny from the national team.

Monthly performance meetings with acute trusts are in place to review progress against the trust specific trajectories and ICDT Team members attend internal trust meetings relating to A&E performance delivery as well as multi agency A&E Delivery Board meeting.

---

### Impact or potential impact of the current performance position on the quality of care and mitigation actions in place

- Quality implications relating to sub optimal ED performance is a scheduled discussion at the three Trust CQRG meetings. Specific concerns/cases will be raised directly with the Trusts via the quality alert systems.

### Known equality or health inequality issues related to this standard

- No known equality issues known related to this standard. Trusts have measures in place to ensure that all the organisation’s obligations under equality, diversity and human rights legislation are complied with.
**A&E and urgent care: monthly update**

<table>
<thead>
<tr>
<th>What has changed since last month?</th>
<th>New actions taken in the last month</th>
<th>Proposed actions in the next quarter</th>
<th>SEL BAF risk</th>
</tr>
</thead>
</table>
| • GSTT, KCH and LGT did not meet the A&E trajectory in October.  
• Performance in October improved compared to September for all three Trusts. | • ICDT have coordinated capital bids to support Acute Trusts and the wider system during Winter.  
• ICDT produced analysis of Long Length of Stay for presentation at SEL UEC Board including details of the Discharge Patient Tracking List. | • ICDT to ensure implementation of any successful capital bids.  
• ICDT will participate in the upcoming SEL Winter workshop and will work with Acute providers to embed learning with respective sites.  
• ICDT will review revised Emergency Pathway work plan’s to ensure all key actions are captured and progress is being monitored. | **SEL BAF Reference:**  
• SEL-02  
**Current risk rating:**  
• $4 \times 4 = 16$ (high risk) |

---

### Update on work with CCGs to deliver ICDT recommendations

1. The ICDT along with the STP support the SEL UEC Board and local AEDBs. The need for the following areas to be taken forward have been highlighted in these fora:
   - Ensure equitable access to out of hospital services, including for patients not in the host hospital site
   - Provision of admission prevention services / appropriate referrals to ED
   - Support for timely discharge and associated reduction in LLOS (>21 days)
### LAS: activity and performance headlines

#### Definitions

- **Category 1**
  - Life Threatening: A time critical life threatening event requiring immediate intervention or resuscitation.

- **Category 2**
  - Emergency: Potentially serious conditions that may require rapid assessment and urgent on-scene intervention and/or urgent transport.

- **Category 3**
  - An urgent problem (not immediately life threatening) that needs treatment to relieve suffering and transport or assessment and management at the scene with referral where needed within a clinically appropriate timeframe.

- **Category 4**
  - Problems that are less urgent but require assessment and possibly transport within a clinically appropriate timeframe.

---

#### CCG delivery against ambulance response indicators – M1 - 7 (YTD)

<table>
<thead>
<tr>
<th>Category</th>
<th>Mean Target</th>
<th>Actual 1</th>
<th>Actual 2</th>
<th>Actual 3</th>
<th>Actual 4</th>
<th>Actual 5</th>
<th>Actual 6</th>
<th>Actual 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 1 Mean</td>
<td>00:07:09</td>
<td>00:06:43</td>
<td>00:06:26</td>
<td>00:06:13</td>
<td>00:06:32</td>
<td>00:06:20</td>
<td>00:06:31</td>
<td></td>
</tr>
<tr>
<td>Category 1 90th centile Target</td>
<td>00:11:25</td>
<td>00:11:18</td>
<td>00:10:42</td>
<td>00:10:19</td>
<td>00:10:52</td>
<td>00:10:19</td>
<td>00:10:48</td>
<td></td>
</tr>
<tr>
<td>Category 2 Mean Target</td>
<td>00:23:13</td>
<td>00:20:59</td>
<td>00:19:30</td>
<td>00:16:05</td>
<td>00:19:30</td>
<td>00:14:59</td>
<td>00:18:43</td>
<td></td>
</tr>
<tr>
<td>Category 2 90th centile Target</td>
<td>00:47:40</td>
<td>00:43:00</td>
<td>00:41:13</td>
<td>00:32:44</td>
<td>00:40:03</td>
<td>00:30:13</td>
<td>00:38:38</td>
<td></td>
</tr>
<tr>
<td>Category 3 Mean Target</td>
<td>00:56:17</td>
<td>00:56:31</td>
<td>00:53:19</td>
<td>00:50:24</td>
<td>00:58:53</td>
<td>00:47:04</td>
<td>00:53:16</td>
<td></td>
</tr>
<tr>
<td>Category 4 90th centile Target</td>
<td>03:21:21</td>
<td>02:59:07</td>
<td>02:58:43</td>
<td>02:59:08</td>
<td>03:02:56</td>
<td>03:01:59</td>
<td>03:02:32</td>
<td></td>
</tr>
</tbody>
</table>

---

### Data unavailable until Pan London contract is agreed and signed
**LAS performance: summary of current position**

<table>
<thead>
<tr>
<th>Summary of current south east London performance position</th>
<th>Main drivers of current performance position</th>
<th>High impact actions currently in place to address performance variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 2019 activity figures are not available until the Pan London contract is agreed for 2019/20. The NWL LAS commissioning team are drafting the contract particulars to be finalised this month.</td>
<td>• LAS report an increase in acuity of patients, as seen elsewhere in the urgent care system.</td>
<td>See following slide for planned actions.</td>
</tr>
<tr>
<td>• YTD 2019 performance targets show LAS are unable to meet ambulance response times consistently.</td>
<td>• LAS is also reporting month-on-month increases in demand across London which is affecting response times across all STPs. SEL and SWL have better ambulance response times then NCL, NEL and NWL.</td>
<td></td>
</tr>
<tr>
<td>• Category 1 was achieved for SEL; however, the target was missed by 9 seconds in Bexley. LAS did not achieve Categories 2, 3 or 4 in SEL.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Across the 6 CCGs, Lambeth was the only CCG where LAS met all performance targets.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Impact or potential impact of the current performance position on the quality of care and mitigation actions in place**

- A representative for SEL CCGs attends the LAS CQRG meetings which oversees the delivery of high quality care, including review of Serious Incidents. The current report does not highlight any significant quality concerns relating to LAS delivery of performance standards.

**Known equality or health inequality issues related to this standard**

- There are no known equality or health inequality issues. LAS have measures in place to ensure that all the organisation’s obligations under equality, diversity and human rights legislation are complied with.
**LAS performance: monthly update**

<table>
<thead>
<tr>
<th>What has changed since last month?</th>
<th>New actions taken in the last month</th>
<th>Proposed actions in the next quarter</th>
<th>SEL BAF risk</th>
</tr>
</thead>
</table>
| SEL commissioners have continued discussions with providers to facilitate direct access to their services from the 999 Clinical Hub. Access to services from the 999 Clinical Hub will support the Pan-London agreement to provide additional referral opportunities for 2019/20. | Across SEL we have agreed 13 referral pathways for the 999 Clinical Hub which include: Rapid Response Teams, Mental Health Crisis response and Urgent Treatment Centres. These pathways have been operational since September. | SEL commissioners will continue to deliver new pathways for the 999 Clinical Hub. The new ACP for @home will be available by early December for the 999 Clinical Hub to use. | **SEL BAF Reference:** • SEL-07  
**Current risk rating:** • 3 x 2 = 6 (low risk) |
| The Clinical Assessment Service in NHS 111 IUC continues to revalidate Category 3 and 4 ambulances before they are sent to 999 for dispatch. | Pan London commissioners agreed a core set of codes to be used by LAS which will improve reporting and support commissioners to understand their local activity. A detailed piece of work to improve reporting is taking place which is expected that the codes will be reported from January, | Conversations will continue with providers to allow direct access to maternity units and Emergency Pregnancy Assessment Units. This has progressed with PRUH and Darent Valley agreeing direct referrals to EPAU. The pathway for LGT is still in development. We will continue to pursue conversations at St Thomas’ and Denmark Hill. | |
| LAS submitted their winter plan this month, the plan included predicted demand and performance based on historic data. CCGs have shared hourly predicted demand with local acute trusts in order to support planning for winter. | SEL CCGs have developed plans to reduce demand. Plans aim to make a reduction in both conveyances and demand which will target both SEL-wide and local CCGs. | Lewisham CCG will continue to develop 2 new ACPs for the 999 Clinical Hub and 999 crews. | |
| NHS England is now hosting a fortnightly Pan-London meeting around ambulance handover delays which SEL attends. | SEL commissioners will support a once for SEL approach to communications and consider other demand management schemes where it makes sense to do so. | **SEL BAF Reference:** • SEL-07  
**Current risk rating:** • 3 x 2 = 6 (low risk) |

**Update on work with CCGs to deliver ICDT recommendations**

- SEL CCGs to continue to develop ACPs to allow for direct referrals from the 999 Clinical Hub and 999 crews.
## 111 performance: headlines and month-on-month trend

<table>
<thead>
<tr>
<th></th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>August</th>
<th>September</th>
<th>October</th>
</tr>
</thead>
<tbody>
<tr>
<td>Call volume</td>
<td>37,967</td>
<td>38,642</td>
<td>36,455</td>
<td>38,542</td>
<td>37,817</td>
<td>35,650</td>
<td>38,963</td>
</tr>
<tr>
<td>Calls answered in 60 seconds (target)</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
<td>95%</td>
</tr>
<tr>
<td>Calls answered in 60 seconds (performance)</td>
<td>85.1%</td>
<td>92.7%</td>
<td>88.9%</td>
<td>76.7%</td>
<td>75.0%</td>
<td>73.7%</td>
<td>66.8%</td>
</tr>
</tbody>
</table>

### Urgent and Emergency Care Referrals from SEL 111 IUC

- **111 calls resulting in ambulance dispatch**
- **111 calls resulting in referral to ED/UTC**
## 111 performance: summary of current position

<table>
<thead>
<tr>
<th>Summary of current south east London performance position</th>
<th>Main drivers of current performance position</th>
<th>High impact actions currently in place to address performance variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>• October 2019’s call volumes were 6.31% above forecast (compared to 9.27% above forecast in September and 14.78% above forecast in August 2019). Call volumes have impacted on the performance of ‘calls answered within 60 seconds’ which has reduced to 66.8% in October from 73.7% in September.</td>
<td>• 111 call activity, especially in hours (8am – 6.30pm) is above the modelled demand. This is impacting on waiting times for patients and the performance of ‘calls answered within 60 seconds’ and ‘calls abandoned after more than 30 seconds’.</td>
<td>• A Recovery Action Plan around the ‘calls answered in 60 seconds’ performance target has been agreed with LAS and is monitored via monthly contract management meetings. Actions include recruitment of permanent staff with less reliance on agency suppliers and implementation of productivity and performance reviews of staff.</td>
</tr>
<tr>
<td>• Poor performance around call handing has impacted the ‘calls abandoned after more than 30 seconds’. This has increased in October to 6%, which is above the KPI of 5%.</td>
<td>• LAS have experienced difficulty in filling rotas for all skill sets due to workforce shortages: particularly call handlers and Advanced Nurse Practitioners (ANPs) and GPs. The call handler shortage, along with calls being above forecast is impacting on the performance of the KPIs above. There are Pan-London discussions being led by HLP focused on workforce turnover, attrition and sustainability and how this can be improved across the system.</td>
<td>• LAS are identifying areas / symptoms which have prolonged call lengths to inform call handler training to support improved management and call times.</td>
</tr>
<tr>
<td>• The proportion of Category 3 and 4 ambulance dispositions revalidated in October by a clinician before sending to 999 was 75.8%, above the KPI target of 50%.</td>
<td>• LAS implemented a new telephone system in SEL which has experienced a number of technical issues. Call patterns suggest technical issues may be impacting on performance.</td>
<td>• LAS are completing a technical review of the telephone system to understand potential barriers to service delivery.</td>
</tr>
<tr>
<td>• The proportion of 111 calls resulting in ambulance dispatch or referral to a ED/UTC has remained low since December 2018.</td>
<td>• A number of 111 IUC providers across the country have gone into divert due to technical issues or upgrades throughout the month, resulting in increased activity coming into the SEL service.</td>
<td>• NHS England and NHS Improvement have allocated additional winter funding to 111 IUC services across the country to improve call handling and help with peak demand. LAS is currently develop a plan of how the funding will be used to improve rotas in SEL.</td>
</tr>
<tr>
<td>• 66% of the 38,963 calls in October received clinical input from the Clinical Assessment Service (CAS) within the 111 service.</td>
<td>• LAS’s approach to revalidation of ambulances and ETC dispositions means that – of all the London 111 providers – they continue to have the lowest proportion of calls resulting in ambulance dispatch or referral to ED / UTC.</td>
<td></td>
</tr>
</tbody>
</table>

### Impact or potential impact of the current performance position on the quality of care and mitigation actions in place

- A SEL 111 IUC Quality and Safety Committee is in place which meets bi-monthly to oversee the quality and safety of care within the new service. This is supplemented by a smaller sub group meeting on alternate months. A benefits realisation plan between LAS and SEL commissioners has been developed, consisting of a series of reviews that will take place over the course of the year to ensure all aspects of the service specification are appropriately implemented and are delivering the expected outcomes for patients.
- HLP are leading on a Pan-London 111 IUC workforce review, looking at rates of pay across the skill sets by provider with the aim of agreeing consistent pay London-wide in order to mitigate the recruitment and retention issues that all 111 IUC providers are currently experiencing.
- There is a Pan-London CAS development group, overseeing the development and safety of the Clinical Assessment Services within 111 IUC services. A local SEL CAS Group has also been established to enable more focused review of the SEL CAS.

### Known equality or health inequality issues related to this standard

- There are no known equality or health inequality issues. LAS have measures in place to ensure that all the organisation’s obligations under equality, diversity and human rights legislation are complied with.
### 111 performance: monthly update

#### What has changed since last month?

<table>
<thead>
<tr>
<th>New actions taken in the last month</th>
<th>Proposed actions in the next quarter</th>
<th>SEL BAF risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The SEL 111 IUC Alliance Memorandum of Understanding (MoU) – which has been in development for approximately two years – has been signed by 12 of the 19 participants, since it was finalised in July 2019.</td>
<td>• Collect remaining signatures on the SEL 111 IUC Alliance MoU.</td>
<td>SEL BAF Reference: No risks at this time. Not included on SEL BAF.</td>
</tr>
<tr>
<td>• The CSU’s 111 data warehouse which will include call daily data from 111 IUC is due to be completed in December 2019. This will allow commissioners access to data describing the full patient journey within the 111 IUC service. Both SEL and NEL STPs have agreed to pay for the development of the CSU’s 111 data warehouse, to accommodate the new call log data extract scripts. Regular meetings are being held with HLP, LAS, NEL, SEL and the CSU to progress this work.</td>
<td>• CSU/SEL/NEL to continue work on the development of the 111 data warehouse. Estimated date of completion: beginning of December 2019.</td>
<td></td>
</tr>
<tr>
<td>• Analysis of primary care demand via 111 has been shared with CCG primary care commissioners so they can review GP Hub appointment availability and demand to minimise patients attending UTCs unnecessarily.</td>
<td>• CCG commissioners to work with their GP hub providers to ensure they adopt the new clinical profile, expand the opening hours listed for their services on the Directory of Services and increase the number of appointments available to 111.</td>
<td></td>
</tr>
<tr>
<td>• Work continues with SEL providers to improve access for patients via the Directory of Services. This involves reviewing profiles of each provider to ensure they care configured correctly.</td>
<td>• Work will continue with providers to review 111 IUC referral pathways to make sure that 111 has the correct and appropriate access.</td>
<td></td>
</tr>
<tr>
<td>• A new ICDT programme of work has started around GP Connect. This new technology will allow the 111 IUC service to directly book appointments into GP Practices across SEL. An implementation plan has been developed working with HLP and NHS Digital.</td>
<td>• Configuration and testing to begin with GP Practices to allow for GP Connect and the ability to directly book appointments into SEL GP Practices.</td>
<td></td>
</tr>
</tbody>
</table>

#### Update on work with CCGs to deliver ICDT recommendations

- The ICDT has confirmed with CCGs the need to work with GP Federations to provide more appointments slots Monday through Friday for the 111 IUC service.
### Cancer waiting times: performance headlines and month-on-month trend

Tables on the following two pages set out the current performance position of each SEL CCG and provider against national standards. The position against the standard is RAG-rated and the position against the previous month’s performance is indicated by the arrow as per the below key.

#### Key
- **Performance position**
  - Not achieving national standard
  - Achieving national standard
  - Outside of SPC process limit (good performance)
  - Outside of SPC process limit (poor performance)
  - Within SPC limits (within expected levels of variation)

<table>
<thead>
<tr>
<th></th>
<th>Bexley</th>
<th>Bromley</th>
<th>Greenwich</th>
<th>Lambeth</th>
<th>Lewisham</th>
<th>Southwark</th>
<th>SEL CCGs</th>
<th>GSTT</th>
<th>KCH</th>
<th>LGT</th>
<th>SEL Acute</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cancer 62 day waits - % of patients waiting 62 days or less from urgent GP referral (85%) – September 2019</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Planned trajectory</td>
<td>83.3</td>
<td>85.4</td>
<td>80.0</td>
<td>81.6</td>
<td>80.0</td>
<td>80.0</td>
<td>-</td>
<td>77.5</td>
<td>86.5</td>
<td>80.0</td>
<td>-</td>
</tr>
<tr>
<td>Current month</td>
<td>83.6</td>
<td>71.4</td>
<td>78.4</td>
<td>80.0</td>
<td>59.5</td>
<td>81.1</td>
<td>75.7</td>
<td>70.0</td>
<td>72.6</td>
<td>78.7</td>
<td>74.4</td>
</tr>
<tr>
<td>SPC position</td>
<td>Within limits</td>
<td>Within limits</td>
<td>Within limits</td>
<td>Within limits</td>
<td>Within limits</td>
<td>Within limits</td>
<td>-</td>
<td>Within limits</td>
<td>Within limits</td>
<td>Within limits</td>
<td>-</td>
</tr>
</tbody>
</table>

| **Cancer 31 day waits - % of patients waiting 31 days or less between definitive diagnosis and first treatment (96%) – September 2019** |
| Current month     | 95.6   | 96.9    | 100.0     | 97.8    | 96.7     | 98.6      | 97.5     | 97.0 | 96.0 | 97.9 | 96.9      |
| SPC position      | Within limits | Within limits | Within limits | Within limits | Within limits | Within limits | -        | Within limits | Within limits | Within limits | -         |

| **Cancer 2 week waits - % of patients waiting two week or less between urgent GP referral and first appointment with a specialist (93%) – September 2019** |
| Current month     | 94.0   | 91.8    | 93.8      | 95.3    | 92.1     | 94.4      | 93.5     | 96.2 | 92.3 | 91.9 | 93.5      |
| SPC position      | Within limits | Within limits | Within limits | Within limits | Within limits | Within limits | -        | Within limits | Within limits | Below lower limits | -         |
Cancer waiting times – 62 day: summary of current position

<table>
<thead>
<tr>
<th>Summary of current south east London performance position</th>
<th>Main drivers of current performance position</th>
<th>High impact actions currently in place to address performance variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>• SEL trusts/CCGs did not meet the 62 day performance in 18/19, and despite improvements at KCH over the course of 18/19, there was a deterioration in performance at LGT, which resulted in the overall SEL performance remaining static.</td>
<td>During the course of 19/20, there have been three key areas driving the current risk:</td>
<td>• Trusts have developed action plans to deliver their 62 day trajectory including a SEL recovery plan specifically focusing on shared pathway actions and performance.</td>
</tr>
<tr>
<td>Overall LGT have seen some improvement during Quarter 2, GSTT performance has remained static and KCH has deteriorated. SEL overall saw improvement between Quarter 1 and 2.</td>
<td>• The overall performance at LGT and the timeliness of Inter Provider Transfers performance (IPT) for patients transferring from LGT to GSTT.</td>
<td>• Monthly performance meeting are in place with acute trusts – focus on internal trust performance and actions relating to them are in place. A monthly system leadership group – 62 day leadership meeting is in place, with a focus on the shared pathway actions and performance</td>
</tr>
<tr>
<td>Due to the drivers behind performance against the 62 Day standard, there is differential impact by CCGs. Lambeth and Southwark CCGs will tend to be closer to delivering the 62 day standard because a higher proportion of their patients will start and finish their cancer pathway either within GSTT or KCH - Denmark Hill.</td>
<td>• The timeliness of IPT performance for patients transferring from KCH to GSTT.</td>
<td>• The SEL recovery plan has been agreed between commissioners and trusts with SMART actions and senior level action owners, KPIs to measure delivery of the actions, and a risk and issues log, all of which will be updated monthly:</td>
</tr>
<tr>
<td>For Lewisham, Greenwich, Bexley and Bromley CCGs, patients will start their pathway at a local trust/site e.g. Princess Royal University Hospital (PRUH), University Hospital Lewisham, and for some treatment pathways will be transferred to GSTT or KCH - Denmark Hill for treatment. These patients are therefore more likely to have issues with meeting the required standards as the timeliness of transfers is one of the key drivers.</td>
<td>• The ability for the treatment trust to treat the patients within the standard if the patient arrives late or not at a diagnostic stage that would support the start of treatment.</td>
<td>• Full utilisation of TP biopsy in outpatients. – Completed but capacity issues remain.</td>
</tr>
<tr>
<td>• Trusts have developed action plans to deliver their 62 day trajectory including a SEL recovery plan specifically focusing on shared pathway actions and performance.</td>
<td>Within the above there are tumour pathways which are more challenged than others, e.g. urology, lung and Gynaecology.</td>
<td>• Recruitment to 28 day faster diagnosis project lead for SEL. Completed</td>
</tr>
<tr>
<td>• Monthly performance meeting are in place with acute trusts – focus on internal trust performance and actions relating to them are in place. A monthly system leadership group – 62 day leadership meeting is in place, with a focus on the shared pathway actions and performance</td>
<td></td>
<td>• Continue SEL cancer diagnostic fund for CT and MRI. Agreed – to be reviewed in 2020/21</td>
</tr>
<tr>
<td>• The SEL recovery plan has been agreed between commissioners and trusts with SMART actions and senior level action owners, KPIs to measure delivery of the actions, and a risk and issues log, all of which will be updated monthly:</td>
<td>• Transformation was assigned to a specialist SEL cancer management sector workforce to be recruited and based at individual Trust Sites. Now in place but delayed recruitment and smaller team than anticipated.</td>
<td>• Full utilisation of One Stop and Straight to Test pathways for key tumour sites: lung – in place, gynaecology – delays across SEL, breast in place GSTT/LGT, upper GI – mixed uptake</td>
</tr>
<tr>
<td></td>
<td>• Endobronchial ultrasound (EBUS) services to begin at Woolwich and PRUH. In place at PRUH and QEH. Some capacity issues remain.</td>
<td>• Endobronchial ultrasound (EBUS) services to begin at Woolwich and PRUH. In place at PRUH and QEH. Some capacity issues remain.</td>
</tr>
<tr>
<td></td>
<td>• Additional lung and lower GI oncologists recruited at GSTT and oncology workforce review conducted by the ACN. Recruited to but ongoing review required for system oncology. Oncology capacity an ongoing risk for the system</td>
<td>• Additional lung and lower GI oncologists recruited at GSTT and oncology workforce review conducted by the ACN. Recruited to but ongoing review required for system oncology. Oncology capacity an ongoing risk for the system</td>
</tr>
<tr>
<td></td>
<td>• Implement a model to expedite abnormal CXRs to CT in the lung pathway within 48 hours. Delays in the sector.</td>
<td>• Implement a model to expedite abnormal CXRs to CT in the lung pathway within 48 hours. Delays in the sector.</td>
</tr>
<tr>
<td></td>
<td>• Recruitment to joint urology workforce roles at the PRUH with Denmark Hill – Consultants recruited, middle grade recruitment still required.</td>
<td>• Recruitment to joint urology workforce roles at the PRUH with Denmark Hill – Consultants recruited, middle grade recruitment still required.</td>
</tr>
<tr>
<td></td>
<td>• Fully roll out telephone assessment clinic model for 100% of appropriate lower GI patients. To be in place by year end. Denmark Hill only site remaining.</td>
<td>• Fully roll out telephone assessment clinic model for 100% of appropriate lower GI patients. To be in place by year end. Denmark Hill only site remaining.</td>
</tr>
</tbody>
</table>

Impact or potential impact of the current performance position on the quality of care and mitigation actions in place

• Individual trusts complete Root Cause Analysis of all patients that are treated beyond 62 days, for IPT patients this is a joint exercise between relevant Trusts. Findings are shared at the relevant SEL tumour group (clinically led meetings), and summary findings are shared at the 62 day group, to ensure that current actions match the emerging issues.

Known equality or health inequality issues related to this standard

• No known equality issues known related to this standard. Trusts have measures in place to ensure that all the organisation’s obligations under equality, diversity and human rights legislation are complied with.
### What has changed since last month?

- All three trusts (and SEL as a sector) missed the performance trajectory in September. Early view of October is showing a slight reduction in performance, it’s therefore likely to be a challenge to meet the October trajectory.

- Performance has been challenged in the first half of 2019/20. A number of issues have impacted the prostate and lung pathways which are the biggest contributors to breaches in the sector. Whilst some issues for prostate have now been resolved, there are still further actions required to address issues in both pathways. Prostate performance in particular has been impacted by a deterioration in oncology capacity within the sector. Improvement has been shown by LGT from the start year position but KCH have not yet shown the improvement required to bring SEL back on to trajectory.

### New actions taken in the last month

- SEL cancer performance improvement plans (PIPs) reviewed and updated.
- 62 day Leadership group – Provider level deep dives into Urology, Lung and Gynaecology – updated pathway templates completed by the group with additional next steps for improvement.
- Rapid Assessment Diagnostic Clinic (RADC) transformation funding requirements agreed plan to expand GSTT service produced.
- 360 degree ACN members board governance review responses collated and presented.
- Additional management support from NHSE/I In place at LGT. Trust has recruited to internal cancer lead position and has had recruitment process for new director of performance. Shared care cancer team in place at LGT
- GP ‘Red Whale’ training to be offered across SEL
- Additional GP leads advertised focussing on cancer education, Screening projects, Living with and beyond cancer.
- New 6 month outsourcing contract agreed for Sector CT and MRI.

### Proposed actions in the next quarter

- Continued employment of remaining staff for specialist cancer management sector workforce.
- 62 Day group to review Lung, Urology and Gynaecology deep dive actions for progress.
- Invoices for sector diagnostic fund to be completed taking £1.8 million for sector diagnostics. £450k from each organisation.
- Cancer section of the long term plan to be finalised.
- Support package for Cancer MDT Leadership and Team Development to be procured.
- Transformation funding to be invoiced by providers
- KCH Lower GI Telephone Assessment clinic funding agreed and clinic expanded
- Review transformation funding underspend and highlight key areas for investment
- Hold system business planning event to begin planning for 2020/21
- RCA review to be held at 62 day leadership group

### SEL BAF risk

- **SEL BAF Reference:**
  - SEL-01
- **Current risk rating:**
  - 4 x 4 = 16 (high risk)

## Update on work with CCGs to deliver ICDT recommendations

CCGs should be leading cancer locality meetings (with support from the SEL Cancer Alliance), with particular focus on:

- stratified follow-up – to facilitate appropriate patients being managed in a non acute setting,
- ensuring 2ww referrals are in line with agreed process e.g. full patient workup, appropriate documentation with referral, patients aware they are on a 2ww pathway etc,
- working with providers to ensure that eRS is fit for purpose and support their referrals.
- Improving uptake and roll out of FIT
- Improve uptake of cancer screening
## Diagnostic waiting times: performance headlines and month-on-month trend

### 6 weeks Diagnostics - % of patients waiting for 6 weeks of less (99%) – September 2019

<table>
<thead>
<tr>
<th>Planned trajectory</th>
<th>Bexley</th>
<th>Bromley</th>
<th>Greenwich</th>
<th>Lambeth</th>
<th>Lewisham</th>
<th>Southwark</th>
<th>SEL CCGs</th>
<th>GSTT</th>
<th>KCH</th>
<th>LGT</th>
<th>SEL Acute</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current month</td>
<td>2.9</td>
<td>10.0</td>
<td>2.2</td>
<td>5.4</td>
<td>2.6</td>
<td>6.3</td>
<td>-</td>
<td>2.8</td>
<td>11.4</td>
<td>1.0</td>
<td>-</td>
</tr>
<tr>
<td>SPC position</td>
<td>Within limits</td>
<td>Within limits</td>
<td>Within limits</td>
<td>Within limits</td>
<td>Below lower limit</td>
<td>Below lower limit</td>
<td>-</td>
<td>Within limits</td>
<td>Within limits</td>
<td>Within limits</td>
<td>-</td>
</tr>
</tbody>
</table>

**Key**

- **Performance position**
  - Not achieving national standard
  - Achieving national standard

- **Current month SPC position**
  - Within limits
  - Outside of SPC process limit (good performance)
  - Outside of SPC process limit (poor performance)
  - Within SPC limits (within expected levels of variation)

- **Key**
  - Worst performer
  - Best performer
### Diagnostic waiting times: summary of current position

#### Summary of current south east London performance position

- At the start of the year GSTT had a trajectory that shows compliance with the national standard from January 2020. Performance for September was above the revised trajectory with more long waiters than planned.
- KCH have a trajectory that moves towards compliance in 19/20 and shows a compliant position from March 2020. Performance for September is below planned trajectory (less long waiters than planned) but is not compliant with the national standard.
- LGT have a trajectory that is compliant with the national standard throughout 19/20, performance for September is above this trajectory and is therefore not compliant with the national standard.

#### Main drivers of current performance position

- At GSTT waits for endoscopy continue to be the main driver behind the performance.
- At KCH endoscopy on the PRUH site remains the primary driver of poor performance.
- At LGT echocardiography has the highest number of breaches (88 – accounting for 76% of all breaches). This was driven by a combination of IT issues and staffing shortages. The Trust report resolution of these issues and are forecasting improvement from November.

#### High impact actions currently in place to address performance variance

- All trusts performance improvement plans agreed between commissioners and providers with SMART actions and senior level action owners, KPIs to measure delivery of the actions, and a risk and issues log, all of which will be updated monthly.
- Monthly performance meeting are in place with acute trusts which will review progress against the trust specific trajectories.
- The KCH plan focuses on echocardiography for Denmark Hill, and endoscopy for PRUH, including expanding capacity by utilising available in and outsourcing options.
- KCH have secured a mobile decontamination unit which is located at Orpington Hospital, this will be used to support additional endoscopy activity for PRUH and south sites.
- GSTT have identified additional capacity both on and off site to support improvements in Endoscopy. Alongside pathway improvements for certain endoscopy procedures.

### Impact or potential impact of the current performance position on the quality of care and mitigation actions in place

- Serious Incidents are under investigation at KCH (PRUH) relating to delayed non 2WW diagnostics which resulted in a cancer diagnosis. A weekly endoscopy briefing is produced by the Trust which gives a detailed update on clinical harm review process which is being undertaken.

### Known equality or health inequality issues related to this standard

- No known equality issues known related to this standard. Trusts have measures in place to ensure that all the organisation’s obligations under equality, diversity and human rights legislation are complied with.
### Diagnostic waiting times: monthly update

#### What has changed since last month?
- GSTT performance for September shows an improved position compared to August but is above the revised planned trajectory.
- KCH performance for September shows an improved position compared to August and is below planned trajectory.
- LGT did not achieve the standard or trajectory in September.

#### New actions taken in the last month
- ICDT provided a detailed briefing covering drivers, actions and mitigations and outlined the transformation plans in relation to diagnostics to the IGP.
- ICDT supported providers in the submission of bids for additional monies for diagnostic resource.
- GSTT and KCH have been awarded monies for additional CT and MRI scanners (details to be confirmed).

#### Proposed actions in the next quarter
- ICDT continue to work with the regional team who are seeking solutions to pan-London capacity issues such as endoscopy.

<table>
<thead>
<tr>
<th>SEL BAF risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reference: SEL-06</td>
</tr>
</tbody>
</table>

### Current risk rating:

- **SEL BAF Reference:**
- **SEL-06**
- **Current risk rating:**
  - 3 x 4 = 12 (medium risk)

---

### Update on work with CCGs to deliver ICDT recommendations

- CCGs to be aware of the prolonged waits for endoscopy services at PRUH & GSTT.
- CCGs should highlight to GPs that referrals to endoscopy services should be flagged as urgent only when appropriate to do so. This recommendation applies to referrals for specialties where endoscopy is a standard part of the pathway.
There are currently 69 adult inpatients, 16 above the BRS target, but 3 below the recovery target position for end November 2019*

- The TCP is forecasting an end March 2020 position of 64 adult inpatients.
- The target was built on an analysis of the current cohort as well as a modelling based on review of the historical data and expected positive impact that new services will have in the trajectory.

*Position at 14/11/2019. Total of 75 patients on the TC Register does not include 1 Adult CCG patient admitted awaiting confirmation of diagnosis by the case manager and Deputy SRO approval before addition to register.

DATA SOURCE: SEL TCP Inpatient Tracker 14/11/2019 v4
There are currently 75 inpatients (69x adults / 6x children)*

<table>
<thead>
<tr>
<th></th>
<th>FY 18/19 Q4</th>
<th>FY 19/20 Q1</th>
<th>FY 19/20 Q2</th>
<th>FY 19/20 Q3</th>
<th>FY 19/20 Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatients</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>85</td>
<td>89</td>
<td>91</td>
<td>84</td>
<td>81</td>
</tr>
<tr>
<td>CCG</td>
<td>38</td>
<td>41</td>
<td>41</td>
<td>39</td>
<td>36</td>
</tr>
<tr>
<td>Spec Comm Adults</td>
<td>39</td>
<td>40</td>
<td>39</td>
<td>38</td>
<td>39</td>
</tr>
<tr>
<td>Spec Comm Children</td>
<td>8</td>
<td>8</td>
<td>7</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>Adult Inpatients per million pop'n (IAF)</td>
<td>63</td>
<td>66</td>
<td>65</td>
<td>62</td>
<td>61</td>
</tr>
<tr>
<td><strong>TCP Forecast</strong></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>BRSTrajectory</strong></td>
<td>61</td>
<td>60</td>
<td>58</td>
<td>58</td>
<td>57</td>
</tr>
<tr>
<td><strong>Recovery Trajectory</strong></td>
<td>61</td>
<td>60</td>
<td>58</td>
<td>84</td>
<td>83</td>
</tr>
<tr>
<td><strong>Net</strong></td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>-9</td>
<td>-3</td>
</tr>
<tr>
<td><strong>Admissions</strong></td>
<td>11</td>
<td>10</td>
<td>8</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td><strong>Discharges</strong></td>
<td>9</td>
<td>7</td>
<td>5</td>
<td>13</td>
<td>10</td>
</tr>
</tbody>
</table>

*Position at 14/11/2019. Total of 75 patients on the TC Register does not include 1 Adult CCG patient admitted awaiting confirmation of diagnosis by the case manager and Deputy SRO approval before addition to register.

**The TCP Forecast target was built on the analysis of the current cohort and modelling based on the review of historical data, and the expected positive impact new services will have on the trajectory.

DATA SOURCE: SEL TCP Inpatient Tracker 14/11/2019 v4
Of the 75 inpatients, 27 are estimated to be suitable for discharge by the end of March 2020*

- There are 46 inpatients not expected to be discharged before March 2020, 32 of whom are Specialised Commissioning adults.
- There are 2 recent admissions that the expected discharge date (EDD) is still not confirmed, those are rated as ‘TBC’.

*Position at 18/10/19. Total of 78 patients doesn’t include 1 Adult CCG patient admitted awaiting confirmation of diagnosis by the case manager and Deputy SRO approval before addition to register.

**DATA SOURCE:** SEL TCP Inpatient Tracker 18/10/2019 v.1.
There are currently 75 inpatients (69x adults / 6x children)*

- ~33% (23) of current adult inpatients admitted presented at hospital with mental health diagnoses/conditions, which are in addition to diagnoses of ASD/LD, The presenting problem therefore being mental ill-health but in the context of an underlying ASD/LD diagnosis. Out of those patients:
  - 6 patients had ASD as a primary diagnosis, 4 patients had ASD as a secondary.
  - 8 patients had LD as a primary diagnosis, 6 patients had LD as a secondary.
- All current CYP inpatients were admitted to hospital with an ASD diagnosis. Presentations may however be due to behaviours that challenge families and services such as self-harm.

*Position at 14/11/2019. Total of 75 patients on the TC Register does not include 1 Adult CCG patient admitted awaiting confirmation of diagnosis by the case manager and Deputy SRO approval before addition to register.
DATA SOURCE: SEL TCP Inpatient Tracker 14/11/2019 v4
The TCP PMO team has been tracking issues beyond TCP control which have resulted in CTR non-compliance. These issues have been escalated to the Strategic Case Manager and NHSE regional team via monthly assurance meetings.

<table>
<thead>
<tr>
<th>Borough Overall compliance</th>
<th>Bexley</th>
<th>Bromley</th>
<th>Greenwich</th>
<th>Lambeth</th>
<th>Lewisham</th>
<th>Southwark</th>
<th>Spec Comm</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>100%</td>
<td>33%</td>
<td>83%</td>
<td>78%</td>
<td>100%</td>
<td>83%</td>
<td>75%</td>
</tr>
</tbody>
</table>

- Metric 1 - Adults - % admissions in rolling quarter with pre-admission CTR within 28 days or post-admission CTR within 28 days of admission.
- Metric 2 - Non-secure adults - % current inpatients with CTR in last 6 months.
- Metric 3 - Secure adults - % current inpatients with CTR in last 12 months.
- Metric 4 - Under 18s - % admissions in rolling quarter with pre-admission CTR within 28 days or post-admission CTR within 14 days of admission.
- Metric 5 - Under 18s - % current inpatients with CTR in last 3 months.
The SEL TCP cohort had a total of 17 CTR breaches at the end of October 2019. Six (6) of these breaches are due to consent not being given by people with capacity; three (3) due to it being clinically best to delay the CTR. Therefore only eight (8) breaches due provider or commissioner capacity fall within the scope of the programme to improve this performance.

**Metric 1 (CCG/Spec Comm) - Adults - % admissions in rolling quarter with pre-admission CTR within 28 days or post-admission CTR within 28 days of admission.**
1x BRO_CCG: Consent not given from individual (with capacity).
1x LAM_SC: Consent not given from individual (with capacity).

**Metric 2 (CCG) - Non-secure adults - % current inpatients with CTR in last 6 months.**
1x BRO: Consent not given from individual (with capacity).
1x GRE: Clinical best interest to delay CTR. Patient transitioning to a new placement (step down pathway).
1x LAM: Consent not given from individual (with capacity).
1x LAM: Provider capacity. CTR booked for 19/11/19.
1x SOU: Commissioner capacity in booking CTR in a timely manner. CTR booking in progress (liaising with provider).

**Metric 3 (Spec Comm) - Secure adults - % current inpatients with CTR in last 12 months.**
1x BRO: Consent not given from individual (with capacity).
1x GRE: Provider capacity. CTR booked for 30/10/19 (awaiting to hear back regarding attendance).
1x LAM: Clinical best interest to delay CTR. CTR booked for 05/11/19.
1x LAM: Clinical best interest to delay CTR. CTR booked for 12/11/19.
1x LAM: Provider capacity. CTR booking in progress (liaising with provider).
1x LEW: Provider capacity. CTR booked for 30/10/19 (awaiting to hear back regarding attendance).
1x LEW: Provider capacity. CTR booked for 26/11/19.
1x SOU: Consent not given from individual (with capacity).
2x SOU: Provider capacity. CTR booking in progress (liaising with provider).
### Transforming Care Programme: summary of current position

<table>
<thead>
<tr>
<th>Summary of current south east London performance position</th>
<th>Main drivers of current performance position</th>
<th>High impact actions currently in place to address performance variance</th>
</tr>
</thead>
</table>
| • The south east London Transforming Care Partnership has been set a target of reducing transforming care inpatients from 71 to 58 by March 2019, in line with national Building the Right Support (BRS) bed reduction plans. | • The SEL inpatient cohort is complex which results in challenging discharge pathways. 70% of the current cohort is amenable to change and 30% is not (Black RAG rated) due to complex care needs and/or MoJ restrictions. These two distinct groups require different approaches to improve care and facilitate return to the community. | Discharge improvement:  
• Dedicated case managers in post.  
• Regular case management rhythm established.  
• Monthly inpatient surgeries.  
• Escalation channels open to SEL AO and NHSE national. |
| • This did not however allow for local demographic considerations and a significant increase in existing cohort numbers, as identified within the first year of the programme. | • There are a lack of local specialised support services for people living in the community with learning disabilities and/or autism and their families. | Admission prevention:  
• Introduction of compulsory admissions root cause analysis.  
• PBS training to family carers and professional workforce.  
• Autism awareness training to professional workforce.  
• Borough level review of risk register processes. |
| • Whilst the end of year inpatient position was 26 patients above the BRS trajectory, targeted interventions are in place, aimed at rapidly improving the performance position. | • CCGs, Local Authorities and providers do not always effectively share information regarding patients at risk of admission. This limits the ability of the TCP to put in place support to manage escalating crises in the community. | Capacity building:  
• Mobilisation of SLaM & Oxleas autism support services pilots.  
• Commission of new BBG intensive community support service pilot. Due to start mobilisation in November 2019.  
• Expansion of Lambeth Without Walls service.  
• Commissioning of Lewisham Intensive Community Support service. Mobilisation data yet to be determined.  
| • The TCP is maintaining a consistently high discharge rate, facilitated by increased case management and programme management support, however continuing pressure from admissions continues to impact net change. | • Care and Treatment Review (CTR) compliance is challenged for the pre/post admission KPIs, metrics 1 and 4. This is being driven by provider capacity challenges, TCP capacity challenges and community risk information sharing issues. | |
| • SEL TCP was set a target of reducing TC adult inpatients from 84 to 50 by March 2020, in line with national Building the Right Support (BRS) bed reduction plans. However, this did not allow for local demographic considerations and a significant increase in existing cohort numbers, as identified within the first year of the programme. | • The SEL inpatient cohort is complex which results in challenging discharge pathways. 70% of the current cohort is amenable to change and 30% is not (Black RAG rated) due to complex care needs and/or MoJ restrictions. These two distinct groups require different approaches to improve care and facilitate return to the community. | |
| • The operational target agreed with NHS England for SEL TCP adult inpatients is 64, 14 above the BRS target. The non-compliant target was built on analysis of the current cohort as well as modelling based on analysis of the historical data and expected positive impact that new services will have in the trajectory. | • There are a lack of local specialised support services for people living in the community with learning disabilities and/or autism and their families. | |

### Impact or potential impact of the current performance position on the quality of care and mitigation actions in place

• No impact identified on quality of care consequence of the performance.

### Known equality or health inequality issues related to this standard

• There are several barriers that are stopping people with a learning disability (LD) and/or autism (ASD) from getting good quality healthcare which the SEL TC Partnership is trying to tackle, those include: patients not being identified as having an LD/ASD; staff having little understanding about LD/ASD; failure to recognise that a person with a learning disability is unwell; failure to make a correct diagnosis; lack of joint working from different care providers; inadequate/insufficient aftercare or follow-up care. Patients are admitted to mental health ward environments that are not conducive to ASD/LD needs and as such, the lack of reasonable adjustments to mental health ward environments creates inequity.
## Transforming Care Programme: monthly update

<table>
<thead>
<tr>
<th>High Impact Action</th>
<th>Expected completion date and status</th>
<th>Key risks to delivery of the action</th>
<th>SEL BAF risk</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Discharge improvement:</strong></td>
<td></td>
<td><em>Fixed term contacts for PMO and Case Management team. In case of significant turnover in the PMO and Case Management teams there is a risk that specialist knowledge will be lost, causing the programme to lose momentum/ effectiveness.</em></td>
<td>SEL BAF</td>
</tr>
<tr>
<td>• Regular case management rhythm established including monthly surgery meetings chaired by Deputy SRO, supported by weekly case manager/TCP PMO update and escalation calls.</td>
<td>• Ongoing case management and monitoring. • Ongoing case management and monitoring.</td>
<td></td>
<td>Reference:</td>
</tr>
<tr>
<td>• Escalation channels open to SEL AO and NHSE national team.</td>
<td></td>
<td></td>
<td>SEL-08</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Current risk rating:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 3 x 3 = 9 (medium risk)</td>
<td></td>
</tr>
<tr>
<td><strong>Admission prevention:</strong></td>
<td></td>
<td><em>There is a shortage of suitable community support services which can lead to unnecessary admissions/ re-admissions and can cause delays to discharges.</em></td>
<td></td>
</tr>
<tr>
<td>• Enhanced process for the Dynamic Risk register under review.</td>
<td>• Q4 2019/20 • Implemented.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Introduction of compulsory root cause analysis for all admissions and monthly CTR breaching reporting.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Capacity building:</strong></td>
<td></td>
<td><em>There is a lack of clarity regarding NHSE and Spec Comm programme funding beyond 2019/20. This may impact the ability of the TCP to retain key programme team resources.</em></td>
<td></td>
</tr>
<tr>
<td>• Evaluation SLaM &amp; Oxleas autism support services pilots.</td>
<td>• Ongoing. • Q3 2019/20 • Ongoing. • TBC.</td>
<td><em>There is a lack of skilled LD/ ASD workforce in SEL, including specialisms such as psychology, mental health/ LD nursing and community carer. This is impacting the quality of care available and limiting the ability of NHS and independent providers to mobilise new services at pace.</em></td>
<td></td>
</tr>
<tr>
<td>• Mobilising p BBG intensive community support service pilot.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Evaluation of Lambeth “Without Walls” service expansion.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Kick-off mobilisation of the Lewisham CCG proposal for community support services pilot.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
SEL CCGs Finance Report
Month 7 2019/20
Contents

1. Executive Summary
2. Identified material Risks/ Issues
3. Financial Position
4. QIPP Position
5. Acute Start Year Risk Assessment
6. Budget Overview
7. Underlying Position
8. Risks
9. Debtors
10. Revenue Resource Limit (In Year)

Appendix

1. 2018/19 Comparison
2. CCG Position and Recovery Actions
1. Executive Summary

At a glance position at Month 7

At Month 7 the CCGs are reporting on plan year to date (YTD) across each of the six CCGs. The full year forecast outturn (FOT) for all CCGs remains unchanged and assumes delivery of the full year control totals. As a result of the increased pressures described in this report, the FOT position assumes the full use of the £14.3m of contingency funding. At Month 7 the CCG is reporting a full year gross risk position of £16.2m, as set out in section 9 of this report, and a net risk position of £9.5m. Further work in month has subsequently improved the net risk to £6.1m; further details on this position are provided on the next slide, with an update on the individual recovery actions provided within Appendix 2. These actions plus any additional mitigations will need to generate an impact of at least £6.1m in order that the collective control total is meet.

At Month 7, CCGs are forecasting full year QIPP delivery of 96.4% or £95.3m against a plan of £98.9m. During Month 6 Bexley CCG have reduced their unidentified value by £0.9m, and continue to look for additional opportunities to close the balance, £0.7m.

The YTD position has a number of cost pressures which are set out in section 3 and 7. The CCGs are completing their work to mitigate the unplanned cost pressures on the primary care budgets (£4.4m annual pressure). Whilst the CCGs are continuing to identify appropriate mitigations, this position has moved £0.9m in month and further increases will reduce the CCGs ability to meet the challenge that this presents.

Acute - For Month 7, CCGs are reporting breakeven against their main acute contracts, however the unadjusted position on Lewisham and Greenwich is above the position required to trigger a contractual discussion. This position is in the process of being finalised but does represent a significant risk to the CCGs’ position.

CCGs have used Month 5 SLAM data to report acute positions on its non South East London Contracts. This indicates a forecast overspend of £6.4m with particular pressures within all CCGs in relation to London Ambulance (contractual), Moorfields (All CCGs except Bromley and Greenwich), Southwark (Barts); and Bromley (Croydon). Further work is on-going to validate the recurrent impact of these positions.

Prescribing - CCGs have received 5 months of Prescribing data, this indicates that prescribing costs and activity have increased above expectation in year and the CCGs are presently forecasting a £3.9m overspend. This represents impact of costs associated with central pressures (i.e. Category M Drugs and Non Stock items), £2.2m in the reported position; and the non delivery of the 1% outturn reduction assumed in the South East London Financial Planning, £2.1m. In addition the CCGs have identified an additional £4.9m of risk, £3.3m related to Non Stock Items and Cat M Changes; £1.6m for further activity growth.

Of the £8.8m pressure this represents, £5.5m relates to centrally generated costs; we are currently awaiting clarification from regional regulators on whether additional national funding will be made available to support these cost pressures which are outside of the CCGs ability to control. In the absence of the clarification around external funding in Month 7, the CCGs have reflect the additional £3.3m NCSO pressure against the contingency, leaving only the £1.6m activity growth risk reported outside of the ledger.
### Executive Summary - Risk

**At a glance position at M07**

At Month 7 the CCGs are forecasting a risk to their position of £16.2m with mitigations identified totalling £6.7m. This gives the CCGs a net risk position of £9.5m. Given this position, in Month 6 the CCGs SMT agreed to implement a number of actions to either minimize the risk or to identify further mitigations. The impact of this work is presently being fully quantified however the work around QIPP risk has resulted in an improvement of £1.4m; with further work around the remaining risks expected to improve the risk position by an estimated £2.0m. This would reduce the net risk position to £6.1m.

**Acute Contracts:** There is a £4m risk identified against the CCG’s acute contracts, £1m of which relates to Bexley MSK services. In month, the acute team have commenced a work to limit this risk by investigating the potential for year end agreements on our largest external contracts (DGT + Croydon); reviewing prior year balances to identify in year flexibility; and working with local CCGs to implement the recommendations to the Planning and Delivery Group around maximising the impact of the referral advisory services/ MECs services. Further work is commencing at an STP/ ICS level to maximise the opportunities for repatriating patients to with the SEL footprint, although this work isn’t expected to deliver in 19/20. In relation to the MSK pressure within Bexley, work is on-going across all providers and commissioners to reduce the unmitigated expenditure forecast. This is built into the quarterly closedown process with focus on waiting time equalisation and ensuring the appropriate management of inpatients.

**Continuing Healthcare:** One of the CCGs’ key risks is the delivery of the Continuing Healthcare position. The main risk sits within the Greenwich budget where the QIPP delivery is dependant on the CCG’s ability to agree service change with the local borough. Discussions are on-going and the CCG expects to provide a final proposal to the local borough by the end of November. Across all CCGs, targeted resource has been identified to eliminate back-logs and provide additional capacity for complex case work. Whilst work is in its early stages this should lead to reduced risk within this area.

**Drug Pressures:** SEL CCGs are presently challenged to mitigate the impact of £5.5m central price pressures, and deliver a 1% reduction compared to 18/19 outturn. Work has commenced focusing on the key QIPP areas and their delivery both against the QIPP target and in absolute terms. These discussions are being driven between borough GP prescribing leads and chief pharmacists. An updated is expected after the SEL prescribing meeting on the 26th November.

**QIPP Delivery:** At month 7, CCGs are forecasting QIPP risk of £3.3m. Work is on-going to de-risk this position however initial work has lead to a revision of £1.4m to the position, with further work in place to address the remaining pressure. The main remaining risk is £0.7m unidentified QIPP within Bexley, efforts are on-going and as highlighted elsewhere in this report this position represents a £0.9m improvement on Month 6.

**Reserves/ Non Recurrent Mitigations:** The CCGs are in the process of completing their Month 7 deep dive meetings. These have looked to review discretionary spend, old year benefits, non pay expenditure, and challenged the presented reporting position to see what else is possible. These have been seen to have had a positive impact on the position, whilst this need to be quantified further details by CCG are provided in Appendix 2.
### 2. Summary of Key Risks

The below table sets out all of the issues that have arisen in Month, what actions or mitigations need to be taken, the Lead, the SRO, the deadline for resolving and escalation points.

<table>
<thead>
<tr>
<th>Issue/Risk</th>
<th>Summary of Issue/Risk</th>
<th>SRO</th>
<th>Mitigation</th>
<th>Month Identified</th>
<th>Expected Date for Completion</th>
<th>£m’s</th>
<th>BAF Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Continuing Healthcare Spend</strong></td>
<td>Continuing Healthcare budgets in 2019-20 were set assuming a 5% growth rate (net of QIPP) as opposed to historical growth of 8%. The financial value is made up on FoT overspend of £1.2m and £4.4m additional risk. Individual teams have been asked to developed mitigations to reduce individual pressures by £0.5m (£2.8m across SEL).</td>
<td>Managing Directors (MDs) (For each Borough)</td>
<td>Review of application of eligibility criteria</td>
<td>May</td>
<td>Quarter 4</td>
<td>£5.6m</td>
<td>3 3 9</td>
</tr>
<tr>
<td><strong>Primary Care Pressures</strong></td>
<td>The CCGs are facing a £4.4m pressure reflecting the impact of Primary Care population changes. This represents a £0.9m worsening from the previously reported position and this position remains open; opening the possibility for an increased pressure in coming months.</td>
<td>CFO</td>
<td>CCGs are continuing to identified appropriate mitigations to offset this position. Discussions are on-going with NHSE/I to clarify the financial impact.</td>
<td>October</td>
<td>Quarter 3</td>
<td>£4.4m</td>
<td>3 3 9</td>
</tr>
<tr>
<td><strong>Non Block Acute</strong></td>
<td>The available M05 data indicates a £6.4m risk on non block contracts which is included in the reported FoT. In addition we have identified an additional risk of £4.0m related to these contracts which may arise if activity increases above the current trend; plus the specific MSK risk of £1m.</td>
<td>SC + MDs</td>
<td>Each CCG to work on demand management schemes to reduce unnecessary activity within non local providers.</td>
<td>May</td>
<td>Quarter 3</td>
<td>£10.4m</td>
<td>4 4 16</td>
</tr>
<tr>
<td><strong>Acute Underlying Position</strong></td>
<td>CCGs have the majority of their acute spend within a block for 2019/20. If activity was to over-perform materially then the is a risk contracts could be reopened or that an unaffordable starting point will need to be funded in 2020/21</td>
<td>SC + MDs</td>
<td>Each CCG to ensure they identify and deliver the key milestones in their QIPP programme.</td>
<td>May</td>
<td>Quarter 3</td>
<td>n/a</td>
<td>3 4 12</td>
</tr>
<tr>
<td><strong>Prescribing Position</strong></td>
<td>CCGs have been notified of potential changes to the Cat M drugs and Non stock items which may amount to a £5.5m pressure across the 6 CCGs. This is in addition to a £2.1m pressure from the 1% outturn reduction QIPP (part delivered) and the potential for further activity changes, £1.6m.</td>
<td>MDs</td>
<td>SEL CCGs are working collaboratively across the patch to identify the cost drivers and to deliver mitigations where appropriate</td>
<td>July</td>
<td>Quarter 3</td>
<td>£8.8m</td>
<td>4 4 16</td>
</tr>
</tbody>
</table>
3. Overall Financial Position

Overview:

- South East London CCGs are required to deliver a £1.28m revised deficit control total in year. This reflects the CCGs initial start control totals of £3.9m less £2.65m of Commissioning Sustainability Funding (CSF) in Bexley. Bexley continue to be eligible for a further £6.75m of CSF.

- At Month 7, all CCGs are showing delivery against their control totals. This assumes the mitigation of the £4.4m adjustment to CCG allocations reflecting the NHSE identified impact of changes in patient flow. This is expected to be mitigated through the use of contingencies and other actions.

- The CCGs have validated the Month 5 acute data for its non local contracts and based on this a forecast overspend of £6.7m is predicted. This is set out in more detail on slides 16 and 17.

- The position is reflective of the acute blocks delivered on the main acute providers for 2019/20.

- The main non acute pressures sit within,
  - Primary Care where following the changes in allocations an unexpected pressure has been identified within SEL, in particular within Lambeth and Southwark.
  - And within prescribing where the impact of Category M drugs and Short Stock items have generated an increased forecast position across the CCGs.
4. QIPP Position

QIPP Financial Performance

Year to Date QIPP Performance

<table>
<thead>
<tr>
<th></th>
<th>Bexley</th>
<th>Bromley</th>
<th>Greenwich</th>
<th>Lambeth</th>
<th>Lewisham</th>
<th>Southwark</th>
<th>Total SEL CCGs</th>
</tr>
</thead>
<tbody>
<tr>
<td>£’000s</td>
<td>£’000s</td>
<td>£’000s</td>
<td>£’000s</td>
<td>£’000s</td>
<td>£’000s</td>
<td>£’000s</td>
<td>£’000s</td>
</tr>
<tr>
<td>YTD Planned QIPP Savings</td>
<td>5,797</td>
<td>14,649</td>
<td>7,083</td>
<td>11,066</td>
<td>8,439</td>
<td>8,239</td>
<td>55,273</td>
</tr>
<tr>
<td>YTD Actual QIPP Savings</td>
<td>7,313</td>
<td>14,147</td>
<td>6,796</td>
<td>11,158</td>
<td>8,039</td>
<td>8,239</td>
<td>55,692</td>
</tr>
<tr>
<td>YTD QIPP Savings (Under)/Overdelivery</td>
<td>1,516</td>
<td>(502)</td>
<td>(287)</td>
<td>92</td>
<td>(400)</td>
<td>-</td>
<td>419</td>
</tr>
<tr>
<td>YTD QIPP Savings Delivery %</td>
<td>126.2%</td>
<td>96.6%</td>
<td>95.9%</td>
<td>100.8%</td>
<td>95.3%</td>
<td>100.0%</td>
<td>100.8%</td>
</tr>
</tbody>
</table>

Forecast Year End QIPP Performance

<table>
<thead>
<tr>
<th></th>
<th>Bexley</th>
<th>Bromley</th>
<th>Greenwich</th>
<th>Lambeth</th>
<th>Lewisham</th>
<th>Southwark</th>
<th>Total SEL CCGs</th>
</tr>
</thead>
<tbody>
<tr>
<td>£’000s</td>
<td>£’000s</td>
<td>£’000s</td>
<td>£’000s</td>
<td>£’000s</td>
<td>£’000s</td>
<td>£’000s</td>
<td>£’000s</td>
</tr>
<tr>
<td>FOT Planned QIPP Savings</td>
<td>12,264</td>
<td>25,112</td>
<td>12,750</td>
<td>18,671</td>
<td>14,467</td>
<td>15,661</td>
<td>98,925</td>
</tr>
<tr>
<td>FOT Actual QIPP Savings</td>
<td>11,794</td>
<td>23,980</td>
<td>11,984</td>
<td>18,109</td>
<td>13,799</td>
<td>15,661</td>
<td>95,327</td>
</tr>
<tr>
<td>FOT QIPP Savings (Under)/Overdelivery</td>
<td>(470)</td>
<td>(1,132)</td>
<td>(766)</td>
<td>(562)</td>
<td>(668)</td>
<td>-</td>
<td>(3,598)</td>
</tr>
<tr>
<td>FOT QIPP Savings Delivery %</td>
<td>96.2%</td>
<td>95.5%</td>
<td>94.0%</td>
<td>97.0%</td>
<td>95.4%</td>
<td>100.0%</td>
<td>96.4%</td>
</tr>
</tbody>
</table>

Last Month FOT QIPP Savings (Under)/Overdelivery

<table>
<thead>
<tr>
<th></th>
<th>Bexley</th>
<th>Bromley</th>
<th>Greenwich</th>
<th>Lambeth</th>
<th>Lewisham</th>
<th>Southwark</th>
<th>Total SEL CCGs</th>
</tr>
</thead>
<tbody>
<tr>
<td>£’000s</td>
<td>£’000s</td>
<td>£’000s</td>
<td>£’000s</td>
<td>£’000s</td>
<td>£’000s</td>
<td>£’000s</td>
<td>£’000s</td>
</tr>
<tr>
<td>(604)</td>
<td>(794)</td>
<td>(818)</td>
<td>(784)</td>
<td>(670)</td>
<td>-</td>
<td>-</td>
<td>(3,670)</td>
</tr>
</tbody>
</table>

Programme FY Plan £’000s RAG % Month 7 FOT £’000s Variance £’000s Main Risks

<table>
<thead>
<tr>
<th>Programme</th>
<th>FY Plan £’000s</th>
<th>RAG %</th>
<th>Month 7 FOT £’000s</th>
<th>Variance £’000s</th>
<th>Main Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>49,479</td>
<td>98%</td>
<td>48,539</td>
<td>(940)</td>
<td>Variance driven by Non Local Providers</td>
</tr>
<tr>
<td>Continuing Healthcare (CHC)</td>
<td>4,102</td>
<td>76%</td>
<td>3,112</td>
<td>(990)</td>
<td>BGL + Lambeth Risk</td>
</tr>
<tr>
<td>Mental Health</td>
<td>1,134</td>
<td>100%</td>
<td>1,134</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>18,568</td>
<td>97%</td>
<td>18,081</td>
<td>(487)</td>
<td>50% of this plan relates to Bromley CCG</td>
</tr>
<tr>
<td>Other Non-Recurrent Savings</td>
<td>9,572</td>
<td>102%</td>
<td>9,784</td>
<td>212</td>
<td></td>
</tr>
<tr>
<td>Prescribing</td>
<td>11,096</td>
<td>87%</td>
<td>9,703</td>
<td>(1,393)</td>
<td>Identified as a risk across BGL</td>
</tr>
<tr>
<td>Running/ Corporate Costs</td>
<td>4,248</td>
<td>100%</td>
<td>4,248</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Unidentified</td>
<td>726</td>
<td>100%</td>
<td>726</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>96,925</td>
<td>96%</td>
<td>95,327</td>
<td>(3,598)</td>
<td></td>
</tr>
</tbody>
</table>

Overview:

- Following the 2019/20 planning round, a QIPP gap of £98.9m, was identified across South East London. At Month 7, CCGs are forecasting 96.4% delivery against schemes, £95.3m. In delivering its 2018/19 position, CCGs delivered 85.8% of their QIPP in year.

- The reported position includes the assumption that the £0.7m unidentified QIPP within Bexley is delivered in full in 2019-20. Bexley continue to work to reduce the level of unidentified QIPP and at Month 7 this has improved by £0.9m compared to Month 6.

- Given the YTD and FOT pressures on the CHC and Prescribing budgets the delivery of the QIPPs, in these areas, will be a significant challenge.
5. Acute In Year Position

Overview:
At Month 7, the CCGs have received Month 6 SLAM data, however to ensure a robust position can be used for reporting non local contracts, this position is based on Month 5 SLAM information. This position is higher than anticipated, particularly at Moorfields and Croydon; further details of the position by contract are provided on the following slide.

As previously highlighted, the key individual risk is the London Ambulance Contract, work has continued in month with the expected risk reduced to £0.3m.
5. Acute In Year Position (Non Locals)

Overview:
A slight worsening in reported position this month, with Royal Marsden and Imperial being the largest movers; affecting Bromley and Lewisham. The main drivers by trust are outlined below.

Croydon
A&E and Emergency are significantly over-spent, particularly for Bromley and Lambeth, driven by increased usage of new A&E unit. Further discussions are on-going to ensure the contract is being appropriately managed by the host.

Moorfields
Known that low contract value was set, coupled with increased growth trend since month 6 last year, through a 25% referral increase. Further work is required locally by CCGs to ensure they maximise the benefit of the local Optometrist Triage Services.

Barts
Planned Care is particularly over-spent, with a number of HEMS cases occurring for CCGs, and Critical Care catch up this month for Lam & Sou.

C&W
Due to Planned Care usage, and a steep increase in Maternity spend over the last few months.

Further work is being undertaken which focuses on data and reporting assurance, investigating high trend data to identify the nature of its cost and to allow the pressures to be mitigate appropriately.

<table>
<thead>
<tr>
<th>BY PROVIDER</th>
<th>YEAR TO DATE - SLAM MONTH</th>
<th>SLAM MONTH FORECAST</th>
</tr>
</thead>
<tbody>
<tr>
<td>REPORTED POSITION - VARIANCE AGAINST PLAN UNDER/(OVER)</td>
<td>Plan</td>
<td>Actual</td>
</tr>
<tr>
<td>£'000s</td>
<td>£'000s</td>
<td>£'000s</td>
</tr>
<tr>
<td>Barts Health NHS Trust</td>
<td>5,080</td>
<td>5,473</td>
</tr>
<tr>
<td>BMI Healthcare</td>
<td>4,969</td>
<td>4,858</td>
</tr>
<tr>
<td>Chelsea and Westminster NHS Foundation Trust</td>
<td>3,137</td>
<td>3,489</td>
</tr>
<tr>
<td>Croydon Health Services NHS Trust</td>
<td>3,543</td>
<td>6,114</td>
</tr>
<tr>
<td>Epsom and St. Helier University Hospital NHS Trust</td>
<td>810</td>
<td>749</td>
</tr>
<tr>
<td>Great Ormond Street Hospital For Children NHS Trust</td>
<td>322</td>
<td>345</td>
</tr>
<tr>
<td>Homerton University Hospital NHS Foundation Trust</td>
<td>448</td>
<td>406</td>
</tr>
<tr>
<td>Imperial College Healthcare NHS Trust</td>
<td>2,489</td>
<td>2,507</td>
</tr>
<tr>
<td>King's College Hospital NHS Foundation Trust</td>
<td>960</td>
<td>968</td>
</tr>
<tr>
<td>London North West Healthcare NHS Trust</td>
<td>624</td>
<td>613</td>
</tr>
<tr>
<td>Maidstone and Tunbridge Wells NHS Trust</td>
<td>539</td>
<td>599</td>
</tr>
<tr>
<td>Medway NHS Foundation Trust</td>
<td>772</td>
<td>709</td>
</tr>
<tr>
<td>Moorfield's Eye Hospital NHS Foundation Trust</td>
<td>5,579</td>
<td>6,375</td>
</tr>
<tr>
<td>Queen Victoria Hospital NHS Foundation Trust</td>
<td>580</td>
<td>526</td>
</tr>
<tr>
<td>Royal Brompton and Harefield NHS Foundation Trust</td>
<td>351</td>
<td>561</td>
</tr>
<tr>
<td>Royal Free NHS Foundation Trust</td>
<td>1,125</td>
<td>953</td>
</tr>
<tr>
<td>Royal National Orthopaedic Hospital NHS Trust</td>
<td>770</td>
<td>660</td>
</tr>
<tr>
<td>University College London Hospital NHS Foundation Trust</td>
<td>6,731</td>
<td>6,854</td>
</tr>
<tr>
<td>Whittington Hospital NHS Trust</td>
<td>223</td>
<td>202</td>
</tr>
</tbody>
</table>

Reported: Contracts 41,147 42,591 -2,144 -5.2% -4,303 -1,087 -164 -1,738 -145 -1,236 -183 -838 -4,302

FOT Reported: Contracts 82,295 86,598 -4,303 -5.2% -4,303 -1,087 -164 -1,738 -145 -1,236 -183 -838 -4,302
5. Acute In Year Risk Position

Overview:
In reporting a likely acute position of £6.4m, an assessment had been made on the present positions being reported by the individual trusts.

If the CCGs were to assume that:

- There was no re-opening of local contracts.
- There the London Ambulance contract was settled £0.3m above the present reported level.
- Bexley MSK budget over-performs by £1m.
- Non Local contract activity increases by at least 1%, with higher levels of increase seen within Dartford, 1.5%.

Then the reported position would increase from £6.4m to £10.4m i.e. a net risk of £4m.

<table>
<thead>
<tr>
<th>Bridge from Reported to Worst Case</th>
<th>£'000s</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>GST</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>KCH</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>LGT</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>DGT</td>
<td>-394</td>
<td>-31</td>
</tr>
<tr>
<td>SGH</td>
<td>-4</td>
<td>-15</td>
</tr>
<tr>
<td>LAS</td>
<td>-33</td>
<td>-42</td>
</tr>
<tr>
<td>Non Local Contracts</td>
<td>-85</td>
<td>-350</td>
</tr>
<tr>
<td>Sub Total: Contracts</td>
<td>-516</td>
<td>-438</td>
</tr>
<tr>
<td>Non Contracted Activity</td>
<td>-116</td>
<td>-110</td>
</tr>
<tr>
<td>Sexual Health</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>MSK</td>
<td>-1,000</td>
<td>0</td>
</tr>
<tr>
<td>Earmarked Reserves/All Other Budgets</td>
<td>0</td>
<td>-4</td>
</tr>
<tr>
<td>Total Worst Case increase</td>
<td>-1,632</td>
<td>-552</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Percentage</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>GST</td>
<td>0.0%</td>
</tr>
<tr>
<td>KCH</td>
<td>0.0%</td>
</tr>
<tr>
<td>LGT</td>
<td>0.0%</td>
</tr>
<tr>
<td>DGT</td>
<td>-1.0%</td>
</tr>
<tr>
<td>SGH</td>
<td>-1.0%</td>
</tr>
<tr>
<td>LAS</td>
<td>-0.3%</td>
</tr>
<tr>
<td>Non Local Contracts</td>
<td>-1.5%</td>
</tr>
<tr>
<td>Sub Total: Contracts</td>
<td>-1.5%</td>
</tr>
<tr>
<td>Non Contracted Activity</td>
<td>-2.0%</td>
</tr>
<tr>
<td>Sexual Health</td>
<td>-1.0%</td>
</tr>
<tr>
<td>MSK</td>
<td>-16.7%</td>
</tr>
<tr>
<td>Earmarked Reserves/All Other Budgets</td>
<td>-1.0%</td>
</tr>
<tr>
<td>Total Worst Case increase</td>
<td>-1.0%</td>
</tr>
</tbody>
</table>

**FORECAST OUTTURN - BEST/LIKELY/WORST CASE**

<table>
<thead>
<tr>
<th></th>
<th>Besley</th>
<th>Bromley</th>
<th>Greenwich</th>
<th>Lambeth</th>
<th>Lewisham</th>
<th>Southwark</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>£’000s</td>
<td>£’000s</td>
<td>£’000s</td>
<td>£’000s</td>
<td>£’000s</td>
<td>£’000s</td>
<td>£’000s</td>
<td>£’000s</td>
</tr>
<tr>
<td>Best Case</td>
<td>1,120</td>
<td>-2,167</td>
<td>-41</td>
<td>-1,426</td>
<td>-675</td>
<td>-1,058</td>
<td>-4,247</td>
</tr>
<tr>
<td>Likely / Reported Position</td>
<td>566</td>
<td>-2,528</td>
<td>-272</td>
<td>-2,027</td>
<td>-877</td>
<td>-1,295</td>
<td>-6,434</td>
</tr>
<tr>
<td>Worst Case</td>
<td>-1,066</td>
<td>-3,080</td>
<td>-713</td>
<td>-2,741</td>
<td>-1,176</td>
<td>-1,632</td>
<td>-10,408</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>GST</td>
</tr>
<tr>
<td>KCH</td>
</tr>
<tr>
<td>LGT</td>
</tr>
<tr>
<td>DGT</td>
</tr>
<tr>
<td>SGH</td>
</tr>
<tr>
<td>LAS</td>
</tr>
<tr>
<td>Non Local Contracts</td>
</tr>
<tr>
<td>Sub Total: Contracts</td>
</tr>
<tr>
<td>Non Contracted Activity</td>
</tr>
<tr>
<td>Sexual Health</td>
</tr>
<tr>
<td>MSK</td>
</tr>
<tr>
<td>Earmarked Reserves/All Other Budgets</td>
</tr>
<tr>
<td>Total Worst Case increase</td>
</tr>
</tbody>
</table>
5. Acute QIPP Position

**QIPP Summary at Q1**

- Reported position here relates to the Trust-led SIP plans guaranteed within the acute contracts
- Figures taken from Q1 assessments, noting that these are CSU-derived assessments still being reviewed by trusts
- Position estimates a 65% achievement against a phased plan at Q1
- Notable achievement comes through Prescribing, savings for all Trusts, higher than planned levels, due mostly to the price reduction of Adalimumab
- Emergency benefits are in the form of AEC usage and reduction in length of stays, however this is currently below expectation, so pressure to increase as the year progresses
- Out Patient pathway changes and method of delivery are anticipated to take effect after Q1, however evidence suggests a visible increase in telephone and virtual clinics and Advice and Guidance usage at all Trusts

**GST** agreed a Q1 position of 40% achievement against a phased plan as a place-holder assessment whilst further reviews, and new schemes, get underway. A November follow up meeting with Trust will assess this position further.

- GST plan to review Emergency assessment, to consider both AEC price and scope in order to advance SIP achievement.

**KCH** has undertaken some actions towards delivery of SIP which is notably evidenced in their Outpatient and Drugs PODs. Emergency SDEC achievements are being overshadowed by increases in activity, casemix and LoS generally, so further work is required to ensure appropriate SIP delivery

- An additional workstream is reviewing delivery of EBI against new clinical criteria
- CSU assessment shows high year to date achievement, noting the plan is heavily back-loaded.

**LGT** SIP discussions are secondary to more pressing discussions on ambulatory care performance at Q1. Trusts initial view of SIP is an over-delivery; whilst we do not align to this view, we estimate a sizable delivery of 84%.

- Emergency SIP delivery is of particular note, given the SLAM over-performance, however we acknowledge there is a switch to short stay admissions and an increase in AEC activity
6. Budget Overview

Overview:

- The finance figures in this table are reported in line with national NHSE reporting classifications. There will be some differences to local reports which are reflective of local reporting hierarchies. Reporting hierarchies are currently being reviewed with a view to standardisation across SEL CCGs and will be reflected as part of Q3 reporting.

- In order to deliver the agreed control totals at year end, CCGs are forecasting to utilise their £14.3m contingency in full. This will be required to offset the reduction in primary care allocations that the CCGs have been notified about; plus the impact of the prescribing pressures.

- The acute contract positions reflect the Month 5 SLAM positions for Non Locals, with Local contracts reported in line with the aligned incentive contracts.

- The main reported pressure relates to the impact of GP@Hand allocation changes, £4.4m; work is on-going to resolve these and offset actions can be seen within the Primary Care Services exc Prescribing and Other reporting categories.

- In Month 7, following the publication of Month 5 PPA data, CCGs continue to see emerging pressures within prescribing. This position is being reviewed by the SEL Medicines Management team but indicates a non delivery of the 1% outturn adjustment assumed within CCG QIPP plans, plus additional pressures from Short Stock items and Cat M changes.

- Within continuing care, three CCGs are forecasting material overspends, due to the increased number and complexity of patients needing to be actively managed. Work is on-going at a South East London level to identify targeted resources to respond to this challenge.

- The Running cost underspend reflects the impact of CCG QIPP (separate allocation).

### Budget Area Position

<table>
<thead>
<tr>
<th>Budget Area Position</th>
<th>Bexley</th>
<th>Bromley</th>
<th>Greenwich</th>
<th>Lambeth</th>
<th>Lewisham</th>
<th>Southwark</th>
<th>Total SEL CCGs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year to Date (Over)/ Underspend</td>
<td>£’000s</td>
<td>£’000s</td>
<td>£’000s</td>
<td>£’000s</td>
<td>£’000s</td>
<td>£’000s</td>
<td>£’000s</td>
</tr>
<tr>
<td>Acute Services (including Local Acute Services)</td>
<td>717</td>
<td>(1,527)</td>
<td>(183)</td>
<td>(662)</td>
<td>(596)</td>
<td>(931)</td>
<td>(3,372)</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>(19)</td>
<td>(82)</td>
<td>(575)</td>
<td>324</td>
<td>-</td>
<td>244</td>
<td>(108)</td>
</tr>
<tr>
<td>Community Health Services</td>
<td>48</td>
<td>136</td>
<td>(96)</td>
<td>657</td>
<td>(24)</td>
<td>(55)</td>
<td>626</td>
</tr>
<tr>
<td>Continuing Care Services</td>
<td>277</td>
<td>385</td>
<td>(485)</td>
<td>(668)</td>
<td>(361)</td>
<td>164</td>
<td>(688)</td>
</tr>
<tr>
<td>Primary Care Services exc Prescribing</td>
<td>17</td>
<td>146</td>
<td>(33)</td>
<td>(684)</td>
<td>(228)</td>
<td>(793)</td>
<td>(1,575)</td>
</tr>
<tr>
<td>Prescribing</td>
<td>(368)</td>
<td>(235)</td>
<td>(302)</td>
<td>(554)</td>
<td>(237)</td>
<td>(767)</td>
<td>(2,463)</td>
</tr>
<tr>
<td>Other Programme Services</td>
<td>(662)</td>
<td>(57)</td>
<td>83</td>
<td>455</td>
<td>(84)</td>
<td>1,096</td>
<td>831</td>
</tr>
<tr>
<td>Total Programme Services</td>
<td>10</td>
<td>(1,234)</td>
<td>(1,591)</td>
<td>(1,372)</td>
<td>(1,520)</td>
<td>(1,042)</td>
<td>(6,749)</td>
</tr>
<tr>
<td>Running Costs (subset of Management cost)</td>
<td>(10)</td>
<td>123</td>
<td>-</td>
<td>453</td>
<td>-</td>
<td>25</td>
<td>591</td>
</tr>
<tr>
<td>Contingency (Requires CFO Agreement)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1,111</td>
<td>1,591</td>
<td>919</td>
<td>1,520</td>
</tr>
<tr>
<td>Total (Over)/ Underspend</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1,111</td>
<td>1,591</td>
<td>919</td>
<td>1,520</td>
</tr>
</tbody>
</table>

### FOT (Over)/ Underspend

<table>
<thead>
<tr>
<th>FOT (Over)/ Underspend</th>
<th>Bexley</th>
<th>Bromley</th>
<th>Greenwich</th>
<th>Lambeth</th>
<th>Lewisham</th>
<th>Southwark</th>
<th>Total SEL CCGs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year to Date (Over)/ Underspend</td>
<td>£’000s</td>
<td>£’000s</td>
<td>£’000s</td>
<td>£’000s</td>
<td>£’000s</td>
<td>£’000s</td>
<td>£’000s</td>
</tr>
<tr>
<td>Acute Services (including Local Acute Services)</td>
<td>615</td>
<td>(2,410)</td>
<td>(224)</td>
<td>(2,044)</td>
<td>(47)</td>
<td>(1,295)</td>
<td>(5,604)</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>-</td>
<td>(141)</td>
<td>(282)</td>
<td>(442)</td>
<td>-</td>
<td>(29)</td>
<td>(894)</td>
</tr>
<tr>
<td>Community Health Services</td>
<td>46</td>
<td>223</td>
<td>(380)</td>
<td>856</td>
<td>19</td>
<td>(18)</td>
<td>755</td>
</tr>
<tr>
<td>Continuing Care Services</td>
<td>52</td>
<td>661</td>
<td>(609)</td>
<td>(601)</td>
<td>(774)</td>
<td>220</td>
<td>(1,311)</td>
</tr>
<tr>
<td>Primary Care Services exc Prescribing</td>
<td>174</td>
<td>250</td>
<td>126</td>
<td>(748)</td>
<td>(184)</td>
<td>(1,316)</td>
<td>(2,299)</td>
</tr>
<tr>
<td>Prescribing</td>
<td>(623)</td>
<td>(404)</td>
<td>(518)</td>
<td>(1,136)</td>
<td>(406)</td>
<td>(857)</td>
<td>(3,944)</td>
</tr>
<tr>
<td>Other Programme Services</td>
<td>(1,800)</td>
<td>(1,001)</td>
<td>(149)</td>
<td>719</td>
<td>(1,134)</td>
<td>1,097</td>
<td>(2,358)</td>
</tr>
<tr>
<td>Total Programme Services</td>
<td>(1,625)</td>
<td>(2,813)</td>
<td>(2,296)</td>
<td>(3,597)</td>
<td>(2,526)</td>
<td>(2,498)</td>
<td>(15,355)</td>
</tr>
<tr>
<td>Running Costs (subset of Management cost)</td>
<td>(41)</td>
<td>211</td>
<td>52</td>
<td>764</td>
<td>30</td>
<td>1,016</td>
<td></td>
</tr>
<tr>
<td>Contingency (Requires CFO Agreement)</td>
<td>1,666</td>
<td>2,602</td>
<td>2,244</td>
<td>2,833</td>
<td>2,526</td>
<td>2,468</td>
<td>14,339</td>
</tr>
<tr>
<td>Total (Over)/ Underspend</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>
6. Budget Overview (Straight-Line Reporting)

**Overview:**
- The CCGs forecast on the previous page, shows a forecast overspend of £15.4m on programme services before the application of running cost savings and contingencies.

- If the Month 6 position was forecast on a straight-line basis this position would be £3.8m better i.e. in delivering their position CCGs are expecting a net worsening in their position.

- The main driver to this position is the forecast impact of Short Stock Drug items. In the absence of external funding this will need to be charged against contingency, and is therefore reported against other programme services.

- There is a favourable movement in the Greenwich Mental health position where the position assumes an expected improvement in the non contract placement spend. The year to date position reflects a quarter 1 spike in Female PICU placements which has subsequently been reduced.

- There is a forecast £1m worsening in the Lambeth Mental Health position. This is based on the present LD Client base which has increased in year. This position is partially offset by the Lambeth Continuing Care position where there is on-going work to mitigate the impact of high cost clients particular in Physical Disability and Children’s.

- The acute position reflects the forecasting approach undertaken by the CSU which considers one-off expenditure, seasonal spend profiles across providers and PODs.

<table>
<thead>
<tr>
<th>FOT (Over)/ Underspend</th>
<th>Bexley</th>
<th>Bromley</th>
<th>Greenwich</th>
<th>Lambeth</th>
<th>Lewisham</th>
<th>Southwark</th>
<th>Total SEL CCGs</th>
</tr>
</thead>
<tbody>
<tr>
<td>£'000s</td>
<td>£'000s</td>
<td>£'000s</td>
<td>£'000s</td>
<td>£'000s</td>
<td>£'000s</td>
<td>£'000s</td>
<td>£'000s</td>
</tr>
<tr>
<td>FOT (Over)/ Underspend</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Services (including Local Acute Services)</td>
<td>616</td>
<td>(2,410)</td>
<td>(224)</td>
<td>(2,044)</td>
<td>(47)</td>
<td>(1,129)</td>
<td>(5,404)</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community Health Services</td>
<td>46</td>
<td>232</td>
<td>(380)</td>
<td>856</td>
<td>19</td>
<td>(18)</td>
<td>755</td>
</tr>
<tr>
<td>Continuing Care Services</td>
<td>52</td>
<td>661</td>
<td>(869)</td>
<td>(601)</td>
<td>(774)</td>
<td>220</td>
<td>(3,111)</td>
</tr>
<tr>
<td>Primary Care Services exl Prescribing</td>
<td>174</td>
<td>250</td>
<td>126</td>
<td>(949)</td>
<td>(184)</td>
<td>(1,616)</td>
<td>(2,199)</td>
</tr>
<tr>
<td>Prescribing</td>
<td>(623)</td>
<td>(404)</td>
<td>(518)</td>
<td>(1,136)</td>
<td>(406)</td>
<td>(857)</td>
<td>(3,944)</td>
</tr>
<tr>
<td>Other Programme Services</td>
<td>(1,890)</td>
<td>(1,001)</td>
<td>(149)</td>
<td>719</td>
<td>(1,134)</td>
<td>1,097</td>
<td>(2,358)</td>
</tr>
<tr>
<td>Total Programme Services</td>
<td>(1,625)</td>
<td>(2,813)</td>
<td>(2,296)</td>
<td>(3,597)</td>
<td>(2,526)</td>
<td>(2,498)</td>
<td>(15,355)</td>
</tr>
<tr>
<td>Running Costs (subset of Management cost)</td>
<td>(41)</td>
<td>211</td>
<td>52</td>
<td>764</td>
<td>30</td>
<td>1,016</td>
<td></td>
</tr>
<tr>
<td>Contingency (Requires CFO Agreement)</td>
<td>1,666</td>
<td>2,602</td>
<td>2,244</td>
<td>2,833</td>
<td>2,526</td>
<td>2,468</td>
<td>14,339</td>
</tr>
<tr>
<td>Total (Over)/ Underspend</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>-</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Movement in Straight-line</th>
<th>Bexley</th>
<th>Bromley</th>
<th>Greenwich</th>
<th>Lambeth</th>
<th>Lewisham</th>
<th>Southwark</th>
<th>Total SEL CCGs</th>
</tr>
</thead>
<tbody>
<tr>
<td>£'000s</td>
<td>£'000s</td>
<td>£'000s</td>
<td>£'000s</td>
<td>£'000s</td>
<td>£'000s</td>
<td>£'000s</td>
<td>£'000s</td>
</tr>
<tr>
<td>Movement in Straight-line</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Services (including Local Acute Services)</td>
<td>(613)</td>
<td>208</td>
<td>90</td>
<td>(566)</td>
<td>958</td>
<td>301</td>
<td>377</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>33</td>
<td>0</td>
<td>704</td>
<td>(997)</td>
<td>-</td>
<td>(447)</td>
<td>(709)</td>
</tr>
<tr>
<td>Community Health Services</td>
<td>(36)</td>
<td>(1)</td>
<td>(215)</td>
<td>(202)</td>
<td>60</td>
<td>76</td>
<td>(318)</td>
</tr>
<tr>
<td>Continuing Care Services</td>
<td>(423)</td>
<td>1</td>
<td>(38)</td>
<td>544</td>
<td>(155)</td>
<td>(61)</td>
<td>(313)</td>
</tr>
<tr>
<td>Primary Care Services exl Prescribing</td>
<td>145</td>
<td>(0)</td>
<td>183</td>
<td>224</td>
<td>207</td>
<td>(257)</td>
<td>501</td>
</tr>
<tr>
<td>Prescribing</td>
<td>8</td>
<td>(1)</td>
<td>0</td>
<td>(186)</td>
<td>0</td>
<td>458</td>
<td>278</td>
</tr>
<tr>
<td>Other Programme Services</td>
<td>(755)</td>
<td>(903)</td>
<td>(291)</td>
<td>(61)</td>
<td>(990)</td>
<td>(782)</td>
<td>(3,783)</td>
</tr>
<tr>
<td>Total Programme Services</td>
<td>(1,642)</td>
<td>(698)</td>
<td>431</td>
<td>(1,245)</td>
<td>80</td>
<td>(712)</td>
<td>(3,785)</td>
</tr>
</tbody>
</table>
6. Budget Overview (Prescribing)

Overview:

- The CCGs are forecasting an overspend of £3.9m on prescribing services. This is driven by,
  
  - Changes in Central Charges/ Items outside the CCGs’ local control. On a like for like comparison to 2018/19 the impact of Short stock items and Category M price changes is £2.2m
  
  - The non delivery of the 1% QIPP stretch. CCGs undertook to reduce prescribing spend below the 18/19 outturn position. This compares to a national expectation of a minimum 0.5% increase in activity/cost per year. Based on present reporting CCGs have delivered £0.4m of the £2.1m required (this represents a 0.18% reduction on 18/19 outturn).
  
  - The CCGs are the forecasting further risks of £4.9m.
    
    - £3.3m of this risk relates to Short stock items and this risk is reflect against the increased contingency usage in month (reported under other). Whilst the precise impact isn’t know the present climate indicates that short stock items will continue at their present level for the foreseeable future.
    
    - The remaining £1.6m relates to an activity risk and is built of a possible 2% increase in activity between Months 6-12. This position will be monitored and work is on-going with the SEL prescribing teams to mitigate this where possible.

<table>
<thead>
<tr>
<th>Prescribing</th>
<th>NHS BEXLEY CCG</th>
<th>NHS BROMLEY CCG</th>
<th>NHS GREENWICH CCG</th>
<th>NHS LAMBETH CCG</th>
<th>NHS LEWISHAM CCG</th>
<th>NHS SOUTHWARK CCG</th>
<th>Total South East London CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td>PPA Forecast Outturn</td>
<td>30,064</td>
<td>42,472</td>
<td>30,525</td>
<td>34,337</td>
<td>34,525</td>
<td>29,640</td>
<td>201,562</td>
</tr>
<tr>
<td>Reduced for Short Stock Items Months 6-12 (estimated)</td>
<td>(485)</td>
<td>(664)</td>
<td>(514)</td>
<td>(577)</td>
<td>(533)</td>
<td>(535)</td>
<td>(3,308)</td>
</tr>
<tr>
<td>Reported Position</td>
<td>29,579</td>
<td>41,808</td>
<td>30,011</td>
<td>33,760</td>
<td>33,992</td>
<td>29,105</td>
<td>198,255</td>
</tr>
<tr>
<td>Budget</td>
<td>28,864</td>
<td>40,949</td>
<td>29,820</td>
<td>32,203</td>
<td>33,586</td>
<td>28,248</td>
<td>193,671</td>
</tr>
<tr>
<td>Variance</td>
<td>(715)</td>
<td>(858)</td>
<td>(191)</td>
<td>(1,557)</td>
<td>(406)</td>
<td>(857)</td>
<td>(4,584)</td>
</tr>
<tr>
<td>Other Variances</td>
<td>92</td>
<td>454</td>
<td>(327)</td>
<td>421</td>
<td>-</td>
<td>0</td>
<td>640</td>
</tr>
<tr>
<td>Prescribing Variance</td>
<td>(623)</td>
<td>(404)</td>
<td>(518)</td>
<td>(1,136)</td>
<td>(406)</td>
<td>(857)</td>
<td>(3,944)</td>
</tr>
<tr>
<td>Changes in Pricing (Central Pressures)</td>
<td>356</td>
<td>449</td>
<td>337</td>
<td>422</td>
<td>304</td>
<td>361</td>
<td>2,228</td>
</tr>
<tr>
<td>1% Outturn</td>
<td>303</td>
<td>442</td>
<td>331</td>
<td>342</td>
<td>360</td>
<td>322</td>
<td>2,100</td>
</tr>
<tr>
<td>Unexplained Difference to Outturn</td>
<td>36</td>
<td>487</td>
<td>150</td>
<td>(372)</td>
<td>258</td>
<td>(174)</td>
<td>384</td>
</tr>
</tbody>
</table>
7. Underlying Position

Overview:

- The SEL CCGs are presently reporting a £41.6m underlying position. This reflects the reversal of all material non-recurrent mitigations within the position; and reflects the need to restate the contingency utilised in year.

- This position has worsened by £0.7m in month, this reflects the recurrent impact of the changes in allocations relating to Primary Care budgets.

Further adjustments to the underlying position include:

- The main driver to the position is the expected exit run rate on the local acute contracts. This position has been updated in month to reflect the impact of the Quarter 1 conversations. The underlying position will be further reviewed as part of the contract discussions for 2020/21.

- SEL CCGs have utilised non-recurrent measures to managing the Primary Care pressures outlined within this report. These are one-off mitigations and have been adjusted for in the underlying position.

- In the CCGs baseline plan, four of the six CCGs identified a number of non-recurrent solutions to the in year pressures. These are one-off mitigations and have been adjusted for in the underlying position.

- In agreeing mental Health contracts for 2019/20, CCGs agreed phased investment plans were agreed with our partners in Oxleas and SLAM. These commitments will need to be funded on a recurrent basis.

### CCG Underlying Position

<table>
<thead>
<tr>
<th></th>
<th>Bexley</th>
<th>Bromley</th>
<th>Greenwich</th>
<th>Lambeth</th>
<th>Lewisham</th>
<th>Southwark</th>
<th>Total SEL CCGs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>£’000s</strong></td>
<td>£’000s</td>
<td>£’000s</td>
<td>£’000s</td>
<td>£’000s</td>
<td>£’000s</td>
<td>£’000s</td>
<td></td>
</tr>
<tr>
<td>Forecast Outturn</td>
<td>(4,875)</td>
<td>0</td>
<td>3,600</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>(3,150)</td>
</tr>
<tr>
<td>Reversal of CSF</td>
<td>(2,625)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>(2,625)</td>
</tr>
<tr>
<td>Contingency Restatement</td>
<td>(1,666)</td>
<td>(2,602)</td>
<td>(2,244)</td>
<td>(2,833)</td>
<td>(2,526)</td>
<td>(2,468)</td>
<td>(14,339)</td>
</tr>
<tr>
<td>Unwinding of Risk Share</td>
<td>(4,100)</td>
<td>(1,200)</td>
<td>5,300</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Acute - Guys</td>
<td>(162)</td>
<td>(178)</td>
<td>(214)</td>
<td>(967)</td>
<td>(390)</td>
<td>(906)</td>
<td>(2,817)</td>
</tr>
<tr>
<td>Acute - Kings</td>
<td>(68)</td>
<td>(369)</td>
<td>(39)</td>
<td>(153)</td>
<td>(72)</td>
<td>(174)</td>
<td>(875)</td>
</tr>
<tr>
<td>Acute - Lewisham</td>
<td>(1,557)</td>
<td>(264)</td>
<td>(2,688)</td>
<td>(28)</td>
<td>(2,891)</td>
<td>(86)</td>
<td>(7,514)</td>
</tr>
<tr>
<td>Other Non Recurrent Solutions</td>
<td>1,463</td>
<td>655</td>
<td>9</td>
<td>(2,223)</td>
<td>(1,487)</td>
<td>(1,750)</td>
<td>(3,333)</td>
</tr>
<tr>
<td>Planned Non Recurrent Mitigations</td>
<td>0</td>
<td>(3,250)</td>
<td>(1,407)</td>
<td>(164)</td>
<td>(2,100)</td>
<td>(6,921)</td>
<td></td>
</tr>
<tr>
<td>FYE of Mental Health Contracts</td>
<td>(148)</td>
<td>(254)</td>
<td>(291)</td>
<td>(387)</td>
<td>(420)</td>
<td>(405)</td>
<td>(1,905)</td>
</tr>
<tr>
<td><strong>Underlying Position Month 7</strong></td>
<td>(13,738)</td>
<td>(6,262)</td>
<td>(3,067)</td>
<td>(7,998)</td>
<td>(2,650)</td>
<td>(7,889)</td>
<td>(41,604)</td>
</tr>
<tr>
<td><strong>Underlying Position Month 6</strong></td>
<td>(13,813)</td>
<td>(7,435)</td>
<td>(1,908)</td>
<td>(8,987)</td>
<td>(1,220)</td>
<td>(7,592)</td>
<td>(40,955)</td>
</tr>
</tbody>
</table>

---

15
7. Underlying Position (Acute)

**Overview:**
- SEL CCGs agreed aligned incentive contracts for its main three acute providers for 2019/20. This looked to mitigate the financial risk within the system and to facilitate constructive conversations about managing the challenges on a health economy basis.
- The ICDT are in the process of undertaking the quarterly closedown process but the positions above reflect the underlying activity at full PbR before adjustment for system wide mitigations and other validation adjustments.

<table>
<thead>
<tr>
<th>UNDERLYING POSITION VARIANCE AGAINST PLAN UNDER(OVER)</th>
<th>FORECAST OUTFURN</th>
<th>Variance (Pressure) Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>VARIANCE UNDER(OVER) PLAN</td>
<td>Under (Over)</td>
<td>%</td>
</tr>
<tr>
<td>Elective</td>
<td>76,018</td>
<td>75,464</td>
</tr>
<tr>
<td>Outpatient 1st</td>
<td>30,004</td>
<td>30,652</td>
</tr>
<tr>
<td>Outpatient Follow Up</td>
<td>34,054</td>
<td>35,679</td>
</tr>
<tr>
<td>Outpatient Procedure</td>
<td>19,047</td>
<td>19,831</td>
</tr>
<tr>
<td>Total Planned Care</td>
<td>159,233</td>
<td>161,607</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>22,597</td>
<td>22,722</td>
</tr>
<tr>
<td>Non Elective</td>
<td>70,676</td>
<td>71,911</td>
</tr>
<tr>
<td>Critical Care</td>
<td>17,451</td>
<td>17,281</td>
</tr>
<tr>
<td>Total Unplanned Care</td>
<td>116,773</td>
<td>117,551</td>
</tr>
<tr>
<td>Maternity Pathway</td>
<td>31,217</td>
<td>30,868</td>
</tr>
<tr>
<td>Drugs &amp; Devices</td>
<td>17,532</td>
<td>16,900</td>
</tr>
<tr>
<td>Direct Access</td>
<td>12,174</td>
<td>12,852</td>
</tr>
<tr>
<td>Unbundled Diagnostics</td>
<td>5,926</td>
<td>6,563</td>
</tr>
<tr>
<td>Other</td>
<td>8,666</td>
<td>12,120</td>
</tr>
<tr>
<td>Total Other</td>
<td>75,514</td>
<td>79,304</td>
</tr>
<tr>
<td>Community</td>
<td>95,350</td>
<td>95,049</td>
</tr>
<tr>
<td>Total Underlying</td>
<td>446,760</td>
<td>453,511</td>
</tr>
<tr>
<td>Contractual Adjustments</td>
<td>0</td>
<td>-3,936</td>
</tr>
<tr>
<td>Total Cost &amp; Volume</td>
<td>446,760</td>
<td>449,575</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>KCH</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LGT</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Overview:**

- SEL CCGs agreed aligned incentive contracts for its main three acute providers for 2019/20. This looked to mitigate the financial risk within the system and to facilitate constructive conversations about managing the challenges on a health economy basis.
- The ICDT are in the process of undertaking the quarterly closedown process but the positions above reflect the underlying activity at full PbR before adjustment for system wide mitigations and other validation adjustments.
8. Risks (Not in the Position)

At Month 7 SEL CCGs’ have identified risks of £16.2m, this position has improved in month due to the crystallisation of some of the pressures within Prescribing and in relation to the LAS contract. At this point in the year the CCGs are expecting to mitigate this risk through development of in year mitigating actions. At Month 7 £6.7m of mitigations had been identified, with a further £3.4m identified as part of the CCGs’ work around the further management actions. Work remains on-going but net risk has improved by £5.1m in month to stand at £6.1m.

The main risks being seen as follows:

**Acute Contract Performance:** As outlined in section 6, the CCGs face a material risk to their acute contract performance of £10.4m, £4.0m above the present reported position; this includes the £1m MSK risk in Bexley. The ICDT in collaboration with the CCGs are actively looking to mitigate this position, and further work will be undertaken as robust in year activity comes through.

**Primary Care Contract:** Following the completion of the CCGs planning round, Primary Care funding was reduced across the board adding a financial pressure to SEL, and in particular Lambeth and Southwark. In reporting the position the CCGs have assumed that a SEL mitigation can be identified for this pressure.

**Continuing Healthcare:** One of the CCGs’ key focuses in delivering its 19/20 position is containing the impact of increased complexity and demand within its Continuing Care Budget. The CHC spend has risen year on year, and SEL CCGs are working collaboratively to find mitigations to the pressures that this presents.

**Drug Pressures:** In 19/20 the CCG budgets have been exposed to £5.5m of unforeseen pressures relating to short stock drugs and Category M changes. This changes have been factored into the reporting position but have severely limited the CCGs’ ability to respond to further pressures or changes within the prescribing budget. To mitigate the impact of further changes the CCGs’ prescribing teams continue to work to ensure QIPP delivery is maximised.

**QIPP Delivery:** In closing its planning gap for 19/20 CCGs identified QIPP targets totalling £98.9m, in reporting its Month 7 position a 96.4% delivery has been assumed, however there is a further £3.3m delivery risk (outside of acute). CCGs are working to mitigate this position and ensure a robust delivery process is in place to ensure in year delivery.
### 8. Risks (not in the position)

#### CCG Risk (not in the position)

<table>
<thead>
<tr>
<th></th>
<th>Bexley</th>
<th>Bromley</th>
<th>Greenwich</th>
<th>Lambeth</th>
<th>Lewisham</th>
<th>Southwark</th>
<th>Total SEL CCGs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute Services Risk</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non Local Contracts</td>
<td>(599)</td>
<td>(510)</td>
<td>(402)</td>
<td>(666)</td>
<td>(260)</td>
<td>(289)</td>
<td>(2,726)</td>
</tr>
<tr>
<td>MSK Performance</td>
<td>(1,000)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(1,000)</td>
</tr>
<tr>
<td><strong>Total Acute Services Risk</strong></td>
<td>(1,632)</td>
<td>(552)</td>
<td>(441)</td>
<td>(714)</td>
<td>(299)</td>
<td>(337)</td>
<td>(3,975)</td>
</tr>
</tbody>
</table>

|                      |        |         |           |         |          |           |                |
| **Non Acute Risk**   |        |         |           |         |          |           |                |
| MH Placements Risk/ Contract Risk | (150) | (500) | (200) | (300) | (1,150) |          |                |
| Community Health Services Activity | (200) | (150) | (85) | (435) |          |           |                |
| CHC Activity Risk    | (500)  | (500)   | (1,250)   | (500)   | (1,500)  | (200)     | (4,450)        |
| NCSO                 |        |         |           |         |          |           |                |
| Other Drug Pressures | (236)  | (320)   | (249)     | (270)   | (264)    | (245)     | (1,583)        |
| Primary Care Co-Commissioning Risk | (162) | (400) | (300) | (90) | (436) | (1,388) |                |
| Other Programme Services QIPP Delivery | (2,107) | (250) | (250) | (400) | (250) | (3,257) |                |
| Running Cost QIPP Delivery |        |        |         |         |          |           |                |
| **Total Non Acute Risk** | (3,205) | (1,770) | (2,249) | (1,755) | (1,854) | (1,431) | (12,263)      |

**Total Risks**

<p>| | | | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(4,837)</td>
<td>(2,322)</td>
<td>(2,690)</td>
<td>(2,469)</td>
<td>(2,153)</td>
<td>(1,768)</td>
<td>(16,238)</td>
<td></td>
</tr>
</tbody>
</table>
9. Debtors

Overview:

- During Month 7 the CCGs debtor position has increased from £20.7m to £21.5m. Of this position £6.5m is not yet due (£2.5m intra-SEL CCGs, £2.7m relating to MSK services in Greenwich).

- £7.8m of the £15.0m overdue relates to debts with the council, with the majority of this position relating to Bromley (£6.2m), the invoices relate to Better Care Fund and System Resilience funding.

- £1.2m of invoices relate to intra-SEL CCGs, work is on-going in month to resolve these positions.

- £3.2m of the remaining debt relates to NHS England, with a sizeable proportion relating to GP IT capital funding. Conversations are on-going to ensure this funding is secured at the earliest opportunity.

- Work remains on-going across the South East London finance teams to continue to improve this position especially as we now move to prepare for the merger of the six CCGs.
### 10. Revenue Resource Limit (In Year)

#### Overview:

- In Month 7, the CCGs received allocations for:
  - GPFV Monies (funding from Southwark)
  - MH Liaison
  - Hospice Support

- These contribute to a £6.3m increase in allocation in month, and which match expenditure commitments across the CCGs.

<table>
<thead>
<tr>
<th>Revenue Resource Limit Limit</th>
<th>Besley</th>
<th>Bromley</th>
<th>Greenwich</th>
<th>Lambeth</th>
<th>Lewisham</th>
<th>Southwark</th>
<th>Total SEL CCGs</th>
</tr>
</thead>
<tbody>
<tr>
<td>£’000s</td>
<td>£’000s</td>
<td>£’000s</td>
<td>£’000s</td>
<td>£’000s</td>
<td>£’000s</td>
<td>£’000s</td>
<td></td>
</tr>
<tr>
<td><strong>Revenue Resource Limit (RRL)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Month 6</td>
<td>359,965</td>
<td>514,336</td>
<td>445,188</td>
<td>568,047</td>
<td>501,618</td>
<td>504,407</td>
<td>2,893,561</td>
</tr>
<tr>
<td>Total Movement in Month</td>
<td>3,310</td>
<td>2,460</td>
<td>2,180</td>
<td>4,144</td>
<td>3,136</td>
<td>(8,956)</td>
<td>6,274</td>
</tr>
<tr>
<td>Total Month 7</td>
<td>363,275</td>
<td>516,796</td>
<td>447,368</td>
<td>572,191</td>
<td>504,754</td>
<td>495,451</td>
<td>2,899,835</td>
</tr>
<tr>
<td><strong>Running Cost Allowance (RCA)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Month 6</td>
<td>5,299</td>
<td>7,340</td>
<td>6,120</td>
<td>7,703</td>
<td>6,696</td>
<td>6,537</td>
<td>39,695</td>
</tr>
<tr>
<td>Total Movement in Month</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total Month 7</td>
<td>5,299</td>
<td>7,340</td>
<td>6,120</td>
<td>7,703</td>
<td>6,696</td>
<td>6,537</td>
<td>39,695</td>
</tr>
<tr>
<td><strong>Total RRL and RCA</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Month 6</td>
<td>365,264</td>
<td>521,676</td>
<td>451,308</td>
<td>575,750</td>
<td>508,314</td>
<td>510,944</td>
<td>2,911,293</td>
</tr>
<tr>
<td>Total Movement in Month</td>
<td>3,310</td>
<td>2,460</td>
<td>2,180</td>
<td>4,144</td>
<td>3,136</td>
<td>(8,956)</td>
<td>6,274</td>
</tr>
<tr>
<td>Total Month 7</td>
<td>368,574</td>
<td>524,136</td>
<td>453,488</td>
<td>579,894</td>
<td>511,450</td>
<td>501,988</td>
<td>2,939,530</td>
</tr>
</tbody>
</table>
Appendix

1. 2018/19 Comparison
2. CCG Position and Recovery Actions
3. Mitigations
## Appendix 1 – 2018/19 vs 2019/20

### Headline Financial Performance

<table>
<thead>
<tr>
<th></th>
<th>Bexley</th>
<th>Bromley</th>
<th>Greenwich</th>
<th>Lambeth</th>
<th>Lewisham</th>
<th>Southwark</th>
<th>Total SEL CCGs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£'000s</td>
<td>£'000s</td>
<td>£'000s</td>
<td>£'000s</td>
<td>£'000s</td>
<td>£'000s</td>
<td>£'000s</td>
</tr>
<tr>
<td><strong>Year to Date Expenditure Position</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2018/19</td>
<td>206,404</td>
<td>287,724</td>
<td>246,629</td>
<td>330,683</td>
<td>278,539</td>
<td>269,713</td>
<td>1,613,530</td>
</tr>
<tr>
<td>2019/20</td>
<td>219,626</td>
<td>295,744</td>
<td>241,201</td>
<td>338,369</td>
<td>299,213</td>
<td>270,427</td>
<td>1,704,407</td>
</tr>
<tr>
<td>Increase (£)</td>
<td>11,222</td>
<td>18,020</td>
<td>14,572</td>
<td>17,588</td>
<td>11,056</td>
<td>20,499</td>
<td>92,957</td>
</tr>
<tr>
<td>Increase (%)</td>
<td>5.4%</td>
<td>6.3%</td>
<td>5.9%</td>
<td>5.5%</td>
<td>4.0%</td>
<td>7.6%</td>
<td>0</td>
</tr>
<tr>
<td><strong>Forecast Spend</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2018/19</td>
<td>345,495</td>
<td>493,323</td>
<td>427,193</td>
<td>570,894</td>
<td>511,430</td>
<td>501,988</td>
<td>2,764,393</td>
</tr>
<tr>
<td>2019/20</td>
<td>373,449</td>
<td>524,136</td>
<td>449,688</td>
<td>579,988</td>
<td>521,040</td>
<td>510,222</td>
<td>2,940,805</td>
</tr>
<tr>
<td>Increase (£)</td>
<td>27,954</td>
<td>30,813</td>
<td>22,695</td>
<td>30,151</td>
<td>31,894</td>
<td>32,905</td>
<td>176,412</td>
</tr>
<tr>
<td>Increase (%)</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>-</td>
</tr>
<tr>
<td><strong>Forecast Outturn Surplus/ (Deficit)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2018/19</td>
<td>111,000</td>
<td>3,000</td>
<td>300</td>
<td>988</td>
<td>300</td>
<td>989</td>
<td>(10,737)</td>
</tr>
<tr>
<td>2019/20</td>
<td>(4,875)</td>
<td>3,000</td>
<td>300</td>
<td>988</td>
<td>200</td>
<td>989</td>
<td>1,275</td>
</tr>
<tr>
<td>Increase (£)</td>
<td>9,125</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>100</td>
<td>0</td>
<td>9,462</td>
</tr>
<tr>
<td>Increase (%)</td>
<td>85.2%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>0</td>
<td>88.1%</td>
</tr>
</tbody>
</table>

### QIPP Financial Performance

<table>
<thead>
<tr>
<th></th>
<th>Bexley</th>
<th>Bromley</th>
<th>Greenwich</th>
<th>Lambeth</th>
<th>Lewisham</th>
<th>Southwark</th>
<th>Total SEL CCGs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£'000s</td>
<td>£'000s</td>
<td>£'000s</td>
<td>£'000s</td>
<td>£'000s</td>
<td>£'000s</td>
<td>£'000s</td>
</tr>
<tr>
<td><strong>Year to Date QIPP Position</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2018/19</td>
<td>7,393</td>
<td>9,653</td>
<td>7,612</td>
<td>11,030</td>
<td>9,118</td>
<td>9,189</td>
<td>(10,737)</td>
</tr>
<tr>
<td>2019/20</td>
<td>7,313</td>
<td>14,147</td>
<td>6,796</td>
<td>11,158</td>
<td>8,039</td>
<td>8,239</td>
<td>9,462</td>
</tr>
<tr>
<td>Increase (£)</td>
<td>(80)</td>
<td>4,494</td>
<td>(816)</td>
<td>128</td>
<td>(300)</td>
<td>(989)</td>
<td>1,697</td>
</tr>
<tr>
<td>Increase (%)</td>
<td>-1.1%</td>
<td>46.6%</td>
<td>-10.7%</td>
<td>1.2%</td>
<td>-11.8%</td>
<td>-10.3%</td>
<td>0</td>
</tr>
<tr>
<td><strong>Forecast Outturn QIPP Performance</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2018/19</td>
<td>9,885</td>
<td>14,945</td>
<td>12,670</td>
<td>17,692</td>
<td>16,323</td>
<td>15,681</td>
<td>91,028</td>
</tr>
<tr>
<td>2019/20</td>
<td>11,794</td>
<td>23,980</td>
<td>11,984</td>
<td>18,109</td>
<td>13,799</td>
<td>15,661</td>
<td>95,327</td>
</tr>
<tr>
<td>Increase (£)</td>
<td>1,909</td>
<td>9,035</td>
<td>(686)</td>
<td>(1,404)</td>
<td>(3,893)</td>
<td>(662)</td>
<td>4,299</td>
</tr>
<tr>
<td>Increase (%)</td>
<td>19.3%</td>
<td>60.5%</td>
<td>-5.4%</td>
<td>-7.2%</td>
<td>-22.0%</td>
<td>-4.1%</td>
<td>9.9%</td>
</tr>
<tr>
<td><strong>Forecast Outturn % Delivery</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2018/19</td>
<td>62.1%</td>
<td>80.1%</td>
<td>88.7%</td>
<td>100.0%</td>
<td>87.0%</td>
<td>98.6%</td>
<td>86.0%</td>
</tr>
<tr>
<td>2019/20</td>
<td>96.2%</td>
<td>95.5%</td>
<td>94.0%</td>
<td>97.0%</td>
<td>95.4%</td>
<td>100.0%</td>
<td>96.4%</td>
</tr>
<tr>
<td>Increase (£)</td>
<td>34.1%</td>
<td>14.4%</td>
<td>5.3%</td>
<td>3.0%</td>
<td>8.4%</td>
<td>1.4%</td>
<td>9.5%</td>
</tr>
</tbody>
</table>

### Total Net Risk

<table>
<thead>
<tr>
<th></th>
<th>Bexley</th>
<th>Bromley</th>
<th>Greenwich</th>
<th>Lambeth</th>
<th>Lewisham</th>
<th>Southwark</th>
<th>Total SEL CCGs</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£'000s</td>
<td>£'000s</td>
<td>£'000s</td>
<td>£'000s</td>
<td>£'000s</td>
<td>£'000s</td>
<td>£'000s</td>
</tr>
<tr>
<td><strong>Total Net Risk</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2018/19</td>
<td>(12,400)</td>
<td>(11,000)</td>
<td>(12,240)</td>
<td>(1740)</td>
<td>(2,700)</td>
<td>(130)</td>
<td>(20,241)</td>
</tr>
<tr>
<td>2019/20</td>
<td>(4,859)</td>
<td>(5,521)</td>
<td>(1,844)</td>
<td>(1,457)</td>
<td>(134)</td>
<td>(103)</td>
<td>(10,754)</td>
</tr>
<tr>
<td>Reduction/ (Increase) (£)</td>
<td>7,541</td>
<td>5,479</td>
<td>(1,394)</td>
<td>(583)</td>
<td>(1,564)</td>
<td>(227)</td>
<td>9,487</td>
</tr>
<tr>
<td>Reduction/ (Increase) (%)</td>
<td>64.1%</td>
<td>64.1%</td>
<td>43.0%</td>
<td>50.0%</td>
<td>50.0%</td>
<td>50.0%</td>
<td>10.0%</td>
</tr>
</tbody>
</table>
### Appendix 2 - CCG Focus: Bexley, Greenwich and Lewisham (QIPP)

#### Overview:

- In underlying terms, the BGL CCGs are forecasting an adverse variance of £5.1m (including delivery of £0.7m unidentified QIPP), 85% of the QIPP target. On a non recurrent basis, due to the impact of the contractual arrangements, the CCGs are reporting delivery of 95.1% of their QIPP, £37.5m.

- Planned care schemes centre on the implementation of the RAS within the Outpatient optimisation programme.

- Recovery plans are being developed for non elective activity which look to mitigate the impact of under-delivery on the recurrent run rate.

- Work on-going within CHC to de-risk the position and to deliver as close to the budget as possible (overall position £2.0m net risk on CHC across BGL).

- The reported position includes £0.7m unidentified QIPP within Bexley. Bexley continue to work to reduce the level of unidentified QIPP and at Month 7 this has improved by £0.9m compared to Month 6.

#### Bexley

<table>
<thead>
<tr>
<th>Programme</th>
<th>FY Plan £’000s</th>
<th>RAG %</th>
<th>Month 7 FOT £’000s</th>
<th>Variance £’000s</th>
<th>Main Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>6,474</td>
<td>100%</td>
<td>6,474</td>
<td>-</td>
<td>£723k contractual benefit identified</td>
</tr>
<tr>
<td>Continuing Healthcare (CHC)</td>
<td>596</td>
<td>70%</td>
<td>415</td>
<td>(181)</td>
<td>CHC Activity risk to QIPP delivery</td>
</tr>
<tr>
<td>Other</td>
<td>1,871</td>
<td>100%</td>
<td>1,871</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Other Non-Recurent Savings</td>
<td>742</td>
<td>100%</td>
<td>742</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Prescribing</td>
<td>1,513</td>
<td>81%</td>
<td>1,223</td>
<td>(290)</td>
<td>CCG activity in line with 18/19 outturn</td>
</tr>
<tr>
<td>Running/ Corporate Costs</td>
<td>342</td>
<td>100%</td>
<td>342</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Unidentified</td>
<td>726</td>
<td>100%</td>
<td>726</td>
<td>-</td>
<td>CCG working to delivery further mitigations</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>12,264</strong></td>
<td><strong>96%</strong></td>
<td><strong>11,794</strong></td>
<td><strong>(470)</strong></td>
<td></td>
</tr>
</tbody>
</table>

#### Greenwich

<table>
<thead>
<tr>
<th>Programme</th>
<th>FY Plan £’000s</th>
<th>RAG %</th>
<th>Month 7 FOT £’000s</th>
<th>Variance £’000s</th>
<th>Main Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>5,846</td>
<td>100%</td>
<td>5,846</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Continuing Healthcare (CHC)</td>
<td>1,000</td>
<td>45%</td>
<td>451</td>
<td>(549)</td>
<td>CHC Activity risk to QIPP delivery</td>
</tr>
<tr>
<td>Other</td>
<td>2,739</td>
<td>100%</td>
<td>2,730</td>
<td>(9)</td>
<td></td>
</tr>
<tr>
<td>Other Non-Recurent Savings</td>
<td>891</td>
<td>100%</td>
<td>891</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Prescribing</td>
<td>1,655</td>
<td>87%</td>
<td>1,447</td>
<td>(208)</td>
<td>CCG activity in line with 18/19 outturn</td>
</tr>
<tr>
<td>Running/ Corporate Costs</td>
<td>619</td>
<td>100%</td>
<td>619</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>12,750</strong></td>
<td><strong>94%</strong></td>
<td><strong>11,984</strong></td>
<td><strong>(766)</strong></td>
<td></td>
</tr>
</tbody>
</table>

#### Lewisham

<table>
<thead>
<tr>
<th>Programme</th>
<th>FY Plan £’000s</th>
<th>RAG %</th>
<th>Month 7 FOT £’000s</th>
<th>Variance £’000s</th>
<th>Main Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>8,969</td>
<td>97%</td>
<td>8,660</td>
<td>(309)</td>
<td>Variance driven by Non Local Providers</td>
</tr>
<tr>
<td>Continuing Healthcare (CHC)</td>
<td>571</td>
<td>75%</td>
<td>431</td>
<td>(140)</td>
<td>CHC Activity risk to QIPP delivery</td>
</tr>
<tr>
<td>Other</td>
<td>1,434</td>
<td>85%</td>
<td>1,215</td>
<td>(219)</td>
<td></td>
</tr>
<tr>
<td>Other Non-Recurent Savings</td>
<td>1,010</td>
<td>100%</td>
<td>1,010</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Prescribing</td>
<td>1,798</td>
<td>100%</td>
<td>1,798</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Running/ Corporate Costs</td>
<td>685</td>
<td>100%</td>
<td>685</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>14,467</strong></td>
<td><strong>95%</strong></td>
<td><strong>13,799</strong></td>
<td><strong>(668)</strong></td>
<td></td>
</tr>
</tbody>
</table>
Overview:

- The graphs to the left are an attempt to show the run rate position compared to 2018/19 and in relation to the Forecast outturn position. These are replicated for each CCG. It should be noted that axis differ in reading this report.

- For Lewisham and Greenwich, the increases seen in Month 4 represent the point when the initial acute and PPA information were published. This has led to increased expenditure within the monthly position. There is minimal impact on the FOT position as these pressures and changes have been "smoothed" by the utilisation of contingency.

- The graphs to the right look to show the risk position by CCG. A comparison is included to the risk positon in 2018/19.

- For all 3 CCGs the risk position is improved from a similar stage in 2018/19; and for most CCGs represent a month on month improvement on the position. The in month movement in the risks within Bexley reflect the joint work being undertaken to mitigate the central pressures around Primary Care and prescribing; on a like for like basis there would have been a c£1m improvement on the risk position.
### Appendix 2 - CCG Focus: Bexley, Greenwich and Lewisham (Recovery Actions) continued

<table>
<thead>
<tr>
<th>Area</th>
<th>Action Required</th>
<th>CCG Response</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non Pay Review</strong></td>
<td>All Non Pay expenditure to be reviewed and classified between contract expenditure, discretionary spend and reserves</td>
<td>This has been actioned as part of the Deep Dive meetings; work now required to compile the outcome of this work.</td>
</tr>
<tr>
<td><strong>Referral Advisory Services/ MECs</strong></td>
<td>To work within the parameters of the existing Referral advice services and MECs contracts to maximise the opportunities that present pathways present. Working with local providers to ensure care within SEL is seen as the default referral outcome. Local implementation of the recommendations presented to the Planning and Delivery Group to mitigate the current run rate at Moorfields.</td>
<td>The recommendations presented to the Planning and Delivery Group are being taken through the CCG’s practice visits to support the change in referral practices.</td>
</tr>
<tr>
<td><strong>Review of all External Acute Activity</strong></td>
<td>To work with local providers to identify referral patterns to non South East London organisations, identifying capacity opportunities with which to divert activity.</td>
<td>As an STP/ICS system we have agreed to work together to identify opportunities to manage referral/activity patterns to non South East London organisations with the objective of repatriating work back locally within the SEL footprint.</td>
</tr>
<tr>
<td><strong>Review of Prescribing</strong></td>
<td>Review of the prescribing position to be undertaken across South East London, looking to identify benchmarks based on spend per 100,000. Benchmarks to be present to November South East London Prescribing committee to identify best practice and potential for any offsetting mitigations.</td>
<td>The prescribing reporting position across SEL now consistent across CCGs. Benchmarking information will be reviewed at the SEL Prescribing QIPP meeting on 26th November to implement best practice and identify further savings.</td>
</tr>
<tr>
<td><strong>Review of All Investment Decisions to ensure benefits as intended</strong></td>
<td>The CCGs made a number of investment decisions over the last 18 months. It is proposed that all CCGs undertake a post implementation review to ensure the benefits are being delivered in line with initial business case. Where they are not that this is review and either corrective action agreed or the investment decision reconsidered.</td>
<td>Work to assess the return on investments to be undertaken from the start of December. All CCG managers aware that all future investments require sign off from all parts of the SEL system.</td>
</tr>
<tr>
<td><strong>Review of all invoices received from local providers</strong></td>
<td>CCGs to review all invoices received from local providers and verify that they are in respect of agreed contractual exclusions from 1920 aligned incentive/block contracts then where appropriate dispute these invoices and request credit notes.</td>
<td>Actioned as part of “normal” working practices; conversations on-going with providers where issues have been identified.</td>
</tr>
<tr>
<td><strong>Review of all CCG Income</strong></td>
<td>Ensure that all invoices/IATs for third party income and recharges have been built into CCG positions and that invoices/IATs have been raised and processed.</td>
<td>Review of invoices/income undertaken as part of the usual month-end process and budget Deep Dives. Any outstanding invoices to be issued by end of November at the latest.</td>
</tr>
</tbody>
</table>
Appendix 2 - CCG Focus: QIPP Position – Bromley

Overview:

• We have secured delivery of £19.7m, representing 78% of the total 2019/20 QIPP Plan, via contractual efficiencies and risk share arrangements.

• This would mean that the CCG has to realise £4.2m in ‘real’ savings in order to achieve the NHS England requirement that all CCGs deliver at least 95% of their agreed QIPP Plan.

• The CCG is currently reporting a forecast 95.5% achievement which means we remain on ‘Green status’.

• We have included the risk of slippage against 3 projects within the QIPP programme. These are the Outpatient Pathway savings for Non Local Acute SLA’s where block contracts haven’t been agreed, the Medicines Management schemes where some are not working as well as expected and from this month slippage against the £0.5m BMI QIPP where we are overspending.

• The position for each scheme has been assessed with input from the Project Managers, progress against plans and management of risks and issues. Activity data has been extracted from various sources including; SLA monitoring, referrals datasets, Community activity, and is validated using SUS data (where applicable).

• We have currently a forecast 95.5% achievement which means we remain on ‘Green status’.

• The position for each scheme has been assessed with input from the Project Managers, progress against plans and management of risks and issues. Activity data has been extracted from various sources including; SLA monitoring, referrals datasets, Community activity, and is validated using SUS data (where applicable).

• The Month 7 QIPP Position shows a YTD achievement of 96.8%, and an adverse forecast Year end variance of £1,133k. This is a reduction in achievement from Month 6 and relates to the worsened position against the Medicines Management schemes as well as the BMI shortfall, slightly offset by an increased achievement against the CHC QIPP.

• The CCG is currently able to manage this slippage.

<table>
<thead>
<tr>
<th>Programme</th>
<th>FY Plan £’000s</th>
<th>RAG %</th>
<th>Month 7 FOT £’000s</th>
<th>Variance £’000s</th>
<th>Main Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>10,147</td>
<td>94%</td>
<td>9,517</td>
<td>(631)</td>
<td>Variance driven by Non Local Providers</td>
</tr>
<tr>
<td>Continuing Healthcare (CHC)</td>
<td>666</td>
<td>150%</td>
<td>1,000</td>
<td>304</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>8,555</td>
<td>100%</td>
<td>8,555</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Other Non-Recurent Savings</td>
<td>2,798</td>
<td>100%</td>
<td>2,798</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Prescribing</td>
<td>2,211</td>
<td>62%</td>
<td>1,375</td>
<td>(836)</td>
<td>Activity data indicates that this variance is likely for the FY</td>
</tr>
<tr>
<td>Primary Care Budgets</td>
<td>469</td>
<td>100%</td>
<td>469</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Running/ Corporate Costs</td>
<td>735</td>
<td>100%</td>
<td>735</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>25,112</strong></td>
<td><strong>95%</strong></td>
<td><strong>23,980</strong></td>
<td><strong>(1,133)</strong></td>
<td></td>
</tr>
</tbody>
</table>
## Appendix 2 - CCG Focus: CCG Focus – Bromley (Recovery Actions)

<table>
<thead>
<tr>
<th>Area</th>
<th>Action Required</th>
<th>CCG Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Temporary Staffing</td>
<td>Review of all temporary staffing to ensure appropriate cost/benefit analysis has been undertaken. Consideration should be made about the potential for cross cover given the wider consultation that is being undertaken.</td>
<td>Bromley have relatively few temporary staff and a return is submitted to T Osborne on a monthly basis. Each temporary appointment is reviewed regularly. These appointments are generally cover for clinical staff (Safeguarding/CHC) or key posts (Head of Governance).</td>
</tr>
<tr>
<td>Temporary Staffing</td>
<td>Ensure implementation of PO requisition for all Agency Staff ensuring in line with NHSE/I Procedures.</td>
<td>PO’s are not currently raised for every temporary member of staff, this will be reviewed and corrected.</td>
</tr>
<tr>
<td>Uncommitted and Discretionary Spend</td>
<td>Ensure that controls are in place regarding all uncommitted and discretionary spend for the remainder of the financial year. The default position should be that expenditure does not take place in 2019/20 and by exception any discretionary spend is subject to approval at Managing Director and Director of Finance Level.</td>
<td>Budget holders have been made aware of this control and that any discretionary spend must be approved by the MD, DMD or DoF.</td>
</tr>
<tr>
<td>PO Approval</td>
<td>Review of the Scheme of Delegation to move PO approval to a Director level only.</td>
<td>Work to be started, need to review Scheme of Delegation.</td>
</tr>
<tr>
<td>Budget Deep Dive</td>
<td>Month 7 deep dive to be undertaken on all budgets to identify any discretionary spend and uncommitted budgets. Underspends at month 7 should be 'banked' to deliver CCG financial positions and new financial commitments should not be made. Detailed reviews to be undertaken bi monthly thereafter. Ensure that the financial benefit of staff vacancies is being reported.</td>
<td>This is being carried out as part of the Month 7 Deep Dive meeting on November 20th.</td>
</tr>
<tr>
<td>Balance Sheet Review</td>
<td>Presentation of the balance sheet position to be provided based on the Month 6 Finance position. Position to be presented with in year and old year accruals identified. Ensure that expenditure is being prepaid only where appropriate.</td>
<td>The review of balance sheet and 18/19 unused accruals is on-going with known benefits within existing mitigations. A key part of the SEL merger process to a single financial ledger includes a review of the balance sheet reconciliations in each CCG. This is being led by the Bexley Deputy DoF</td>
</tr>
<tr>
<td>Contract Review</td>
<td>Review of all expiring contracts, with a business case require with CFO/AO approval to agree continuation.</td>
<td>To review contracts that will be expiring in the near future.</td>
</tr>
<tr>
<td>Review of all invoices received from local providers</td>
<td>CCGs to review all invoices received from local providers and verify that they are in respect of agreed contractual exclusions from 1920 aligned incentive/block contracts then where appropriate dispute these invoices and request credit notes.</td>
<td>This work is already in place and is embedded in the monthly reporting cycle.</td>
</tr>
<tr>
<td>Review of all CCG Income</td>
<td>Ensure that all invoices/IATs for third party income and recharges have been built into CCG positions and that invoices/IATs have been raised and processed.</td>
<td>This work is already in place and is embedded in the monthly reporting cycle.</td>
</tr>
</tbody>
</table>
## Appendix 2 - CCG Focus: Bromley (Recovery Actions)

<table>
<thead>
<tr>
<th>Area</th>
<th>Action Required</th>
<th>CCG Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non Pay Review</td>
<td>All Non Pay expenditure to be reviewed and classified between contract expenditure, discretionary spend and reserves</td>
<td>This is being carried out as part of the Month 7 Deep Dive meeting on November 20th.</td>
</tr>
<tr>
<td>Referral Advisory Services/MECs</td>
<td>To work within the parameters of the existing Referral advice services and MECs contracts to maximise the opportunities that present pathways present. Working with local providers to ensure care within SEL is seen as the default referral outcome. Local implementation of the recommendations presented to the Planning and Delivery Group to mitigate the current run rate at Moorfields.</td>
<td>Recommendations presented to the Planning and Delivery Group to mitigate the current run rate were: promotion of local provider services; increased promotion within primary care, eliminating unnecessary referrals into secondary care. These actions are being taken through the CCG’s practice visits to support the change in referral practices.</td>
</tr>
<tr>
<td>Review of all External Acute Activity</td>
<td>To work with local providers to identify referral patterns to non South East London organisations, identifying capacity opportunities with which to divert activity.</td>
<td>As an STP/ICS system we have agreed to work together to identify opportunities to manage referral/activity patterns to non South East London organisations with the objective of repatriating work back locally within the SEL footprint.</td>
</tr>
<tr>
<td>Review of Prescribing</td>
<td>Review of the prescribing position to be undertaken across South East London, looking to identify benchmarks based on spend per 100,000. Benchmarks to be present to November South East London Prescribing committee to identify best practice and potential for any offsetting mitigations.</td>
<td>The prescribing reporting position across SEL now consistent across CCGs. Benchmarking information will be reviewed at the SEL Prescribing QIPP meeting on 26th November to implement best practice and identify further savings.</td>
</tr>
<tr>
<td>Review of All Investment Decisions to ensure benefits as intended</td>
<td>The CCGs made a number of investment decisions over the last 18 months. It is proposed that all CCGs undertake a post implementation review to ensure the benefits are being delivered in line with initial business case. Where they are not that this is review and either corrective action agreed or the investment decision reconsidered.</td>
<td>This is already part of the CCG business case review process.</td>
</tr>
<tr>
<td>Review of all invoices received from local providers</td>
<td>CCGs to review all invoices received from local providers and verify that they are in respect of agreed contractual exclusions from 1920 aligned incentive/block contracts then where appropriate dispute these invoices and request credit notes.</td>
<td>This work is already in place and is embedded in the monthly reporting cycle.</td>
</tr>
<tr>
<td>Review of all CCG Income</td>
<td>Ensure that all invoices/IATs for third party income and recharge have been built into CCG positions and that invoices/IATs have been raised and processed.</td>
<td>This work is already in place and is embedded in the monthly reporting cycle.</td>
</tr>
</tbody>
</table>
Appendix 2 - CCG Focus: Lambeth

Overview:

- The CCG’s financial position is significantly more challenging than in previous years and this has required the CCG to plan and implement a series of QIPP programmes to deliver the required surplus, achieve underlying financial balance and to secure improvements in quality.

- In 19/20 QIPP savings initiative plans total £18.67m. The majority of the CCGs QIPP is contractually guaranteed mainly within our acute and mental health contracts with Trusts. For other schemes most of these have been delivered either through contractual changes or budget reductions and adjustments.

- Following work in month, delivery of the primary care QIPP has been revised upwards by £0.2m and is forecasting under-delivery of £0.3m. The CCG has been adversely impacted by reductions in the primary care allocations related to both national changes and the impact of GP at Hand services. As a result delivery of the total primary care QIPP is seen as high risk. The CCG is working with the other SEL CCGs to identify group wide mitigations to the impact of these allocation changes.

- Work is ongoing with the SEL Primary Care team to identify savings opportunities by reviewing budgets in primary care including estates. Other reviews in primary care include review of all expenditure and identifying any savings opportunities in Walk in Centre budgets.

- The CCG is also identifying other areas of slippage across CCG budgets in order to bridge the gap on a non recurrent basis.

- The increase in spend in month reflects the impact of the changes in the primary care adjustment and prescribing spend.

<table>
<thead>
<tr>
<th>Programme</th>
<th>FY Plan £’000s</th>
<th>Month 7 FOT £’000s</th>
<th>Variance £’000s</th>
<th>Main Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>9,102</td>
<td>9,102</td>
<td>-</td>
<td>CHC Activity risk to QIPP delivery</td>
</tr>
<tr>
<td>Continuing Healthcare (CHC)</td>
<td>661</td>
<td>220</td>
<td>(441)</td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td>1,134</td>
<td>1,134</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>2,842</td>
<td>2,722</td>
<td>(120)</td>
<td></td>
</tr>
<tr>
<td>Other Non- Recurrent Savings</td>
<td>2,483</td>
<td>2,483</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Prescribing</td>
<td>1,710</td>
<td>1,710</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Running/ Corporate Costs</td>
<td>738</td>
<td>738</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>18,670</td>
<td>18,109</td>
<td>(561)</td>
<td></td>
</tr>
</tbody>
</table>
## Appendix 2 - CCG Focus: Lambeth (Recovery Actions)

<table>
<thead>
<tr>
<th>Area</th>
<th>Action Required</th>
<th>CCG Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Temporary Staffing</td>
<td>Review of all temporary staffing to ensure appropriate cost/benefit analysis has been undertaken. Consideration should be made about the potential for cross cover given the wider consultation that is being undertaken.</td>
<td>This has been discussed in the deep dive meetings. Lambeth CCG has a small number of agency staff.</td>
</tr>
<tr>
<td>Temporary Staffing</td>
<td>Ensure implementation of PO requisition for all Agency Staff ensuring in line with NHSE/I Procedures</td>
<td>CCG will implement PO for any new agency appointments with effect from 1 December.</td>
</tr>
<tr>
<td>Uncommitted and Discretionary Spend</td>
<td>Ensure that controls are in place regarding all uncommitted and discretionary spend for the remainder of the financial year. The default position should be that expenditure does not take place in 2019/20 and by exception any discretionary spend is subject to approval at Managing Director and Director of Finance Level.</td>
<td>This is being discussed as part of the Deep Dive Meetings. CCG will be sending out communications following Deep Dive Meetings to include key messages.</td>
</tr>
<tr>
<td>PO Approval</td>
<td>Review of the Scheme of Delegation to move PO approval to a Director level only.</td>
<td>Changes to the scheme of delegation will require Governing Body approval. It has been agreed that the roll out of POs will be incorporated in the CCG merger workplan as training and procurement support will be required to do this.</td>
</tr>
<tr>
<td>Budget Deep Dive</td>
<td>Month 7 deep dive to be undertaken on all budgets to identify any discretionary spend and uncommitted budgets. Underspends at month 7 should be ‘banked’ to deliver CCG financial positions and new financial commitments should not be made. Detailed reviews to be undertaken bi monthly thereafter. Ensure that the financial benefit of staff vacancies is being reported.</td>
<td>Deep Dive Meetings have taken place with all Directors to undertake line by line review of budgets.</td>
</tr>
<tr>
<td>Balance Sheet Review</td>
<td>Presentation of the balance sheet position to be provided based on the Month 6 Finance position. Position to be presented with in year and old year accruals identified. Ensure that expenditure is being prepaid only where appropriate.</td>
<td>Old year balances have been reviewed in detail. Outstanding areas include the Lower Marsh provision which will be reviewed as part of the work to complete the Business Case for Lambeth CCG move to the Civic Centre. This expected to be completed by the end of December. A key part of the SEL merger process to a single financial ledger includes a review of the balance sheet reconciliations in each CCG. This is being led by the Bexley Deputy DoF.</td>
</tr>
<tr>
<td>Contract Review</td>
<td>Review of all expiring contracts, with a business case require with CFO/AO approval to agree continuation.</td>
<td>This was discussed as part of the monthly deep dive meetings. No expired contracts have been identified.</td>
</tr>
</tbody>
</table>
### Appendix 2 - CCG Focus: Lambeth (Recovery Actions)

<table>
<thead>
<tr>
<th>Area</th>
<th>Action Required</th>
<th>CCG Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non Pay Review</td>
<td>All Non Pay expenditure to be reviewed and classified between contract expenditure, discretionary spend and reserves</td>
<td>This has been an ongoing piece of work and following the first round of Deep Dive meetings we will provide a confirmed position by 25 November</td>
</tr>
<tr>
<td>Referral Advisory Services/MECs</td>
<td>To work within the parameters of the existing Referral advice services and MECs contracts to maximise the opportunities that present pathways present. Working with local providers to ensure care within SEL is seen as the default referral outcome. Local implementation of the recommendations presented to the Planning and Delivery Group to mitigate the current run rate at Moorfields.</td>
<td>CCG has well developed MECS service in operation and we are seeing reduction in local referrals. This requires SEL wide discussion to agree process and scope for changes to referral routes.</td>
</tr>
<tr>
<td>Review of all External Acute Activity</td>
<td>To work with local providers to identify referral patterns to non South East London organisations, identifying capacity opportunities with which to divert activity.</td>
<td>The CCG undertook an exercise early in 19/20 as part of CCG led QIPP delivery. As an STP/ICS system we have agreed to work together to identify opportunities to manage referral/activity patterns to non South East London organisations with the objective of repatriating work back locally within the SEL footprint.</td>
</tr>
<tr>
<td>Review of Prescribing</td>
<td>Review of the prescribing position to be undertaken across South East London, looking to identify benchmarks based on spend per 100,000. Benchmarks to be present to November South East London Prescribing committee to identify best practice and potential for any offsetting mitigations.</td>
<td>The prescribing reporting position across SEL now consistent across CCGs. Benchmarking information will be reviewed at the SEL Prescribing QIPP meeting on 26th November to implement best practice and identify further savings.</td>
</tr>
<tr>
<td>Review of All Investment Decisions to ensure benefits as intended</td>
<td>The CCGs made a number of investment decisions over the last 18 months. It is proposed that all CCGs undertake a post implementation review to ensure the benefits are being delivered in line with initial business case. Where they are not that this is review and either corrective action agreed or the investment decision reconsidered.</td>
<td>The CCG does undertake Lessons Learnt on specific areas of activity. We need to agree a proportionate approach and agree timings and areas of focus given capacity and time constraints.</td>
</tr>
<tr>
<td>Review of all invoices received from local providers</td>
<td>CCGs to review all invoices received from local providers and verify that they are in respect of agreed contractual exclusions from 1920 aligned incentive/block contracts then where appropriate dispute these invoices and request credit notes.</td>
<td>This is an ongoing piece of work as part of our monthly reporting. Any disputes are followed up and credit notes requested. This has been discussed at deep dive meetings where applicable.</td>
</tr>
<tr>
<td>Review of all CCG Income</td>
<td>Ensure that all invoices/IATs for third party income and recharges have been built into CCG positions and that invoices/IATs have been raised and processed.</td>
<td>This is reviewed as part of monthly reporting position. A further review of all income accruals will be undertaken to ensure that all invoices are raised by the end of November. For HLP (hosted service) income, much work is done to obtain the necessary documentation and get appropriate sign off before invoices can be raised.</td>
</tr>
</tbody>
</table>
Appendix 2 - CCG Focus: Southwark

Overview:

- After the application of the expected Risk share arrangements across South East London, Southwark CCG needs to deliver QIPP schemes with a total value of £15,661k. This will enable the CCGs to meet financial planning requirements for 2019/20.
- As at today, Southwark have identified the whole of its QIPP schemes, leaving no “unidentified” gap before any reduction for risk assessment; in addition the total includes £661k of “targeted” QIPP in terms of Management cost savings, £1700k non recurrent savings and 477k contractual benefit on local primary care budgets.
- At Month 7, the CCG is forecasting to deliver its QIPP in full, £15,661k.
- Additional delegated primary care schemes totalling 470k have also now been identified, so the current risk assessed totals can be further mitigated by this amount, as all largely sound NR adjustments.
- To enable the system to deliver the savings required, the largest proportion of Southwark’s QIPP is contractually agreed via the SEL ICDT team, which allows for greater alignment with other SEL planning.
- The remaining programme is largely contractually guaranteed, or budget adjustments that have been delivered. There remains some work to do on Acute local schemes.
- The increase in spend in Month 6 reflects the impact of the receipt of Primary Care allocation in relation to the South East London Funding. This offsets in Month 7 when the allocation is transferred to other SEL CCGs.
## Appendix 2 - CCG Focus: Southwark (Recovery Actions)

<table>
<thead>
<tr>
<th>Area</th>
<th>Action Required</th>
<th>CCG Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Temporary Staffing</td>
<td>Review of all temporary staffing to ensure appropriate cost/benefit analysis has been undertaken. Consideration should be made about the potential for cross cover given the wider consultation that is being undertaken.</td>
<td>Southwark CCG sends in regular reports to Theresa Osborne on a monthly basis, detailing its agency and fixed term staffing. Most of the temporary staffing relates to the STP and other SEL budgets. All CCG managers have been made aware of the need to submit documentation to the recruitment panel regarding all proposed changes to staff terms and conditions. These are signed off by both MD/DoF before submission.</td>
</tr>
<tr>
<td>Temporary Staffing</td>
<td>Ensure implementation of PO requisition for all Agency Staff ensuring in line with NHSE/I Procedures</td>
<td>Southwark CCG aims to generate POs for all of its agency staff. To be reviewed by the end of November and additional POs created if not in place. To be completed by end of December.</td>
</tr>
<tr>
<td>Uncommitted and Discretionary Spend</td>
<td>Ensure that controls are in place regarding all uncommitted and discretionary spend for the remainder of the financial year. The default position should be that expenditure does not take place in 2019/20 and by exception any discretionary spend is subject to approval at Managing Director and Director of Finance Level.</td>
<td>This is being carried out as part of the M7 Deep Dive meeting on November 20th. All CCG directors and budget holders will be present at this meeting plus support from senior finance colleagues from other SEL CCGs.</td>
</tr>
<tr>
<td>PO Approval</td>
<td>Review of the Scheme of Delegation to move PO approval to a Director level only.</td>
<td>Work to be started; need to review scheme of delegation. Will be completed by end of December.</td>
</tr>
<tr>
<td>Budget Deep Dive</td>
<td>Month 7 deep dive to be undertaken on all budgets to identify any discretionary spend and uncommitted budgets. Underspends at month 7 should be 'banked' to deliver CCG financial positions and new financial commitments should not be made. Detailed reviews to be undertaken bi-monthly thereafter. Ensure that the financial benefit of staff vacancies is being reported.</td>
<td>This is being carried out as part of the Month 7 Deep Dive meeting on November 20th.</td>
</tr>
<tr>
<td>Balance Sheet Review</td>
<td>Presentation of the balance sheet position to be provided based on the Month 6 Finance position. Position to be presented with in year and old year accruals identified. Ensure that expenditure is being prepaid only where appropriate.</td>
<td>Review of balance sheet position constantly under review; we will have a final view of the position by end of November. A key part of the SEL merger process to a single financial ledger includes a review of the balance sheet reconciliations in each CCG. This is being led by the Bexley Deputy DoF.</td>
</tr>
<tr>
<td>Contract Review</td>
<td>Review of all expiring contracts, with a business case require with CFO/ AO approval to agree continuation.</td>
<td>Contracts to be reviewed as part of the M7 Deep Dive Meeting on 20th November. List of current contracts has been finalised and shared with Theresa Osborne. All budget holders are aware that there is no automatic renewal of contracts without AO/CFO sign-off.</td>
</tr>
</tbody>
</table>
## Appendix 2 - CCG Focus: Southwark (Recovery Actions) continued

<table>
<thead>
<tr>
<th>Area</th>
<th>Action Required</th>
<th>CCG Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non Pay Review</td>
<td>All Non Pay expenditure to be reviewed and classified between contract expenditure, discretionary spend and reserves</td>
<td>Non-Pay spend reviewed as part of regular budget holder meetings - classification to be completed by end of November.</td>
</tr>
<tr>
<td>Referral Advisory Services/ MECs</td>
<td>To work within the parameters of the existing Referral advice services and MECs contracts to maximise the opportunities that present pathways present. Working with local providers to ensure care within SEL is seen as the default referral outcome. Local implementation of the recommendations presented to the Planning and Delivery Group to mitigate the current run rate at Moorfields.</td>
<td>Recommendations presented to the Planning and Delivery Group to mitigate the current run rate were: promotion of local provider services; increased promotion within primary care, eliminating unnecessary referrals into secondary care. Planned care team attending locality meeting in November to discuss and promote alternatives to secondary care referrals including ophthalmology. Practice visits currently being undertaken which include discussions on prescribing, performance data including referrals and quality.</td>
</tr>
<tr>
<td>Review of all External Acute Activity</td>
<td>To work with local providers to identify referral patterns to non South East London organisations, identifying capacity opportunities with which to divert activity.</td>
<td>As an STP/ICS system we have agreed to work together to identify opportunities to manage referral/activity patterns to non South East London organisations with the objective of repatriating work back locally within the SEL footprint.</td>
</tr>
<tr>
<td>Review of Prescribing</td>
<td>Review of the prescribing position to be undertaken across South East London, looking to identify benchmarks based on spend per 100,000. Benchmarks to be present to November South East London Prescribing committee to identify best practice and potential for any offsetting mitigations.</td>
<td>The prescribing reporting position across SEL now consistent across CCGs. Benchmarking information will be reviewed at the SEL Prescribing QIPP meeting on 26th November to implement best practice and identify further savings.</td>
</tr>
<tr>
<td>Review of All Investment Decisions to ensure benefits as intended</td>
<td>The CCGs made a number of investment decisions over the last 18 months. It is proposed that all CCGs undertake a post implementation review to ensure the benefits are being delivered in line with initial business case. Where they are not that this is review and either corrective action agreed or the investment decision reconsidered.</td>
<td>Work to assess the return on investments to be undertaken from the start of December. All CCG managers aware that all future investments require sign off from all parts of the SEL system.</td>
</tr>
<tr>
<td>Review of all invoices received from local providers</td>
<td>CCGs to review all invoices received from local providers and verify that they are in respect of agreed contractual exclusions from 1920 aligned incentive/block contracts then where appropriate dispute these invoices and request credit notes.</td>
<td>This work is already in place and is embedded in the monthly reporting cycle.</td>
</tr>
<tr>
<td>Review of all CCG Income</td>
<td>Ensure that all invoices/IATs for third party income and recharges have been built into CCG positions and that invoices/IATs have been raised and processed.</td>
<td>This work is already in place and is embedded in the monthly reporting cycle.</td>
</tr>
</tbody>
</table>
## Appendix 2 - CCG Focus: Acute & Integrated Community Services (Recovery Actions) – All CCGs

<table>
<thead>
<tr>
<th>Area</th>
<th>Action Required</th>
<th>CCG Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uncommitted and Discretionary Spend</td>
<td>Ensure that controls are in place regarding all uncommitted and discretionary spend for the remainder of the financial year. The default position should be that expenditure does not take place in 2019/20 and by exception any discretionary spend is subject to approval at Managing Director and Director of Finance Level.</td>
<td>A budget review has been undertaken and all uncommitted reserves have been released into the reported forecasts.</td>
</tr>
<tr>
<td>Budget Deep Dive</td>
<td>Month 7 deep dive to be undertaken on all budgets to identify any discretionary spend and uncommitted budgets. Underspends at month 7 should be ‘banked’ to deliver CCG financial positions and new financial commitments should not be made. Detailed reviews to be undertaken bi monthly thereafter. Ensure that the financial benefit of staff vacancies is being reported.</td>
<td>A budget review has been undertaken and all uncommitted reserves have been released into the reported forecasts.</td>
</tr>
<tr>
<td>Balance Sheet Review</td>
<td>Presentation of the balance sheet position to be provided based on the Month 6 Finance position. Position to be presented with in year and old year accruals identified. Ensure that expenditure is being prepaid only where appropriate.</td>
<td>The CSU are working closely with CCG Heads of Finance to provide a reconciliation of final 2018/19 positions against the CSU reported year-end position undertaken to determine whether there is any further flexibility within the accrued position. This is likely to vary by CCG and will need a discussion with the relevant HoF to ensure the accruals position remains accurate.</td>
</tr>
<tr>
<td>Referral Advisory Services/ MECs</td>
<td>To work within the parameters of the existing Referral advice services and MECs contracts to maximise the opportunities that present pathways present. Working with local providers to ensure care within SEL is seen as the default referral outcome. Local implementation of the recommendations presented to the Planning and Delivery Group to mitigate the current run rate at Moorfields.</td>
<td>Work in progress - Further work underway to review the current work in progress position for each CCG/material provider – both in relation to the value as well as the methodology for calculation.</td>
</tr>
<tr>
<td>Review of all External Acute Activity</td>
<td>To work with local providers to identify referral patterns to non South East London organisations, identifying capacity opportunities with which to divert activity.</td>
<td>As an STP/ ICS system we have agreed to work together to identify opportunities to manage referral/activity patterns to non-South East London organisations with the objective of repatriating work back locally to within the SEL footprint (with a future financial and demand/pathway management benefit). This will be considered by the Planned Care and Acute Based Care Boards. However, given RTT and winter pressures and the planning required to implement proposals of this kind there is not consider scope to impact in 2019/20.</td>
</tr>
<tr>
<td>Year end Agreements</td>
<td>Negotiation of fixed year end agreements for material cost &amp; volume contracts.</td>
<td>The CSU are exploring the possibilities of year-end agreement with our material providers on cost &amp; volume contracts working closely with other CSU teams and host CCGs. All possible agreements and recommendations will be brought back to contracting and finance leads for discussion.</td>
</tr>
</tbody>
</table>
| Bexley MSK                         | To address the underlying run rate to reduce the unmitigated expenditure forecast. | The ICDT, CCG and providers are working together to address the underlying overspend position including:  
  • Agreement of MSK activity within the wider quarterly activity closedown process across the full 2019/20 SEL CCG contracts with KCH, LGT and DGT.  
  • Ensure that the new outpatient waiting times have now been equalised across Bexley and other CCGs, to ensure that the full savings for Bexley CCG are being realised and this is being followed up.  
  • Ensuring appropriate management of inpatients, noting that the scope for savings for other Bexley MSK elective inpatients is constrained by the fact that all providers have to treat patients in order and to manage their long waiter positions in line with performance commitments. |
A meeting of the Governing Body  
9 January 2020

| Board Assurance Framework |
|---------------------------|--------------------------|
| LEAD: Martin Wilkinson    | Post: Managing Director  |
| MANAGERIAL LEAD: Charles Malcolm-Smith | Post: Deputy Director (Strategy & Organisational Development) |
| AUTHOR(s): Katie Hitchen  | Post Corporate Services Officer |

The Governing Body is asked:
- To agree that the appropriate risks have been identified against the achievement of the Corporate Objectives
- To agree the current risk scores and the target risk scores for the risks contained within the Board Assurance Framework
- To agree that there are adequate controls in place to mitigate the risks to the Corporate Objectives and where existing controls have not reduced the current risk score to the target risk score there are credible action plans, noting that further work is required to ensure they capture the breadth of work on each risk adequately.

Background

The CCG’s Corporate Objectives sets out key priority areas and actions which the CCG will undertake during 2019/20 to deliver the CCG’s Operating Plan.

The Corporate Objectives for 2019/20 cover:
- Four clinical priority areas:
  - Respiratory
  - Diabetes
  - Mental health
  - Frailty

The focus on these areas is to support the CCG’s goal of making community based care something that can be relied on. Each area has identified initial health and care outcomes to be achieved, key initiatives and expected financial impact.

- Primary Care Support and Development

This includes development of primary care networks, the procurement approach for GP Extended Access Hub for 2020/21, patient engagement in GP Practices, confirmation of the approach translation and Interpreting services across Lambeth, Southwark and Lewisham, and review of primary care services for the homeless

- System development – South East London CCG and place-based arrangements

This objective area covers changing arrangements for Safeguarding Adults across south east London, and for care homes, the partnership children’s safeguarding working in Lewisham and tri-borough Child Death Overview Panel. It will also include quality reporting mechanism.
for local providers, and the CCG role in south east London Integrated Care System Development and the developing and implementing the model for Lewisham place-based integrated commissioning

- Delivering Quality and Financial Plans

This objective area covers delivery of statutory financial duties and financial control total targets, QIPP programme planning and delivery, Enhanced Health in Care Homes (EHCH) model, and emergency optimisation and discharge to assess.

Progress on the Corporate Objectives was reviewed at the last IGC meeting in November and will be updated through the IGC Chairs report.

Throughout the year, work is undertaken to identify and understand the specific risks the CCG may face which may impact the achievement of the CCG’s objectives and strategic aims.

The Board Assurance Framework describes those risks to achieving the agreed Corporate Objectives which have a current score of either “very high” or “high”.

**Board Assurance Framework (BAF)**

The delivery of the Corporate Objectives involves the CCG exposing itself to a wide range of different types and levels of risks to achieve the benefits that are planned to be achieved during 2019/20. These risks, however, should be identified and managed in a controlled manner.

Throughout the course of the year, Lewisham CCG follows a stepped approach to the management of risk, which follows a process of identifying, analysing, examining and monitoring risks to the achievement of the Corporate Objectives.

The Management Team oversees the development of the Corporate Risk Register at the start of each financial year, which is then reviewed on a bi-monthly basis to monitor identified risk and ascertain any new risks.

The Risk Management Group, at their meeting on 10 December, have reviewed the risks associated with the achievement of the Corporate Objectives.

Following this assessment, there are currently four local risks on the CCG Risk Register that meet the criteria for inclusion on the BAF. Risk 101 – Financial Targets 2019/20 score has decreased and is no longer on the BAF. The CCG has further assessed its financial risks and mitigations for the year and these are forecast to be in financial balance. The Summary Risk Table shows the risks rated with 12 or above (ie “High” or “Very High”) Current Score.

Three new Emergency Preparedness, Resilience and Response (EPRR) risks have been identified and added to the Corporate Risk Register, but are not included on the BAF.
There are currently 6 SEL risks that meet the criteria for inclusion on the SEL BAF. The SEL summary risk table shows the risks rated with 12 or above (i.e. “High” or “Very High”) Current Score. Further detail on the SEL BAF and management of those risks is contained in the report on the South East London Integrated Governance & Performance Committee.

<table>
<thead>
<tr>
<th>ID</th>
<th>Risk Title</th>
<th>Original Rating</th>
<th>Original Impact</th>
<th>Original Likelihood</th>
<th>Current Rating</th>
<th>Current Impact</th>
<th>Current Likelihood</th>
<th>Target Rating</th>
<th>Target Impact</th>
<th>Target Likelihood</th>
<th>Risk Movement</th>
</tr>
</thead>
<tbody>
<tr>
<td>99</td>
<td>The NHSE target for CHC Assessments completed in non-acute settings is not delivered and the CCG is not assured by NHSE</td>
<td>6 Moderate Risk</td>
<td>2</td>
<td>3</td>
<td>20 Very High Risk</td>
<td>4</td>
<td>5</td>
<td>2 Low Risk</td>
<td>1</td>
<td>2</td>
<td>None</td>
</tr>
<tr>
<td>100</td>
<td>No integrated care arrangements in place to deliver proactive, holistic and coordinated health and care</td>
<td>12 High Risk</td>
<td>4</td>
<td>3</td>
<td>12 High Risk</td>
<td>4</td>
<td>3</td>
<td>9 High Risk</td>
<td>3</td>
<td>3</td>
<td>None</td>
</tr>
<tr>
<td>83</td>
<td>BGL QIPP Programme delivery for 2019/20 and planning for 2020/21</td>
<td>16 Very High Risk</td>
<td>4</td>
<td>4</td>
<td>12 High Risk</td>
<td>4</td>
<td>3</td>
<td>8 High Risk</td>
<td>4</td>
<td>2</td>
<td>None</td>
</tr>
<tr>
<td>93</td>
<td>Lewisham CCG is unable to meet the 34% CAMHS access target by end March 2020</td>
<td>4 Moderate Risk</td>
<td>4</td>
<td>1</td>
<td>12 High Risk</td>
<td>4</td>
<td>3</td>
<td>4 Moderate Risk</td>
<td>4</td>
<td>1</td>
<td>None</td>
</tr>
</tbody>
</table>
The below heatmap table (figure 3) shows the distribution of all CCG and SEL risks identified through the Corporate Risk Register, by their current risk score.
The BAF attached as Appendix A provides full details of the risks set out in figure 1.

The Governing Body are asked to agree:
- that the appropriate risks have been identified against the achievement of the draft Corporate Objectives
- the current risk scores and the target risk scores for the risks contained within the Board Assurance Framework
- that there are adequate controls in place to mitigate the risks to the Corporate Objectives and where existing controls have not reduced the current risk score to the target risk score there are credible action plans, noting that further work is required to ensure they capture the breadth of work on each risk adequately.
Deep Dive

The Audit Committee previously identified the benefits of a more in-depth discussion at each Governing Body meeting of a particular risk area. This would enable greater understanding of the cause, effects, and actions being taken in respect of the risk, as well as understand the level of risk the Governing Body is willing to tolerate (the risk appetite). The Governing Body are invited to discuss the context and operating environment of the CCG to identify whether there are more actions the CCG can take on system alignment to support a reduction in the high risks of Risk ID 99 in regard to Continuing Healthcare. Lewisham CCG is unable to systematically meet the CHC targets of <15% of assessments completed in acute hospital and > 80% of CHC assessments being completed in 28 days.

Background

In 2018/19, NHSE more proactively monitored the delivery of continuing Healthcare against 2 key targets to better manage an equitable delivery of the NHS’s responsibilities to equitably deliver the requirements of the National Framework for NHS Continuing Healthcare and NHS funded nursing care. These targets reflected other drivers in the wider system such as the long length of stay in hospital and the report from the Parliamentary Audit Committee which was published on 17 January 2017 with a response from the Treasury published 1st March 2018.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>5</td>
<td>50</td>
<td>Q1</td>
<td>33</td>
<td>33</td>
<td></td>
<td>33</td>
<td></td>
</tr>
<tr>
<td>Q2</td>
<td>12</td>
<td>12</td>
<td>Q2</td>
<td>27</td>
<td>27</td>
<td>12</td>
<td>27</td>
<td>12</td>
</tr>
<tr>
<td>Q3</td>
<td>16</td>
<td>16</td>
<td>Q3</td>
<td>47</td>
<td>47</td>
<td>16</td>
<td>47</td>
<td>16</td>
</tr>
<tr>
<td>Q4</td>
<td>20</td>
<td>20</td>
<td>Q4</td>
<td>47</td>
<td>47</td>
<td>20</td>
<td>47</td>
<td>20</td>
</tr>
</tbody>
</table>

As can be seen from the table above, initially the CHC team was delivering well on these metrics. However, there is ongoing deterioration across the whole of 19/20 with Q3 showing an even further dip in performance. A variety of factors have contributed to the shift in compliance.

Staffing

Q4 of 18/19 saw the beginning of the turnover in the CHC team, beginning with the resignation on 2 nurses in that quarter. Then in Q1 of 19/20, there was a significant period of sickness of the Head of CHC (who subsequently resigned at the end of Q2 almost contemporaneously with the resignation of the CHC team leader who also left at the end of Q2. In Q1, one of the nurse assessors went on maternity leave and has subsequently tendered their resignation and will not be returning this January (2020) as expected.

The 28 day target is affected particularly by the stop: start nature of staffing resource as the
complexity of CHC assessments and the collection and interpretation of information is time consuming which means that assessors can change ‘half way through’ the process.

A positive working arrangement between the CCG and the Council has been agreed in Q3. The ‘default’ position of Lewisham Council has been to checklist all people being discharged home from hospital with double handed packages of care 4 times a day. This was resulting in a high number of assessments being undertaken unnecessarily with an extraordinarily low conversion rate. The Council has agreed to no longer apply this blanket requirement and we have jointly agreed a process whereby if the Council believes that someone will meet the criteria for full NHS funding that the CCG will move directly to the full CHC assessment.

Community Beds
One of the biggest impacts on 19/20 performance has been the decision in Q1 of 19/20 to close the community beds at UHL (Sapphire beds). This impacted on the CCG’s ability to ‘step down’ people who no longer required to be in acute hospital beds. This in turn resulted in an increased number of assessments in acute beds. Particularly noticeable is the impact of this lost resource for people who are potentially private funders and who require placement in a nursing home: they will not leave hospital without a full assessment for continuing healthcare because of the potential impact on their estate.

19/20 has witnessed further reduction in the general availability of nursing home beds, particularly nursing residential beds across the whole of the South East of London: Lewisham has restrictions on the admission of complex cases to a Lewisham Home (Alexander Care impacting on access to 78 beds) and 1 of the bigger nursing homes in Greenwich also closed (Gallions View with the loss of 60 beds). This means that people are remaining in hospital for longer while beds are being sourced, which also increases the probability that the assessment will be completed in hospital.

Competing Priorities
A significant part of the work of the CHC team does not relate to assessments at all but to case management, retrospectives and appeals against the outcome of a CHC assessment, and managing reviews of CHC eligible patients.

People eligible for full NHS funding of their care are generally complex. The CCG is supporting people to remain at home with very complex care needs which require frequent review to ensure that they remain safe. People placed in nursing homes also require review at 6 weeks, 3 months and annually thereafter. An additional resource has been identified across South East London to support a programme of reviews in 2020 as meeting review targets for CHC funded patients as this is an issue across all CCGs.

Retrospective and appeals work effectively require the process of CHC assessment to be undertaken again by a different CHC nurse. They also require additional management time to arrange, manage and record the outcome of appeal meetings, and if necessary prepare the case for presentation of NHSE&I.

Complex cases can require ongoing and almost constant support and engagement with the patient and/or their family. Complex cases also often come with complaints and a small number also include Legal challenge from the person and their family. Managing this is significantly time consuming, particularly for the Head of CHC.
CORPORATE AND STRATEGIC OBJECTIVES

The report provides an outline of the corporate objectives for the CCG for 2019/20, and identifies key risks to the achievement of those objectives.

CONSULTATION HISTORY:
Risk Management Group Meeting (10 December 2019) – Review all risks
IGC (28 November 2019) – Corporate Objectives progress update
Risk Management Group Meeting (8 October 2019) – Reviewed all risks
Senior Management Team Meeting (3 September 2019) – High level risks discussed
Corporate Objectives and Risk Management Group (11 June 2019)
IGC (23 May 2019) – Agreement of Corporate Objectives subject to further development of the success measures
IGC Workshop (25 April 2019) - discussed the development of Corporate Objectives and high level Risks.
Corporate Objectives and Risk Management Group (9 April 2019) – Defined the high level risks to the achievement of the Corporate Objectives.

PUBLIC ENGAGEMENT

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

HEALTH INEQUALITY DUTY & PUBLIC SECTOR EQUALITY DUTY

There is a specific risk with regards to Equalities considerations being effectively included in the CCG plans and activities (Risk Identifier 38). These are monitored through the Corporate Objectives and through the management Equality and Diversity Group.

RESPONSIBLE MANAGERIAL LEAD CONTACT:
Name: Charles Malcolm-Smith
E-Mail: Charles.malcolm-smith@nhs.net

AUTHOR CONTACT:
Name: Katie Hitchen
E-Mail: khitchen@nhs.net
**Appendix A – Local BAF December 2019**

<table>
<thead>
<tr>
<th>Corporate Objective:</th>
<th>Urgent and Emergency Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risk</strong></td>
<td>The NHSE target for CHC Assessments completed in non-acute settings is not delivered and the CCG is not assured by NHSE (Risk ID 99)</td>
</tr>
</tbody>
</table>
| **Risk Description:** (What is the risk?) | Failure to deliver the DH ‘must dos’  
  - <15% of CHC assessments to be undertaken in acute hospitals by March 2018 and to be maintained across all 4 quarters of any year  
  - all assessments to be completed within 28 days from checklist to DST  
  - conversion of all CHC packages of care to PHBs  
  - maintaining schedule of reviews for long term CHC packages, Fast Track and FNC eligibility  
  - Non delivery of 2019/20 QIPP  
  - Failure to competently manage Appeals/complaints which is detrimental to the reputation and financial position of the CCG  
  - Increased risk of safeguarding issues not being properly investigated and resolved |

This is caused by:  
- Not being able to discharge people quickly from acute wards to community settings  
- Ongoing changes in and growth to NHSE quality measures and increased assurance  
- Increasing demand for CHC assessments as part of the discharge pathway  
- Insufficient resource in the CHC team to manage this and other priorities relating to reviews due to turnover in the team allied with staff sickness  
- Impact of changes to contracting of Brymore and Sapphire beds

It could lead to:  
- Unsafe discharges to get people home  
- Increased pressure on A&E/inpatient beds through readmissions  
- General capacity issues for CHC Team to manage assessments in dispersed community settings, including out of borough residential and nursing homes
- Increase in referral to decision breaches (>28 days)
- Increased delays in discharges
- Increased risk of future PUPOC
- Increased risk to complex patients in the community
- Increase in complaints and litigation
- Non delivery of QIPP savings
- There is insufficient detailed knowledge of the application of the NHS Framework and lack of continuity within the team to best manage the eligibility assessment process and complex case management

<table>
<thead>
<tr>
<th>Risk Owner:</th>
<th>Hughes, Heather</th>
<th>Risk Manager:</th>
<th>Carlin, Dee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Directorate:</td>
<td>Joint Commissioning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk Appetite:</td>
<td>Low</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk Response:</td>
<td>Mitigate</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Original Score:</th>
<th>Current Score:</th>
<th>Target Score:</th>
<th>Risk Movement:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate Risk</td>
<td>Very High Risk</td>
<td>Low Risk</td>
<td>None</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Impact 2 x Likelihood 3</th>
<th>Impact 4 x Likelihood 5</th>
<th>Impact 2 x Likelihood 2</th>
</tr>
</thead>
</table>

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

- Locum cover for vacant posts [x2 B6, x1 B7, x1 B8b]
- Request ready for permission to recruit post restructure consultation
  - Additional (to establishment) x1 B7 post agreed for 6 months (locum/ short term contract)
  - Implemented interim/without prejudice Responsible Commissioner agreement
  - Continued funding by LBL of additional CHC Nurse based at the hospital
  - Maintaining brokerage team focus on nursing and residential placements
  - Implementation of new process for people with packages of care to be discharged home without checklisting if unlikley to meet CHC criteria, and move straight to CHC assessment if eligibility looks likely
  - Ensuring that any enhanced checklists from hospital for placement are signed off by social work to ensure robustness of recommendation for placements
  - Prioritising CHC Team activity to support enhanced number of community assessments
  - LBL have taken urgent action to identify 5 NEF beds in the community and are seeking to identify Nursing Dementia beds for step down

**Assurance Sources:**

- Current position information is reported monthly to the A&E Delivery Board
- Weekly review of the location of assessments by
<table>
<thead>
<tr>
<th><strong>Heaqd of CHC</strong></th>
<th>Maintenance of a real time assessment location list by CHC Team</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Monthly reporting of the location of assessments to CHC Exec and the SEL STP CHC meetings</td>
</tr>
<tr>
<td></td>
<td>Quarterly reporting to NHS Digital and separately to NHSE (London) CHC Team through AIMS</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Risk Assurances: (What evidence do we have that the controls are working?)</strong></th>
<th>LCCG’s CQIN performance dipped at the end of Q3 18/19 and has maintained through Q1 &amp; 2 in 19/20. The slight improvement seen towards the end of Q2 has not maintained in to Q3 where performance has returned to high level of acute hospital assessment. Therefore controls not fully effective.</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th><strong>Gaps in Risk Controls:</strong></th>
<th>Turnover and therefore discontinuity in the team continues even with locum cover</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Unclear pathway in LCCG/ SELCCG regarding commissioning replacement Saphire/ community placement beds.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Actions:</strong></th>
<th>Continue to seeking to secure Nursing Dementia beds in a local care home with CCG funding (Mar 20)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Retain Head of CHC focus on managing team resources to support community assessments and review post holder workplan to support (revise Jan 20)</td>
</tr>
<tr>
<td></td>
<td>Ensure that new SEL wide resource for review is effectively used to support assessment targets</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Last updated:</strong></th>
<th>Reviewed by: Heather Hughes 29/12/19</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Updated by: Heather Hughes 29/12/19</td>
</tr>
<tr>
<td>Corporate Objective:</td>
<td>Mental Health</td>
</tr>
<tr>
<td>---------------------</td>
<td>---------------</td>
</tr>
<tr>
<td><strong>Risk</strong></td>
<td>Lewisham CCG is unable to meet the 34% CAMHS access target by end March 2020 (Risk ID 93)</td>
</tr>
</tbody>
</table>
| **Risk Description: (What is the risk?)** | Accurate data is not routinely flowed or captured through the Mental Health Service Data Set (MHSDS) via the NHS Digital Portal, to demonstrate increased access to evidence based mental health provision for children and young people. It is caused by:  
  - Variability across providers regarding the 'mental health access' definition  
  - Missed opportunities, by providers, to validate data and ensure accurate reporting  
  - Misinterpretations of the access definition  
  - A complicated and very timeconsuming data reporting process that is challenging for non-NHS providers, particularly for VCS organisations.  
  This could lead to:  
  - Inconsistencies in reporting across different service areas (NHS and non-NHS providers)  
  - Under-reporting  
  - Difficulties when meeting the national target |
| Risk Owner:         | Hirst, Caroline |
| Risk Manager:       | Juon, Jessica |
| Directorate:        | Other |
| Risk Appetite:      | Low |
| Risk Response:      | Mitigate |
| **Original Score:** | **Current Score:** | **Target Score:** | **Risk Movement:** |
| Moderate Risk       | High Risk      | Moderate Risk | None |
| Impact 4 x          | Impact 4 x     | Impact 4 x    | |
| Likelihood 1        | Likelihood 3   | Likelihood 1  | |
| **Controls: (What are we doing to mitigate the risk?)** |  
  - Commissioners continue to work with providers to ensure relevant data is captured to support the CAMHS access targets.  
  - Monthly STP access meetings with SLaM and Oxleas to oversee the risk.  
  - Implementation of NHSI recommendations to ensure that providers strengthen governance and sign off processes related to reported data  
  - The 2019 NHS Lewisham CAMHS Transformation Plan was refreshed and published in early November 2019 and 'improvement against the CAMHS access target' has been incorporated as one of the key priorities.  
  - Data Quality (all SLaM services reporting to MHSDS) - |
this should include all services operating within the YOS, virtual school (DAB) and the CWP programme. In Q2 2019/20, SLaM recruited a Lewisham Transformation Lead, with a focus on regular reconciliation work to drive data capture and accurate reporting.

- Kooth Xenzone (local reporting issues) – Xenzone is now flowing data and has revised the agreed definition with NHSE in June 2019. The Kooth service in Lewisham is not working to full capacity but measures are being taken to review reasons behind this, with the intention to increase uptake. Kooth have developed a Lewisham communication and engagement plan in order to secure improvements and plans are underway to target new and vulnerable groups.
- Measures are being taken to explore some of the challenges that small VSO are experiencing with data flow and the CCG acknowledge the time implications for small VSOs flowing data given the complexities of the system.
- Access is a key consideration in relation to Lewisham's mental health investment standard proposal. 'Outreach services', in the 'getting help' arena, are known to effectively engage CYP. This is therefore hoped to drive improvements in access.
- Lewisham's NHS CAMHS provider, SLaM, are taking a number of actions to manage waiting lists and increase access. The following elements are included in this work programme; the ongoing delivery of twice monthly Saturday clinics (planned until March 2020), evidence based workshops, a collaborative commissioning waiting list initiative, a new 'intake' structure that delivers more timely and robust decision making at the entry point into CAMHS, increased capacity in the crisis team, two additional Children Wellbeing Practitioners and data cleansing activity.
- Whilst much of their work will be strategic, two Mental Health Support Trailblazer Teams will be embedded in Lewisham schools from January 2019. These teams will make some contribution towards access targets.
- In order to more accurately monitor performance and target improvements, Lewisham's NHS CAMHS provider, SLaM, are engaging in a series of NHSI facilitated KPI workshops. Access targets are a priority within this work stream and the CCG is developing a YTD trajectory rather than a monthly target.

Assurance Sources:

- Lewisham Commissioning Service Manager attends a monthly ‘access’ SEL STP assurance meeting
- SLaM Core Contract Meetings
- Newly established monthly commissioner meetings with SLaM
- 4 borough data meetings with SLaM have been established and have resulted in the implementation of a
monthly performance dashboard since October 2019

- 7 borough CAMHS meeting, chaired by Lewisham Commissioning Service Manager
- Contract monitoring processes for SLaM, and non-NHS providers Compass (including Kooth), Core Assets and EYA
- CYP Mental Health and Emotional Wellbeing Programme Board
- An STP level technical group will be re-established to allow commissioners and providers to troubleshoot technical challenges associated with data flow

| Risk Assurances: (What evidence do we have that the controls are working?) | Service and commissioner commitment to improvement as demonstrated via monthly SEL access meetings
| | • Kooth are reporting manual access data to SEL assurance team and commissioners
| | • EYA (previously PSLA) are now flowing data to MHSDS
| | • Additional NHSE resource secured for the delivery of mental health support in school teams.
| | • Based on local data returns between April and October 2019, SEL is now projecting to meet the 34% CYP MH access standard this year at 34.3%, an improvement from our last forecast. Lewisham has risen to achieve 31.6% in October and is confident that this will increase by March 2020. |

| Assurance Type: | Management |
| Assurance level: | Limited |

| Gaps in Risk Controls: | None |

| Actions: | • Application submitted to NHSE for additional resource to increase access and support CAMHS waiting times
| | • Demand and capacity work to be undertaken via the System Dynamic Modelling Tool (Jan 20)
| | • Delivery of a multi-agency event to review understanding and application of the access definition (Jan 20)
| | • Implementation of two Mental Health Support Teams (MHSTs) (Jan 20) |

<p>| Last updated: | Last updated: Jessica Juon 11/12/19 |
| Last reviewed: | Caroline Hirst 13/12/19 |</p>
<table>
<thead>
<tr>
<th>Corporate Objective:</th>
<th>Fianancial Delivery 19/20 &amp; Financial Planning 20/21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk</td>
<td>BGL QIPP Programme delivery for 2019/20 and planning for 2020/21 (Risk ID 83)</td>
</tr>
<tr>
<td>Risk Description: (What is the risk?)</td>
<td>If Bexley, Greenwich &amp; Lewisham (BGL) CCGs do not deliver a credible two-year QIPP Programme this will jeopardise delivery of the financial control total for the current year and 2020/21</td>
</tr>
</tbody>
</table>
| It has been caused by: | • Failure to deliver the 18/19 commissioner/provider/local authority-led commissioning interventions and demand management programmes to reduce both acute and non-acute activity  
• Lack of identified resources, expertise and clarity around process to develop early programmes for 20/21, with heavy reliance placed on block contract negotiations |
| It could lead to: | • An increase in the acute activity run-rate and associated risks with contract negotiations going into 20/21 since 19/20 activity out-turn is the starting point  
• Failing to meet planning expectations of IAF for 19/20  
• Re-opening of block contract agreements with providers  
• Contract mediation and/or arbitration  
• Inability to deliver balanced budget in line with plans  
• Inability to commit to new investments  
• Loss of reputation |
| Risk Owner: | Norton, Annie |
| Risk Manager: | Wilkinson, Martin |
| Directorate: | Other |
| Risk Appetite: | Low |
| Risk Response: | Mitigate |
| Original Score: | Current Score: | Target Score: | Risk Movement: |
| Very High Risk | High Risk | High Risk | None |
| Impact 4 x Likelihood 4 | Impact 4 x Likelihood 3 | Impact 4 x Likelihood 2 |
| Controls: (What are we doing to mitigate the risk?) | • Integrated Contract Delivery Team (ICDT) has secured a large proportion of acute QIPP in the contracts with the main providers for BGL  
• BGL commissioners have made significant investments in community provider(s) to implement services that will |
reduce avoidable acute activity

- Programme Management Office (PMO) for BGL CCGs has been fully in place since the end of May 2019 and leads on providing independent and robust assurance of processes to ensure delivery and implementation progress against plans

**Assurance Sources:**

- The monthly BGL governance and performance management process, which consists of:
  1. Monthly Highlight Report updates from Commissioning Programme Leads, reviewed with PMO
  2. Monthly input from the BGL Business Intelligence (acute activity and financial data) for schemes. This is supplemented with financial performance assessments from the ICDT for contractualised acute schemes and ledger-driven data from Finance for Non-acute schemes
  3. Monthly Planned and Unplanned Care QIPP Assurance Meetings led by the Senior Responsible Officer (SRO) with Programme Leads, PMO and Finance to:
    - Review, understand, challenge and assure the position, including discussion of mitigation or further escalation, as necessary with regard to key issues and risks
  4. Monthly BGL Executive QIPP Assurance Meetings with BGL Managing Directors, Chief Finance Officer, SROs and the PMO covering the entirety of QIPP Programme
- Monthly SEL Finance Assurance Meetings with the Director of Finance for the SEL Clinical Commissioning Alliance, Chief Finance Officer and BGL Managing Directors
- Monthly SEL Delivery Group led by the ICDT with Chief Finance Officers and Directors of Commissioning from across the SEL Clinical Commissioning Alliance
- BGL CCG 19/20 QIPP & Financial Management Internal Audit (Report October 2019)

**Risk Assurances:**

- Highlight Reports and monthly QIPP Assurance Report demonstrating progress and flagging key issues with mitigation details, as per the process outlined above
- QIPP Assurance Report submitted to respective CCGs’ Finance & Investment Committee / Integrated Governance & Performance Committee / Governing Body
- ICDT Integrated Report and contract management meetings with acute providers
- Submissions to NHS England including adhoc returns and review of the NHSE Menu of Opportunities and RightCare data
- BGL CCG 19/20 QIPP & Financial Management Internal Audit management actions: QIPP identification, QIPP Business Cases and QIPP progress monitoring

**Assurance Type:** Management
<table>
<thead>
<tr>
<th>Assurance level:</th>
<th>Limited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gaps in Risk Controls:</td>
<td>• Remaining under-delivery of QIPP (Bexley CCG) for 2019/20 and slippage in delivery</td>
</tr>
</tbody>
</table>
| Actions: | • Development of the joint BGL QIPP resources / expertise package for endorsement by the BGL Managing Directors (August/September – BGL SROs)  
• Temporary resources regarding Lewisham (July) and Bexley (August) CHC recruited to increase focus on delivery with positive impact  
• Resource to assist Bexley has now completed 3m time period and likely to transfer to assist with Greenwich CHC in similar way  
• Significant progress in reducing unidentified gap for Bexley made across M6-M8, with likelihood of further small reductions in M9/10 (M8 figure £423k)  
• Unplanned Care Recovery Plans – all developed and updated w/c 16th December, status currently as follows:  
  ➢ Bexley  
    ▪ baselines and measures for all projects are either in place / being developed to ensure that savings can be accurately tracked against estimated financial benefits projected for each from January 2020 latest  
    ▪ savings projections updated and reduced – further work going on to confirm basis / supporting evidence  
  ➢ Greenwich  
    ▪ actions to facilitate delivery implemented, with original expectation of data to support impact (XSBD) being available in January – unlikely to now deliver in 19/20  
    ▪ savings projections updated and reduced – further work going on to confirm basis / supporting evidence  
  ➢ Lewisham  
    ▪ savings projections updated and reduced – further work going on to confirm basis / supporting evidence  
    ▪ 20/21 Commissioning Intentions Refresh now circulated and work to develop and agree local 20/21 QIPP plans is commencing, alongside SEL Planning Group work |

**Last updated:** Annie Norton 23/12/19  
**Last reviewed:** Martin Wilkinson 23/12/19
<table>
<thead>
<tr>
<th>Corporate Objective:</th>
<th>CCG Development 2019/20</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risk</strong></td>
<td>No integrated care arrangements in place to deliver proactive, holistic and coordinated health and care (Risk ID 100)</td>
</tr>
<tr>
<td><strong>Risk Description: (What is the risk?)</strong></td>
<td>An Integrated Care System for Lewisham is not established as Lewisham’s Health and Care Partners do not take the necessary action to establish effective integrated care arrangements for Lewisham, including a borough based board/integrated care partnership and associated provider alliances.</td>
</tr>
<tr>
<td></td>
<td>It is caused by:</td>
</tr>
<tr>
<td></td>
<td>• A lack of leadership across the system to drive forward and deliver the necessary changes at pace and scale</td>
</tr>
<tr>
<td></td>
<td>• Lack of understanding, engagement and buy in from stakeholders across the system, including staff, public, patients, service users and carers</td>
</tr>
<tr>
<td></td>
<td>• A lack of clarity on the relationship between local integrated arrangements and the wider SEL ICS</td>
</tr>
<tr>
<td></td>
<td>• Decisions taken across system continue to support individual organisational benefit, and do not address risks or establish value to system as a whole</td>
</tr>
<tr>
<td></td>
<td>• Inability to reach agreement on new or redesigned models of care, pathways or services</td>
</tr>
<tr>
<td></td>
<td>• Limited capacity and capability to deliver agreed programmes and projects within agreed timescales</td>
</tr>
<tr>
<td></td>
<td>• A lack of strategic direction, associated plans and capability to progress work on key enablers - workforce (both commissioners and providers), IT and estates – which therefore impedes the delivery of an integrated care system</td>
</tr>
<tr>
<td></td>
<td>• Inability to share key service and activity data to shape the redesign of integrated services and a lack of leadership, ownership and engagement locally to utilise the population health system to identify transformation opportunities</td>
</tr>
<tr>
<td></td>
<td>• Operational pressures limit the ability of those involved to fully engage with transformation activity</td>
</tr>
<tr>
<td></td>
<td>• PCNs not fully engaged with system-wide transformation.</td>
</tr>
<tr>
<td></td>
<td>It could lead to:</td>
</tr>
<tr>
<td></td>
<td>• Failure to target resources to meet local need and address inequalities effectively</td>
</tr>
<tr>
<td></td>
<td>• Further fragmentation of services across the system</td>
</tr>
<tr>
<td></td>
<td>• Failure to deliver co-ordinated and holistic care</td>
</tr>
<tr>
<td>Risk Owner:</td>
<td>Wilkinson, Martin</td>
</tr>
<tr>
<td>------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Directorate:</td>
<td>Corporate Directorate</td>
</tr>
<tr>
<td>Risk Appetite:</td>
<td>High</td>
</tr>
<tr>
<td>Original Score:</td>
<td>Current Score:</td>
</tr>
<tr>
<td>High Risk</td>
<td>High Risk</td>
</tr>
<tr>
<td>Impact 4 x Likelihood 3</td>
<td>Impact 4 x Likelihood 3</td>
</tr>
</tbody>
</table>
| Controls: (What are we doing to mitigate the risk?) | • Commitment to national coverage of Integrated Care Systems (ICSs) by April 2021 set out in NHS Long Term Plan  
• Demonstrable commitment by Lewisham Health and Care Partners and Health and Wellbeing Board to stronger and more collaborative working within existing governance and partnership arrangements  
• Oversight of provider alliance development provided by specific leadership and operational groups for Mental Health (working age adults) and Care at Home  
• An update to the risk register for Care at Home has been drafted for consideration by the SRO. It will be agreed when the new Leadership Group is convened. The SRO |
meets with the Care at Home lead on a fortnightly basis to review progress and issues including key risks
  • The risk register for MH Community Transformation is monitored by the MH Leadership Group.
  • Joint Integrated Commissioning Group for Children and Adults established
  • Refreshed integrated commissioning intentions to be agreed across adults and CYP
  • Development of place-based integrated commissioning functions and governance overseen by SEL CCG System Reform Group
  • Local partnership vision for community based care agreed
  • Regular update reports presented to LHCP, the Health and Wellbeing Board and to the governing bodies of each sovereign organisation
  • Population Health and Care System Programme Board in place to oversee provision of shared analytical platform, common health and care record, and registries of information on specific conditions or population groups. Work includes reviewing the levels of engagement and utilisation across the system
  • LHCP Estates Group established to identify joint opportunities to share and develop estates between health and care
  • SEL CCG System Reform Group monitoring engagement and providing key messages across all stakeholders for SEL ICS development and place-based local care partnerships
  • Six primary care networks established, in line with national guidance, as a key component of Integrated Care Systems.
  • Regular discussions with LBL on future placed based joint commissioning arrangements
  • PCN leads have been assigned to clinical areas.
  • Partnership approach to Frailty agreed with Bexley and Greenwich
  • Social Prescribing Network established to provide local strategic oversight of social prescribing in Lewisham. Coordination provided by Age UK Southwark and Lewisham.
  • Collaborative working between partners to support the new PCN Social Prescribing Link Worker service
  • A Stakeholder Advisory Group has been established to support the co-design of the community space at the Waldron Health Centre.

Assurance Sources:
  • Confirmation from NHS England and NHS Improvement that SEL is first area of London to be part of Wave 3 of Integrated Care Systems (ICS) in England and application submitted
• Reports on progress and planned actions submitted to Health and Wellbeing Board, LHCP Executive Board and to specific leadership and operational groups for Mental Health (working age adults) and Care at Home and minuted accordingly
• Reports on progress and planned actions submitted to sovereign governing bodies for approval - including CCG Governing Body and Strategy and Development
• Discussion and actions recorded at Core Contract meetings
• No decisions affecting sovereign bodies agreed without being taken through appropriate governance and approval routes within each body
• Development of integrated arrangements follows guidance on best practice and information from NHSE, including high impact care models and better care fund examples
• All formal changes fall within existing legal frameworks
• Training undertaken in the use of Experience Based Co-Design by front line staff
• Better Care Fund Plan 2019/20 which supports integrated working was submitted to NHS England on 27 September 2019. Plans will be assured and moderated with final decisions on approval expected by the end of December 2019.
• Cross partnership transformation groups for diabetes and frailty in place to agree areas of focus and identify actions for implementation.
• PCN leads engaged on developing practical short and long term ways in which to implement change to improve patient care based on LHCP strategy and population health and care patient stratification.

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

• HWB and CCG Governing Body supported and endorsed the initial plans to develop integrated community based care on 6 and 11 July 2017 respectively.
• The Care at Home activity continues to develop a wide range of opportunities for joint training (e.g. therapies and nursing input into the Enablement induction programme) and joint working (e.g. trusted assessor pilots across district nursing and social care).
• Positive evaluation of NCT pilots and Local Care Networks
• Approval of investment in population health and care system by CCG and other partners
• Successful application to One Public Estate Programme and s106 monies to support estates developments, particularly neighbourhood hubs
• Membership from across system on Provider Alliance Leadership and Operational Groups for Care at Home and
Shadow Adult Mental Health Alliance
- Provider Alliance Business Cases and Plans approved
  - Care at Home approved by Lewisham CCG Governing Body and LBL Mayor and Cabinet in November 2018 and by Lewisham and Greenwich NHS Trust in February 2019
  - Application of learning from Canterbury NZ and South Tyneside relating to ICS development - 3 May 2019
- All GP practices are sharing data on the population health platform as well as hospital and community services data.
  - A small pilot group, working with PCN leads, One Health Lewisham and community teams established to use the new tools and information available from the population health and care data system. The tools include four cohort registries for people with Diabetes and Respiratory related needs. The pilot group will feed back to the programme team before being widened further.
  - PCN leads now identified for key transformation groups on Frailty, Mental Health and Diabetes
  - Patient cohorts are being identified for targeted action.
  - Commissioning Intentions produced on 30 September

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

**Gaps in Risk Controls:**
- Overarching vision and strategic framework for health and care needs updating in line with clinical strategies
- LCCG is dependent on other local providers and commissioners to mirror CCG’s commitment to the development of an integrated care system and partnership

**Actions:**
- Testing of draft outcomes framework, once measures have been identified (DC - Mar 2020)
- Care at Home Provider Alliance Leadership Group planned for Feb 2020
- Next steps to be identified to establish partnership approach to the delivery of CBC, building on the existing work on Care at Home and MH (CL)
- Work towards establishing an overarching community based care provider alliance by 2021
- MH Provider Alliance workstreams have been finalised with first pilot on community service transformation to commence in Neighbourhood 1 in Feb 2020
- Waldron stakeholder engagement plan to be developed by Feb 2020 (FK)
- Borough Based Board and renewed LHCP membership to be in place by April 2020 (MW)

**Last updated:** SW/KG/CL 17/12/19
**Last reviewed:** Sarah Wainer 19/12/19
# Appendix B – Glossary of Terms

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

<table>
<thead>
<tr>
<th>Risk levels</th>
<th>Key elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 Avoid</td>
<td>Avoidance of risk, and uncertainty is a key organisational objective</td>
</tr>
<tr>
<td>1 Minimal</td>
<td>(as little as reasonably possible)</td>
</tr>
<tr>
<td>2 Cautious</td>
<td></td>
</tr>
<tr>
<td>3 Open</td>
<td></td>
</tr>
<tr>
<td>4 Seek</td>
<td></td>
</tr>
<tr>
<td>5 Mature</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Financial /VFM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avoidance of financial loss is a key objective. Only willing to accept the low cost option. VFM is the primary concern.</td>
</tr>
<tr>
<td>Prepared to accept all possible levels of financial loss if essential. VFM is the primary concern.</td>
</tr>
<tr>
<td>Prepared to accept all possible levels of financial loss if essential. VFM is the primary concern.</td>
</tr>
<tr>
<td>Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered in the context of opportunities and return on opportunities.</td>
</tr>
<tr>
<td>Consistently focused on the best possible return for stakeholders. Resources allocated in ‘social capital’ with confidence that this is a return in itself.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Compliance /regulatory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avoid anything which could be challenged, even unsuccessfully. Play safe.</td>
</tr>
<tr>
<td>Want to be very sure we would win any challenge. Similar situations elsewhere have not broadened compliances.</td>
</tr>
<tr>
<td>Limited tolerance for sticking our nose out. Want to be reasonable sure we would win any challenge.</td>
</tr>
<tr>
<td>Challenges would be problematic, but we are likely to win and the gain will cover the adverse consequences.</td>
</tr>
<tr>
<td>Consistently pushing back on regulatory burden. Front foot approach informs better regulation.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Innovation/Quality/Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Prior for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems /technology developments.</td>
</tr>
<tr>
<td>Innovations always avoided unless essential or commercially obvious. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations.</td>
</tr>
<tr>
<td>Tendency to stick to the status quo. Innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems /technology developments limited to improvements to protect current operations.</td>
</tr>
<tr>
<td>Innovation supported, with demonstration of commercial improvements in management control. Systems /technology developments used consistently to enable operational delivery. Responsibility for non-critical decisions may be devolved.</td>
</tr>
<tr>
<td>Innovation pursued – desire to break the mould and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.</td>
</tr>
<tr>
<td>Innovation the priority – consistently breaking the mould and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reputation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tolerance for risk taking limited to those events where there is little chance of any significant repudiation for the organisation. Decision management distance themselves from chance of exposure to attention</td>
</tr>
<tr>
<td>Tolerance for risk taking limited to those events where there is little chance of any significant repudiation for the organisation. Scared management distance themselves from chance of exposure to attention</td>
</tr>
<tr>
<td>Appetite to take decisions with potential to expose the organisation to additional scrutiny/interest. Preparative management of organisation’s reputation</td>
</tr>
<tr>
<td>Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation</td>
</tr>
<tr>
<td>Track record and investment in communications has built confidence by public, press and politicians that organisation will take the difficult decisions for the right reasons with benefits outweighing the risks.</td>
</tr>
</tbody>
</table>

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

(Source: Risk Management Framework (ver 3.0) ratified on 22nd September 2015)
**Appendix D – Glossary of Terms**

**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><strong>Action Required</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Work that is required to close assurance gaps</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A</th>
<th><strong>Action Target Date</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The date that the actions are due to be completed</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A</th>
<th><strong>Assurance Gaps</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Where the CCG has no evidence of whether or not its controls are effective</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A</th>
<th><strong>Assurance Given</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The evidence that controls are effective or not</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A</th>
<th><strong>Assurance Level</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The strength of the evidence; None, Limited, Adequate, Significant</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A</th>
<th><strong>Assurance Source</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Where the CCG finds evidence that its controls are effective</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A</th>
<th><strong>Assurance Type</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></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><strong>Controls</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></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>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C</th>
<th><strong>Current Score</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The Current ('residual') risk score which is the most recent risk assessment</td>
</tr>
</tbody>
</table>

| O | **Original Score** |
The score that has been assessed at the beginning of the financial year

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

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

Risk appetite is normally smaller or less than risk tolerance.

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

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

Risk Scores
Risk Scoring Matrix

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

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

Risk Tolerance

<table>
<thead>
<tr>
<th>Impact</th>
<th>Almost Certain</th>
<th>Likely</th>
<th>Possible</th>
<th>Unlikely</th>
<th>Rare</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Negligible</td>
<td>Minor</td>
<td>Moderate</td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td>2</td>
<td>Minor</td>
<td>Moderate</td>
<td>High</td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td>3</td>
<td>Moderate</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td>4</td>
<td>Major</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td>5</td>
<td>Catastrophic</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>Low</td>
</tr>
</tbody>
</table>
“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>Target Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>All risks on the CCG Risk Register specify the target risk score (i.e. a desired level of risk that the organisation believes is optimal to meet its objectives by the end of the financial year (unless otherwise stated)). The acceptability of the target risk score is subject to review by senior management and relevant Committee as part of the normal review process for the Risk Register.</td>
</tr>
</tbody>
</table>
A meeting of the Governing Body  
9th January 2020

NHS Lewisham CCG Annual Report and Accounts to the Audit Committee

CLINICAL LEAD: Dr Faruk Majid  
Post  CCG Chair

MANAGERIAL LEAD: David Maloney  
Post  Director of Finance

AUTHOR: Charles Malcolm-Smith  
Post  Deputy Director (Strategy & OD)

RECOMMENDATIONS:
The Governing Body is asked to:

1. Note the timeline for preparing and approving the 2019/20 Annual Report and Accounts.
2. Delegate authority to approve the 2019/20 Annual Report and Accounts to the Audit Committee.
3. Note the management arrangements in place prepare the content of the annual report and accounts.

Summary:

- The 2019/20 NHS Lewisham CCG draft Annual Report is due to be submitted to NHS England by 16th April 2019, and unaudited Annual Accounts by 23rd April and as final audited versions by 28th May 2019.
- The Governing Body is asked to delegate authority to the Audit Committee to approve the 2019/20 Annual Report and Accounts.

Key Issues:
The management arrangements for the oversight and co-ordination of the annual report are unchanged, that is led by the CCG’s Deputy Director (Strategy & OD) working with the Head of Finance reporting to the CCG Managing Director and management team, and that where possible the members of the Audit Committee receive the draft content of the annual report in advance of the other papers for its meeting to allow full and more detailed consideration.

The Governing Body is asked to agree the proposal that authority is delegated to the Audit Committee for approval and submission of the completed report to NHS England. This will include review and approval of the unaudited draft annual report and accounts in April, and subsequent review and approval of the final reports and accounts in May, scheduled to take account of the NHS England submission dates.
2019/20 Annual Report and Accounts Key Dates

The dates as currently set by NHS England are:

<table>
<thead>
<tr>
<th>When</th>
<th>What</th>
</tr>
</thead>
<tbody>
<tr>
<td>16th April</td>
<td>CCGs submit draft annual report, full copy of the draft final head of internal audit opinion statement as issued by the CCG internal auditors.</td>
</tr>
<tr>
<td>23rd April</td>
<td>Unaudited accounts including the annual governance statement, as approved by the accountable officer and chief financial officer (and passed to appointed auditors for audit).</td>
</tr>
<tr>
<td>28th May</td>
<td>CCGs to submit full audited and signed annual report and accounts, as approved in accordance with the CCG scheme of delegation and signed and dated by the accountable office and appointed auditors.</td>
</tr>
<tr>
<td>30th September</td>
<td>CCGs should hold a public meeting which the annual report and accounts should be presented.</td>
</tr>
</tbody>
</table>

CORPORATE AND STRATEGIC OBJECTIVES

Ensure that robust governance arrangements are in place.

CONSULTATION HISTORY INCLUDING MEMBERS ENGAGEMENT:

- None

PUBLIC ENGAGEMENT

- There has been no public engagement in the compilation of the annual report to date
- A readers panel will be asked to comment on a late draft of the 2019/20 Annual Report
- The annual report will include a summary of the CCG’s progress in meeting its responsibilities for public engagement during 2019/20

HEALTH INEQUALITY DUTY & PUBLIC SECTOR EQUALITY DUTY

The Annual Report will report the CCG’s progress in meeting these duties during the 2019/20 financial year.

RESPONSIBLE MANAGERIAL LEAD CONTACT:

Name: David Maloney
E-Mail: d.maloney@nhs.net

AUTHOR CONTACT:

Name: Charles Malcolm-Smith
E-Mail: charles.malcolm-smith@nhs.net
The SE London ICS response to the NHS Long Term Plan

<table>
<thead>
<tr>
<th>CLINICAL LEAD:</th>
<th>Dr Faruk Majid</th>
<th>CCG Chair</th>
</tr>
</thead>
<tbody>
<tr>
<td>MANAGERIAL LEAD:</td>
<td>Julie Lowe</td>
<td>Programme Director - Our Healthier South East London</td>
</tr>
<tr>
<td>AUTHOR:</td>
<td>Tom Henderson</td>
<td>Our Healthier South East London</td>
</tr>
</tbody>
</table>

RECOMMENDATIONS:

The Governing Body is asked to review the Lewisham Local Care Partnership content and provide any additional comments on the Long Term Plan response to the team by 17th January, ahead of approval by the OHSEL board.

SUMMARY:

At its part two meeting on 14th November, the Governing Body reviewed the draft response of the south east London integrated care system to the NHS Long Term Plan, ahead of submitting the final draft on 15th November 2019.

The draft response was also reviewed by the OHSEL Board on 13th November and then submitted to NHS England and Improvement on the 15th November – this was submitted as a draft and was not signed off in public due to the pre-election purdah period. It was agreed that following the election the draft would be published on OHSEL webpage and there would be further opportunity for system partners to provide comment prior to signing off in public at the OHSEL board (in public) on 29th January.

KEY ISSUES:

The attached briefing pack (Appendix 1) summarises the South East London ICS response, and in particular priorities for service transformation by 2023/24:

1. Integrated community based care
2. Reduce pressure on urgent and emergency care
3. Improve planned care outcomes and performance
4. Deliver better outcomes for major health conditions
5. Deliver financial savings and achieve financial sustainability

In parallel, developing plans for 21st century care by:

- Going further on prevention
- Delivering personalised care
- Digital transformation in primary care
- Leveraging research, innovation and genomics
In the SEL LTP response each of the six local care partnerships describes their approach to delivering the LTP and how their priorities respond to local population needs. The Lewisham Local Care Partnership content is found in Appendix 2.

Further developments within the plans broadly fall into three categories:
1. Areas that we know are key challenges for our ICS
2. Areas that historically are less developed in SE London
3. Responding to further national policy and guidance

The next steps for the response are:
1. Sign off final LTP response at the OHSEL Board in public on 29th January.
2. Following sign off, send the response to NHSE&I and publish the response on the OHSEL website.
3. Publish a public facing summary document of the response.
4. Continue with the implementation of the plans identified in the LTP response, further developing the ICS as the delivery vehicle as part of this.

CORPORATE AND STRATEGIC OBJECTIVES
The NHS Long Term Plan and ICS response help to determine the organisation’s objectives and priorities

CONSULTATION HISTORY INCLUDING MEMBERS ENGAGEMENT:
- The Governing Body received the draft response to the Long Term Plan in November 2019

CONFLICT OF INTEREST (CoI):
None identified

PUBLIC ENGAGEMENT
In developing the ICS’s response to the Long Term Plan specific engagement activities were undertaken to help inform the response:
- Healthwatch was nationally commissioned to undertake engagement work across six boroughs (led by Healthwatch Lewisham for SE London) via surveys and focus groups.
- SEL ICS commissioned Kaleidoscope Health and Care to undertake further, complementary engagement work across all six boroughs, comprising a survey, engagement events and bespoke outreach activities for seldom heard groups.

Engagement with the public and patients will remain ongoing throughout implementation of plans outlined within the response.

HEALTH INEQUALITY DUTY & PUBLIC SECTOR EQUALITY DUTY
Reducing health inequalities is a core thread throughout the ICS’s LTP response. An Equality
Impact Assessment has been undertaken on the response, which in turn will support further EQIAs being carried out in individual workstreams.

**RESPONSIBLE MANAGERIAL LEAD CONTACT:**
Name: Julie Lowe  
Programme Director - Our Healthier South East London  
E-Mail: julie.lowe@nhs.net

**AUTHOR CONTACT:**
Name: Tom Henderson  
Our Healthier South East London  
E-Mail: tomhenderson@nhs.net
Introduction

In January 2019, the NHS Long Term Plan (LTP) was published, setting out expectations for the next 10 years to support people in starting well, living well, and ageing well. Whilst refreshing areas such as cancer, mental health and urgent and emergency care, the LTP brought renewed focus to specific major health conditions including cardiovascular disease, stroke, and respiratory disease. In outlining an improved health and care offer for our population, the LTP also emphasised the need to reduce health inequalities, enhance out-of-hospital care, and increase digitally-enabled care.

Every health and care system – in this case the South East London Integrated Care System (ICS) – was required to develop a response to show how the requirements of the Long Term Plan would be locally delivered. In doing so responses were required to:

- Be clinically led and locally owned.
- Be financially balanced.
- Be based on realistic workforce assumptions.
- Deliver the entirety of the LTP.
- Phase activity over 5 years based on local need.

Following release of the LTP implementation guidance in June 2019 we have been developing our ICS response, which is now in the process of being finalised.
The SE London ICS response

Our system’s response to the NHS Long Term Plan sets out how we will deliver nationally agreed priorities, including reducing health inequalities, personalising care and preventing ill health. Our response does not present our strategy for south east London, but is one of a suite of plans across south east London and in each borough that collectively support the delivery of our goals.

As London’s first integrated care system our response outlines plans that:

• **Respond as a partnership to the health and care needs of south east Londoners** – our integrated care system represents a ‘System of Systems’ that prioritises action at the scale at which it has best effect.

• **Focus on addressing the real health inequalities found across our system** – inequality in health outcomes, access and service offers for our population: some of the most diverse communities in England.

• **Prioritise system improvement** – we are proud of many of the outcomes and care we deliver for our residents today, whilst recognising a clear and urgent need to improve key areas of quality, performance and sustainability of our system.

• **Emphasise the collective accountability that our partners have taken for health and wellbeing of our residents** – we must live within our means and that requires a system orientation toward best value, preventative action, innovation and enhanced collaboration across our partners.

Our response is clinically led, and our approach will continue to be informed by engagement with the public. Whilst the Long Term Plan is an NHS plan, we continue to progress work as an integrated care system that responds to our different populations, includes our six local authorities as partners, and recognising that the challenges we face cannot be addressed by health services alone. Our response acknowledges the role of place (borough) level where integrated work between NHS provider organisations, commissioners, local authorities and the voluntary sector is key to the delivery of improved outcomes. In doing this our response also highlights the need to work with neighbourhoods, and particularly Primary Care Networks, to ensure that we are addressing health inequalities and focusing on making a real difference to the health of local residents.

Within our LTP response we have set out a number of actions to be delivered by the end of 2023/24. To support the achievement of our ambitions we will continue to engage with stakeholders including residents and our workforce and assess the impact that our actions will have, expanding on the equality impact assessment we have undertaken on our overarching response.
As the south east London integrated care system our ambition is to deliver a **clinically and financially sustainable system for the future, taking collective action to improve outcomes and address health inequalities in our population**. We are pursuing this vision by adopting a population health management approach and by taking action at different geographical levels – very locally in our neighbourhoods, in each borough, and across south east London. As a ‘System of Systems’ we will operate by bringing our partners together to take action at the optimal scale to effect change.

To deliver our aim we are creating robust and detailed plans for service change which will address our health inequalities gap, improve health outcomes and deliver clinical and financial system sustainability. Our priorities for LTP service transformation by 2023/24 are:

1. **Integrated community based care** - implementing a core offer that ensures people who are frail or have multiple conditions receive timely and personalised care delivered by community multidisciplinary neighbourhood teams, integrated with our 35 PCNs. (p 33 -39)
2. **Reduce pressure on urgent and emergency care** - providing high quality, consistent and timely services by delivering seamless UEC pathways through an integrated network of community and hospital based care that ensures patients are seen in the least intensive setting for their need. (p 40 - 43)
3. **Improve planned care outcomes and performance** - cutting long waits and expanding the volume of planned surgery whilst ensuring sustainability of services by better aligning capacity with demand. Transforming the outpatient model to reduce face to face appointments by a third. (p 44 - 50)
4. **Deliver better outcomes for major health conditions** - taking systematic action that focuses on prevention, early detection and best practice treatments in: Cancer, Adult Mental Health, CVD, Respiratory Disease, Heart Disease and Stroke Care, Diabetes, LD and Autism, CYP (in CYP Mental Health) and Maternity services. (p 51 – 92)
5. **Deliver financial savings and achieve financial sustainability** – setting out our system plan for implementing the LTP commitments over the next four years, whilst addressing our underlying recurrent deficit and working towards our system and organisational improvement trajectories. (Chapter 5, p 135)

In parallel, we are developing our plans for 21st century care by:

- **Going further on prevention** - implementing a population health management approach and targeting interventions to reduce health inequality. (p 93)
- **Delivering personalised care** - implementing a comprehensive personalised model for LTCs, offering personal health budgets to all who are eligible. (p 101)
- **Digital transformation in primary care** - delivering online consultation in every practice by April 2020 and video by April 2021. (p 98)
- **Leveraging research, innovation and genomics** – Speeding up the practical application of research in SEL for the benefit of our patients (p 105)
Both addressing our financial challenge and delivering the commitments of the Long Term Plan can only be achieved through working across the levels within our integrated care system – neighbourhood, place, and system.

At a borough level this requires the development of place-based boards and local care partnerships to design and oversee delivery of integrated health and care for the local population.

As part of this, services will need to work together beyond the scale of the neighbourhood level. For example, primary care networks and community services will need to work together to wrap services around the needs of patients with long term conditions.

At the same time we will need to deliver personalised care as far as possible, aiming to do what is right for the individual person rather than what is easiest for the system.

In the SEL LTP response each of the six local care partnerships describes their approach to delivering the LTP and how their priorities respond to local population needs. (Chapter 4, P 119 – 124)
How our response has been developed

By the time our final response has been finalised there will have been three stages to its development, as shown below. The original date as set nationally for a final response was 15\textsuperscript{th} November, however timescales were then revised in response to the Cabinet Office General Election Guidance 2019. This means that we are now able to sign off the final version of the response in public, at the OHSEL Board on 29\textsuperscript{th} January.

<table>
<thead>
<tr>
<th>Stage</th>
<th>Key activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>First draft</td>
<td>• Initial drafting of response based on the LTP Implementation Framework and regional guidance.</td>
</tr>
<tr>
<td></td>
<td>• Public engagement activities via Healthwatch and Kaleidoscope Health and Care.</td>
</tr>
<tr>
<td></td>
<td>• Session with Clinical Programme Board.</td>
</tr>
<tr>
<td></td>
<td>• Briefings at CCG Governing Body meetings, Health and Wellbeing Boards and the SE London JHOSC.</td>
</tr>
<tr>
<td></td>
<td>• Sign off by OHSEL Board (in private) and submission of first draft.</td>
</tr>
<tr>
<td>Second draft</td>
<td>• Refinement / updating of response to reflect feedback from NHSE&amp;I.</td>
</tr>
<tr>
<td></td>
<td>• Draft content taken to all CCG Governing Bodies and Trust Boards (in private) for review and comment, testing strategic alignment with local plans.</td>
</tr>
<tr>
<td></td>
<td>• Sign off by OHSEL Board (in private) and submission of second draft.</td>
</tr>
<tr>
<td>Final version</td>
<td>• Final review of content by:</td>
</tr>
<tr>
<td></td>
<td>o Clinical Leadership Groups / work streams.</td>
</tr>
<tr>
<td></td>
<td>o Patient and Public Advisory Group.</td>
</tr>
<tr>
<td></td>
<td>o Provider Finance Leads.</td>
</tr>
<tr>
<td></td>
<td>o Clinical Programme Board.</td>
</tr>
<tr>
<td></td>
<td>o CCG Governing Body meetings.</td>
</tr>
<tr>
<td></td>
<td>• Updating response where applicable.</td>
</tr>
<tr>
<td></td>
<td>• Sign off by OHSEL Board (in public) on 29\textsuperscript{th} January.</td>
</tr>
</tbody>
</table>
Further development of our plans

Whilst the end of January will see sign off of our ‘final’ response, our plans will continue to evolve after that point in time. Further developments within in our plans broadly fall into three categories:

1. **Areas that we know are key challenges for our ICS**: There are some parts of our response, such as the chapter on system financial management, where we know that there is more to do if we are to meet national requirements. Whilst a lot of work has gone into developing plans to date, we recognise that we will need to continue to work in partnership across the ICS to make further progress in these areas.

2. **Areas that historically are less developed in SE London**: Due to the previous and current setup of Our Healthier South East London programmes there are some parts of our response where plans are less well developed. For example, whilst we have long standing plans for cancer, mental health and maternity which have been refreshed where necessary in response to the Long Term Plan, we are still in the early stage of developing and delivering our plans for cardiovascular disease prevention, heart disease, and respiratory disease.

3. **Responding to further national policy and guidance**: Our response reflects latest national guidance around the Long Term Plan, but we know that more guidance may be published in the future. For example, our workforce response currently reflects the Interim People Plan, but once the Full People Plan is published we will need to update our plans accordingly.
Implementing our response

Following sign off of our response by the OHSEL Board (in public) we will move fully into the implementation phase of our plans. In some cases implementation has already begun, due to national expectations having been defined prior to (and then reiterated in) the Long Term Plan. For example, the Local Maternity System has previously been working to implement *Better Births*, meaning that many of the requirements within the LTP are already being progressed.

In other instances there is a need to develop more detailed action plans to translate our ambition and supporting strategies into more tangible delivery plans. In doing so there is a need to ensure that across the system there is the right resource and infrastructure in place to support taking forward our plans, and this may mean making changes to the way programmes are currently run at the SE London system level.

However, successful delivery of our plans will only be achieved through all levels – neighbourhood and place as well as system – playing an active role in implementation. We will need to make sure that plans align with the priorities of our six Local Care Partnerships as laid out in our Long Term Plan response.

A further important aspect of taking forward our plans is continued engagement with the public. As an ICS we are developing a refreshed engagement strategy that will sit alongside activities undertaken by and for NHS commissioners, trusts, and local authorities. How we engage the public in the implementation of our LTP response forms part of this work.
Next steps

1. Sign off our final LTP response at the OHSEL Board in public on 29th January.

2. Following sign off, send our response to NHSE&I and publish the response on the OHSEL website.

3. Publish a public facing summary document of our response.

4. Continue with the implementation of the plans identified in our LTP response, further developing our ICS as the delivery vehicle as part of this.
Lewisham Health and Care Partners

Our partnership working

The Lewisham Health and Care Partnership was formally established in 2016, building on Lewisham’s Adult Integrated Care Partnership which had been in place since 2014.

Lewisham Health and Care Partners includes: Lewisham and Greenwich NHS Trust; London Borough of Lewisham; NHS Lewisham Clinical Commissioning Group; One Health Lewisham (Pan-Lewisham GP Federation); South London and Maudsley NHS Foundation Trust; and Lewisham’s Local Medical Committee.

Discussions are taking place to enhance primary care representation and input from the voluntary and community sector given the establishment of primary care networks and the increased recognition of the role of the voluntary and community enterprise sector in maintaining and improving health and wellbeing.

The Partners meet regularly through their Executive Board to provide shared system wide leadership, set the strategic direction for integration and transformation and oversee the changes required for health and care across Lewisham.

Lewisham’s existing joint commissioning arrangements for children’s and adults are governed by section 75 agreements and report into an integrated joint commissioning group. The council and CCG are seeking to further strengthen these commissioning arrangements as part of the development of the place based system and governance.

Alongside Lewisham’s integrated commissioning arrangements, the borough has two emerging provider alliances:

- Care at Home Alliance: brings together local health and care organisations to develop new integrated provider arrangements to deliver care and support for adults in their own homes, improving the coordination, quality and accessibility of that care and support.
- Mental Health Alliance: seeks to provide working age adults with a personalised approach to their treatment, care and support needs, based on the identification of assets and strengths, and facilitating the achievement of personal goals.

Our priorities

A primary focus for Lewisham Health and Care Partners continues to be on the integrated delivery of proactive, co-ordinated and accessible community based care at a neighbourhood level, and on establishing an effective interface between community based care and secondary provision. Four partnership priorities have been identified for system transformation.

These priorities are supported by the development of Lewisham’s data and information management system which is providing the population level data and information necessary to inform and validate the improvement and transformation decisions being taken across Lewisham’s health and care system. Lewisham aims to enhance the local analytical capability to identify further areas for improvement.

Frailty – a dashboard for frailty is being developed to stratify the local population into cohorts of mild, moderate and severe and map against other conditions, service and indices of deprivation. This will be used to target specific cohorts for prevention and early intervention activities and to put in place a range of coordinated anticipatory care to avoid or avert a crisis or other event.

Mental health – the Mental Health Provider Alliance is currently focusing on transforming Front Door and Rapid Crisis Response, Community Support, and Rehabilitation and Complex Care. This activity is seeking to help those living with serious mental illness by: facilitating recovery and helping people to stay healthy and engage in community life; developing and supporting community wellbeing, offering early intervention and prevention; and improving care for service users presenting in crisis.

Respiratory – priority actions include commissioning integrated respiratory community hubs; review of Lung Education Exercise Programme; and delivery of multi-disciplinary team working with primary care, community and social care for respiratory patients so that there is a respiratory model of care that provides a holistic person centre service.

Diabetes – following data analysis, areas of focus have been identified: patients with undiagnosed diabetics; patients at risk of developing diabetes; patients that had gestational diabetes and have not had a 3 and/or 15 month check; patients not in range for 1, 2 or all 3 of the treatment targets. Primary and community care will work with these groups to provide an increased focus on diabetes prevention and to provide better co-ordinated and integrated diabetes services that fit around an individual’s needs.
Report from the Chair of the Strategy & Development Workshop
Date of Meeting(s) reported: 5th December 2019
Author: Dr Charles Gostling

Main Issues discussed

The meeting covered items on CCG system reform and terms of reference for the borough based board, winter preparedness, the Local Area Partnership Special Educational Needs and Disability (SEND) strategy and on the Equality Delivery System and annual equalities report.

- **CCG System Reform and Borough Based Board**

  The CCG Managing Director led a discussion on the draft terms of reference for the Borough Based Board that will be established following the merger of the south east London CCGs. It will provide the formal mechanism to allow SEL CCG Governing Body to delegate locally to CCG representatives, for related LBL spend through their officers to align advice and recommendations to Mayor and Cabinet. Areas of discussion included responsibility for public engagement within the terms of reference, handover of existing priority areas to ensure continuity, alignment of IT systems between partners and providers, and clinical leadership and involvement in the new arrangements.

- **Winter Preparedness**

  The meeting was informed that the SEL A&E Delivery Board, on behalf of the ICS has been overseeing winter planning, supported by local A&E Delivery Boards. A range of schemes and work is underway, including incentive schemes, front door work and social prescribing, and in relation to nursing home long length of stay, most cases are awaiting assessments and that this delay does not originate from the care homes. It was added that work streams for each cohort are set up to review these cases, including over 80 day stays. Other aspects discussed included learning from other areas, site visits, and workforce engagement.

- **Local Area Partnership Special Educational Needs and Disability Strategy**

  The group reviewed and agreed the Lewisham Local Area Partnership Special Education Needs and Disability (SEND) Strategy for 2020 – 2023. The strategy builds on the work already achieved in the previous strategy for 2016 – 2019, and sets out the shared partnership vision, priorities and commitments for the next 3 years for improving life outcomes for Children and Young People with SEND and their families, across health, social care and education. Key points of the strategy highlighted were the range of complex needs covered, underpinning delivery plans, links with mental health services, annual review of the strategy, and transition to adulthood. Other comments made in discussion included recent changes to the Liberty Protection Safeguards, which may have an implication due to a change in the age range included, and promoting the use of
Personal Health Budgets. The Equalities Impact Assessment of the strategy would be sent to the CCG for recording purposes.

- **Equality Delivery System (EDS2) and Annual Equality Report**

The group received the progress report in relation to the EDS2 process, which included specifically the results of the EDS2 external stakeholder panel event for goals 1 & 2 and the goal 4 timeline and actions to complete the process, including Governing Body member participation, and the outline content and case studies for the draft annual equality report that would be presented to the Governing Body. The possible development of a system wide equalities objective, working with the LHCP was also discussed.
**A meeting of the Governing Body**

**January 2020**

---

**EQUALITY AND DIVERSITY UPDATE REPORT**

**ANNUAL EQUALITY REPORT 2019**

<table>
<thead>
<tr>
<th>CLINICAL LEAD:</th>
<th>Dr Charles Gostling</th>
<th>Senior Clinical Director</th>
</tr>
</thead>
<tbody>
<tr>
<td>MANAGERIAL LEAD:</td>
<td>Charles Malcolm-Smith</td>
<td>Deputy Director (Strategy &amp; Organisational Development)</td>
</tr>
<tr>
<td>AUTHOR:</td>
<td>Valerie Richards</td>
<td>Equality &amp; Diversity Lead, NEL Commissioning Support Unit</td>
</tr>
</tbody>
</table>

---

**RECOMMENDATIONS:**

The Governing Body is asked to:

- To review the draft Lewisham CCG Annual Equality report for publication by 31 January 2020.

- Note progress updates in the following areas:
  - Equality Delivery System2 (EDS) process for 2019

---

**SUMMARY:**

Under schedule 1 of the Equality Act all public bodies including CCGs must:

- Publish equality objectives every four years from October 2013.

- Publish information as to how they are meeting the general duties (Public Sector Equality Duty - PSED) for 31 January every year.

It is also good practice to have an Equalities and Diversity Strategy in place.

A small amount of content on the report is outstanding or awaiting update which will be completed prior to final approval and publication.
KEY ISSUES:

1. Background and purpose

1.1 In May 2019, the Governing Body received a report on the completion of the EDS2 2018/19 process and approved Lewisham CCG’s EDS2 Summary Report.

1.2 This report provides an update on the following:

- Lewisham CCG 2019 Annual Equality Report (requesting approval)
- Equality Delivery System2 (EDS) process for 2019/20

2 Lewisham CCG Annual Equality report to be published by 31 January 2020

2.1 In compliance with the Public Sector Equality Duty (PSED), all CCGs must publish relevant, proportionate information that demonstrates how the organisation has used the Equality Duty as part of the process of decision making in the following areas:

- Service delivery - evidence of equality impact analysis that has been undertaken
- Information - details of information taken into account when assessing impact
- Consultation - details of engagement activity that has taken place

2.2 The Annual Equality (PSED) report (Appendix 1) is Lewisham CCG’s seventh and covers the period January 2019 – January 2020.

The report focuses on how the CCG has met the three aims of the General Duties of the Equality Act 2010, to eliminate discrimination, advance equality of opportunity and foster good relations between those people who share a protected characteristic and those people who do not. The report also covers how equality is embedded into the CCG commissioning cycle, Equality Delivery System Implementation, Partnership working and commissioning, Patient and Public Engagement.

2.3 The report gives the results of the EDS2 2019 process up to December 2019. As described in point 3 below, all four Goals of the EDS are to be completed before the end of the financial year (March 2020) and published in the 2019 EDS2 Summary Report.

2.4 The report is presented to the Governing Body as a draft because there are a few of items highlighted to be added and to give members an opportunity to comment or make suggestions about its content. After the Governing Body meeting a final version of the report will incorporate all items and comments.

2.5 It is proposed that the report is approved by Chair’s Action and published on the Lewisham CCG website by 31 January 2020.
3. Lewisham Equality Delivery System Process in 2019

3.1 Equality Delivery System2 (EDS2)

The EDS2 is an equality performance tool for the NHS that all CCGs and Providers 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.

3.2 Goals 1 and 2 (EDS2) progress

**Goal 1:** Better Health Outcomes  
**Goal 2:** Improved Patient Access and Experience

The CCG chose the following three areas upon which to focus the EDS (Goals 1 and 2),

- Community Specialist Palliative Care (St Christopher’s)  
- Core24 Mental Health Liaison Service  
- Extra Support Service (ESS) (formerly known as the High Intensity Users Services and Interventions)

The NELCSU ED Lead worked with CCG Case Study commissioners to gather evidence to be assessed by an invited panel of external stakeholders. The CCG Public Reference Group and local people were invited to join the EDS2 External Stakeholder Panel because they had a connection to one of the services or represented local communities.

3.3 Lewisham CCG EDS2 Grading External Stakeholder Panel – 1 October 2019

The EDS2 Grading External Stakeholder Panel reviewed the above-mentioned services.

All services were robustly critiqued during the event and areas of good practice, excellent patient experience and good outcomes were acknowledged. However, there were also other areas regarding lack of evidence of accessing the services and patient experience that require attention. The results of the Panel event were presented to and discussed by the Equality & Diversity Steering Group on 19 November and by the Strategy and Development Committee as its meeting on 5 December 2019.

3.4 EDS2 Goal 3 – Next Steps to complete the process
Goal 3: A Representative and Supported Workforce

The CCG takes part in NHS National staff survey that includes four of Goal 3 Outcomes and was carried out in November/December 2019. The results of the Staff Survey will be reviewed in February 2020.

3.5 EDS2 Goal 4 – Next Steps to complete the process

Goal 4: Inclusive Leadership

This Goal contains 3 outcomes and requires input from Governing Body members. Outcomes 1 and 2 require an independent third party to assess and grade them. Outcome 4.1 asks Governing Body members to provide examples of how they have demonstrated their commitment to Equality and Diversity since January 2019.

To date, 16 out 20 (80%) of the Governing Body membership have completed their evidence template for Outcome 4.1 and returned them for scrutiny. An independent third party has been invited to assess and grade the available evidence at the end of February 2020.

3.6 EDS2 2018 Summary Report – NHS England EDS2 Dashboard

An EDS2 Summary report with details of the process and evidence reviewed will be submitted to the CCG Governing Body for approval, and then published on the CCG website with the link to the report put on the NHS England EDS2 Dashboard by 31 March 2020.

CORPORATE AND STRATEGIC OBJECTIVES

The report relates to the statutory duties of the CCG.

CONSULTATION HISTORY

- CCG management team; Strategy & Development Workshop

PUBLIC ENGAGEMENT

- Key stakeholders and partners, including Lewisham Healthwatch, Lewisham CCG Public Reference Group and Public Health were involved in the development of the draft equalities objectives and EDS gradings.

HEALTH INEQUALITY DUTY & PUBLIC SECTOR EQUALITY DUTY

The report summarises how the CCG is meeting its Public Sector Equality duties.
<table>
<thead>
<tr>
<th>RESPONSIBLE MANAGERIAL LEAD CONTACT:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name: Charles Malcolm-Smith</td>
</tr>
<tr>
<td>E-Mail: <a href="mailto:Charles.malcolm-smith@nhs.net">Charles.malcolm-smith@nhs.net</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>AUTHOR CONTACT:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name: Valerie Richards</td>
</tr>
<tr>
<td>E-Mail: <a href="mailto:valerierichards@nhs.net">valerierichards@nhs.net</a></td>
</tr>
</tbody>
</table>
Lewisham Clinical Commissioning Group

Public Sector Equality Duty

Annual Report

January 2019 – January 2020

Version 0.2
Contents

<table>
<thead>
<tr>
<th>No.</th>
<th>Title</th>
<th>Page No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Foreword</td>
<td>3</td>
</tr>
<tr>
<td>2.</td>
<td>Introduction</td>
<td>4</td>
</tr>
<tr>
<td>3.</td>
<td>Organisational Context</td>
<td>4</td>
</tr>
<tr>
<td>4.</td>
<td>Our Communities</td>
<td>6</td>
</tr>
<tr>
<td>5.</td>
<td>Embedding Equality within the Commissioning Cycle</td>
<td>9</td>
</tr>
<tr>
<td>6.</td>
<td>Meeting the Public Sector Equality Duties in 2019</td>
<td>17</td>
</tr>
<tr>
<td>7.</td>
<td>Equality Objectives – Progress in 2019</td>
<td>27</td>
</tr>
<tr>
<td>8.</td>
<td>Equality Delivery System 2 in 2019</td>
<td>28</td>
</tr>
<tr>
<td>9.</td>
<td>Lewisham CCG’s Equality Case Studies</td>
<td>30</td>
</tr>
<tr>
<td>10.</td>
<td>Our Partnerships</td>
<td>61</td>
</tr>
<tr>
<td>11.</td>
<td>Our Main Provider Organisations</td>
<td>63</td>
</tr>
<tr>
<td>12.</td>
<td>Safeguarding in Commissioning</td>
<td>66</td>
</tr>
<tr>
<td>13.</td>
<td>Complaints</td>
<td>66</td>
</tr>
<tr>
<td>15.</td>
<td>Lewisham CCG Workforce Information / Training</td>
<td>71/75</td>
</tr>
<tr>
<td>16.</td>
<td>Useful Information</td>
<td>76</td>
</tr>
</tbody>
</table>

This report was commissioned by NHS Lewisham Clinical Commissioning Group and produced by the Equality, Diversity & Inclusion Manager for NEL Commissioning Support Unit. If you would like more details on any of the contents, or extra copies of this document, please contact the CCG Lead or CSU Lead.

Charles Malcolm-Smith
Deputy Director (Strategy & Organisational Development)
Charles.malcolm-smith@nhs.net

Valerie Richards
Equality, Diversity & Inclusion Manager
NEL Commissioning Support Unit
valerierichards@nhs.net

Acknowledgement: Thanks go to all colleagues from Lewisham Clinical Commissioning Group and NEL Commissioning Support Unit who contributed to this report.
1. Foreword

In January 2019, the NHS Long Term Plan (LTP) was published and throughout the year, South East London CCGs have developed proposals to merge the six SEL CCGs which will allow us to work to develop services in a more efficient and effective way across borough boundaries for all our populations, whilst delivering the objectives of the LTP. This decision was finalised in October 2019 and SELCCG will commence from 1 April 2020.

In order to achieve significant and sustainable improvements in care for the major areas of long-term illnesses, our view is that it is necessary to focus on population health, improve service efficiency, reduce duplication of processes, unproductive extra steps and other barriers for patients. An efficient system of community-based care requires us to work jointly with our Local Authority partners.

This report brings together evidence, activities and recommendations that demonstrate how Lewisham CCG has continued to maintain its equalities performance in 2019.

Since Lewisham CCG’s inception in 2013 it has paid attention to the particular needs of the Lewisham population for example by:
• Delivering interventions in Primary Care focused on early detection and management
• Prioritising respiratory diseases and diabetes
• Providing access to primary care for homeless people in Lewisham

These are just some of the interventions made during 2014-2019 that have contributed to Lewisham being one of a few boroughs in England to reduce health inequalities in avoidable admissions to A&E. This was recognised as part of research carried out by NHS England and the University of York (please refer to section 9 for more details).

The NHS Long Term Plan 2019 contains a set of expectations regarding children and young people’s (CYP) mental health services. Lewisham CCG and partners have investigated where the health inequalities are and prepared plans on how to reduce them. There are also CYP reports on i-THRIVE and the Trauma Based Approach to Young Offenders (please refer to section 9 for more details).

Highlights of achievements in 2019 include:
• Community Specialist Palliative Care (St Christopher’s), Core24 Mental Health Liaison Service, Extra Support Service (ESS) (formerly known as the High Intensity Users Services and Interventions) - all were assessed using Goals 1 and 2 of the NHS Equality Delivery System (EDS), an equality assessment tool-kit that helps NHS organisations to identity good practice and identify gaps or areas that require improvement.
• Lewisham WRES Seminar held in November 2019 was an opportunity to start a conversation with other significant employers in the local health and social care economy, about what the challenges are and to learn from each another.
• The CCG has continued to widen its engagement reaching more communities in the Borough facilitating many diverse groups to have their say on Lewisham and south-east London developments.

Many thanks to our member practices and all of Lewisham’s NHS and care staff, for the excellent work they do to treat, care for and support local people and to all the clinicians and staff who continue to be at the heart of clinical commissioning in Lewisham and who are committed to getting it right for our diverse population.
2. Introduction

The Equality Act 2010 provides a legal framework to strengthen and advance equality and human rights. The Act consists of general and specific duties:

The general duty requires public bodies to show due regard to:

- Eliminating unlawful discrimination or any other conduct prohibited by or under the Act
- Advancing equality of opportunity between persons who share a protected characteristic and persons who do not share it.
- Fostering good relations between people who share a relevant protected characteristic and people who do not share it.

There are nine 'protected characteristics' covered by the Equality Act: Age, Disability, Gender re-assignment, Marriage and civil partnership, Pregnancy and maternity, Race including nationality and ethnic origin, Religion or belief, Sex (male/female), Sexual orientation.

The specific duties require public bodies to publish relevant, proportionate information showing how they meet the Equality Duty by 31 January each year, and to set specific measurable equality objectives by 6 April every four years starting in 2012.

Both general and specific duties are known as the Public Sector Equality Duties (PSED). As a statutory public body, the NHS Lewisham Clinical Commissioning Group must ensure it meets these legal obligations and intends to do so by publishing information demonstrating how the organisation has used the Equality Duty as part of the process of decision making.

3. Organisational Context

NHS Lewisham Clinical Commissioning Group (LCCG) assumed statutory responsibilities from 1 April 2013.

The CCG is a membership organisation made up of all the GP practices in Lewisham. Our aim is to secure the best possible health and care services for everybody in Lewisham, to reduce health inequalities and improve health outcomes in a cost effective way that provides good value for money.

We use what we know about the health needs of our residents to plan how and where to provide care and support which we commission from hospitals, community services and other providers of care.

The CCG purchases a range of services from the NEL Commissioning Support Unit (including the Equality, Diversity and Inclusion service), which supports the CCG to discharge its statutory responsibilities, including those within the Equality Act 2010.

All Governing Body members have a collective and individual responsibility to ensure compliance with the Public Sector Equality Duty, which will in turn secure the delivery of successful equality outcomes for us, both as a commissioner and an employer.

A Lay Member has been appointed to the CCG’s Governing Body to lead on patient and public involvement. The Lay Member has oversight responsibility for ensuring that:
• the governance arrangements for promoting equality are effective
• opportunities are created and protected for patient and public involvement and engagement.

The Lay Member chairs the CCG’s Public Engagement and Equalities Forum. This is a committee of the Governing Body and was established in 2016 following a CCG governance review. Its role includes providing feedback and assurance to the CCG Governing Body that equalities responsibilities are being carried out in the best way and meet the legal duties placed on the CCG.

All Governing Body members share the responsibility in seeking assurance that the voice of the local population is heard in all aspects of the CCG’s business. The Governing Body took the lead in defining the organisational values for the CCG that are:

• Everyone Counts – we will work and behave in a way that ensures that everyone counts and feels valued.
• Openness & Transparency - we will strive to be open and transparent in the way we work and make decisions
• Learn & Improve - we are a learning organisation that is self-aware of the impact that we can make to improve health for the people of Lewisham.

At its strategy and development workshop in December 2019, members of the Governing Body reviewed their understanding and implementation of the Public Sector Equality Duty, including progress with the Equality Delivery System.

The CCG’s Managing Director has responsibility for ensuring that the necessary resources are available to progress the equality and diversity agenda within the organisation and for ensuring that the requirements of this framework are consistently applied, co-ordinated and monitored.

The Deputy Director (Strategy & Organisational Development) has operational responsibility for:

• Developing and monitoring the implementation of robust working practices that ensure that equality and diversity requirements form an integral part of the commissioning cycle
• Working with NEL Commissioning Support Unit (NELCSU) to ensure that equality and diversity considerations are embedded within the CCG’s working practices
• Ensuring that the Governing Body, staff and member practices remain up to date with the latest thinking around diversity management and have access to appropriate resources, advice, and informal and formal training opportunities

All line managers have responsibility for:

• Ensuring that employees have equal access to relevant and appropriate promotion and training opportunities.
• Highlighting any staff training needs arising from the requirements of this framework and associated policies and procedures.
• Supporting their staff to work in culturally competent ways within a work environment free from discrimination.

Lewisham CCG Equality and Diversity Steering Group
The CCG convened an Equality and Diversity Steering Group in April 2015 that has a remit to enhance the focus, support and monitor the implementation of the Equality Delivery System to ensure compliance with Equality Duties under the Equality Act 2010. The Group is a management group, chaired by the Managing Director with membership including representatives from the directorates and teams in the CCG.

4. Our Communities

Health Needs of Lewisham Population

The information we use to understand the health and wellbeing and the diverse characteristics and needs of the people of Lewisham, is obtained from the Lewisham’s Joint Strategic Needs Assessment (JSNA).
Source - [http://www.lewishamjsna.org.uk/](http://www.lewishamjsna.org.uk/)

4.1 Population Growth

Lewisham has a population of 303,500, is the 14th largest borough in London by population size and the 6th largest in Inner London. (Source: MYE 2018, Office for National Statistics)

Lewisham has a growing population, projected to increase from 303,500 to 318,000 by 2021 and to climb to 344,500 by the time of the 2031 Census. Lewisham also has a young population with 22.5% of the population being under the age of eighteen.

Around 28,481 residents are above 65 years of age and over 3,700 are aged over 85 years. This latter group is often the most complex and therefore bears a very high proportion of care costs.

This population growth is due to a combination of the number of births exceeding the number of deaths and international migration, people moving to the borough from overseas.

4.2 Deprivation

The Index of Multiple Deprivation 2015 ranks Lewisham 48th of 326 districts in England and 10th out of 33 London boroughs. People living in the most deprived areas have poorer health outcomes and lower life expectancy compared to the England average.

4.3 Disability

According to the 2011 Census, the prevalence of disability in Lewisham is as follows:
- Day-to-day activities limited a lot – 7.1%
- Day-to-day activities limited a little – 7.3%

Source: 2011 Census: Long-term health problem or disability, local authorities in England and Wales

4.4 Ethnicity

Understanding the current and future ethnic composition of the borough is important as some health conditions impact disproportionately on certain ethnic groups, e.g. diabetes. There is also disparity with regard to the ethnicity characteristic in use of and access to some services.
Lewisham is the 14th most ethnically diverse local authority in England - 46.5% of the population are from Black and Minority Ethnic Groups (BME) compared to 40.2% in London and 12.5% in England.

- The ethnic profile of Lewisham residents is forecast to change up to 2050
- By 2028 it is forecast that the White and BME population will be 50/50
- Subsequently the BME population is predicted to exceed the White population

Ethnicity of Young People - between 2011 and 2031 the size of the population of BME children & young people 0-19 will grow at more than three times the rate of their White counterparts.


### 4.5 Gender

Males comprise 49% of Lewisham’s population, females 51%.

Life expectancy is 7.1 years lower for men and 3.4 years lower for women in the most deprived areas of Lewisham than in the least deprived areas. For men this is a decline on 2018 figures.

Source: *Lewisham Health Profile, Public Health England, November 2019*

### 4.6 Significant Health Inequalities in Lewisham

- People living in the most deprived wards in Lewisham have poorer health outcomes and lower life expectancy compared to England’s average. The life expectancy for men in Crofton Park ward is 80.9 which is 6.4 years longer than for New Cross ward at 74.5. For women the gap is the same between Perry Vale ward at 87.3 and New Cross ward at 80.9.
- Health inequalities are considered by ethnic group too. Mental ill health is more prevalent in some black and minority ethnic groups. Black residents are disproportionately over-represented in mental health admissions.
- Lesbian, gay, bisexual, transgender or transsexual people and those who are divorced/widowed/separated also have poorer health outcomes than the general population.

Source: [http://www.lewishamjsna.org.uk/](http://www.lewishamjsna.org.uk/)

### 4.7 Lesbian, Gay, Bisexual

Of the total Lewisham population, 3.2% or 9,344 people are estimated to be lesbian, gay or bisexual.

Source: *Office of National Statistics 2013 (percentage in London)*

### 4.8 Mortality
The main causes of death in Lewisham are cancer (28%), circulatory disease (23%) and respiratory disease (14%). Cancer has overtaken cardiovascular disease as the main cause of death since the 2011-12 reporting period.

Overall the death rates have been falling in Lewisham, and New Cross, Sydenham and Lewisham Central wards had significantly higher death rates than the Lewisham average during the 2013-17 reporting period.

4.9 Religion

According to the 2011 Census, religion in Lewisham is categorised as follows:

<table>
<thead>
<tr>
<th>Religion</th>
<th>Percentage</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Christians</td>
<td>83%</td>
<td>(145,588 people)</td>
</tr>
<tr>
<td>Muslim (Islam)</td>
<td>10%</td>
<td>(17,759 people)</td>
</tr>
<tr>
<td>Hindu</td>
<td>4%</td>
<td>(6,562 people)</td>
</tr>
<tr>
<td>Buddhist</td>
<td>2%</td>
<td>(3,664 people)</td>
</tr>
<tr>
<td>Jewish</td>
<td>0.1%</td>
<td>(643 people)</td>
</tr>
<tr>
<td>Sikh</td>
<td>0.1%</td>
<td>(531 people)</td>
</tr>
<tr>
<td>Other religions</td>
<td>1%</td>
<td>(1,478 people)</td>
</tr>
</tbody>
</table>

Source: 2011 Census: Religion (Detailed), local authorities in England and Wales

4.10 Voluntary and Community Sector

Lewisham has over 800 active voluntary and community sector organisations and more than 200 individual faith groups. All these groups and many others help to strengthen our communities by galvanising our citizens, addressing local concerns and advocating on behalf of some of the most vulnerable in society.

More information about Lewisham’s population is available at www.lewishamjsna.org.uk

4.11 Child Health

In Year 6, 24% (747) of children are classified as obese, worse than the average for England, but a slight increase the 2018 figure.

Source: Lewisham Health Profile, Public Health England, November 2019

4.12 Adult Health

The rate of alcohol-related harm hospital has reduced to 537*, better than the average for England. This represents 1,286 stays per year. The rate of self-harm hospital stays is 99*, better than the average for England. This represents 300 stays per year. Rates of new sexually transmitted infections and new cases of TB are worse than the England average. Rates of hip fractures and people killed and seriously injured on roads are better than average. The rate of under 75 mortality rate from cardiovascular diseases is worse than the England average.

* rate per 100,000 population

Source: Lewisham Health Profile, Public Health England, November 2019
5. Embedding Equality within the Commissioning Cycle

Lewisham CCG is committed to ensuring that the Public Sector Equality Duty is embedded in all aspects of its activities throughout the commissioning cycle:

5.1 Strategic Planning

<table>
<thead>
<tr>
<th>Strategic Planning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessing needs</td>
</tr>
<tr>
<td>Reviewing service provisions</td>
</tr>
<tr>
<td>Deciding priorities</td>
</tr>
</tbody>
</table>

![Diagram showing the commissioning cycle with a focus on strategic planning.](image-url)
5.1.1 Strategic Outcomes Framework

Good commissioning starts with a thorough understanding of local needs, based on the Joint Strategic Needs Assessment (JSNA). The purpose of JSNAs is to help commissioners to determine the priorities and actions to improve the health and wellbeing of the local community and reduce inequalities for all ages.

The CCG’s strategic priorities are based on an analysis of Lewisham’s JSNA that identified health needs of the local population. This includes disease prevalence amongst different ethnic groups, the health needs of different age groups, and the impact of deprivation and other factors which affect health equality and inequalities.

The main cause of death in Lewisham is cancer, followed by respiratory disease and circulatory disease; Lewisham’s Black and Minority Ethnic communities are also at greater risk from health conditions such as diabetes, hypertension and stroke. Identifying those with disease early and treating them optimally is essential, yet cancer screening rates remain low. Despite cancer being the major cause of death in the borough, in terms of reducing inequalities circulatory disease is a greater contributor for both men and women.

The CCG’s ambitions include improving life expectancy, reducing premature mortality from the main causes of death, decreasing infant mortality, and a number of measures of high quality care including emergency admissions, end of life care, and patient experience; further development is being undertaken of equalities considerations for cancer rates, mental health, and diabetes.

5.1.2 South East London’s Sustainability and Transformation Plan

In December 2015, south east London health and care systems came together to create our local blueprint for implementing the Five Year Forward View, for the period up to March 2021, known as Sustainability and Transformation Plans (STPs). Lewisham CCG has been working with the other five south east London CCGs to develop plans that meet the needs of Lewisham’s diverse population, whilst ensuring that we engage and listen to our local communities. Integral to the programme is an equalities steering group that ensures that the programme meets the requirements of the Equality Act 2010 and the Public Sector Equality Duty, including overseeing independent equality analyses of the strategy and plans and which informed the approach to pre-consultation on proposals for changes to elective orthopaedic services. In 2019 south east London started to work towards becoming the first Integrated Care System (ICS) in London, and has been further developing its plans to meet the requirements of the Long Term Plan for the NHS (the LTP).

5.1.3 CCG Alliance for south east London

In April 2018, the six CCGs in south east London (Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark) commenced building on their existing collaboration to commission services more efficiently and effectively for local people in each borough and across south east London. Since then NHS Lewisham CCG has been part of the NHS South East London Commissioning Alliance, and this joint working across the six boroughs will be strengthened with the establishment of the South East London CCG.
5.1.4 Community-based Care Vision

Lewisham’s vision and expectations for the future development and delivery of community-based care is that we want community-based care to be:

- **Proactive and Preventative** – By creating an environment which promotes health and wellbeing, making it easy for people to find the information and advice they need on the support, activities, opportunities available to maintain their own health and wellbeing and to manage their health and care more effectively;

- **Accessible** – By improving delivery and timely access when needed to planned and urgent health and care services in the right setting in the community, which meet the needs of our diverse population and address inequalities. This includes raising awareness of the range of health and care services available and increasing children’s access to community health services and early intervention support.

- **Co-ordinated** – So that people receive personalised health and care services which are coordinated around them, delivered closer to home, and which integrate physical and mental health and care services, helping them to live independently for as long as possible.

As commissioners and providers, we will ensure that our vision for the transformation of community-based care is shared with the public, patients and staff. We will engage, involve and collaborate with them to shape and deliver the care and support that is provided in the community.

Achievement of our vision will require people to take responsibility when appropriate for their own health and care, and will require changes to how, when and where services are currently delivered. As we seek to deliver our vision, some services will need to change and some services will move out of hospital settings into more appropriate community settings. Where changes are needed we will work with the public and other stakeholders to develop more detailed proposals and plans, welcoming challenge and debate, whilst remaining focused on improving health and care outcomes within a sustainable and accessible health and care system.

5.1.5 Commissioning Intentions for 2019/20

In preparation for 2019/20, we developed commissioning intentions with the other five south east London CCGs, building from our STP Integrated Care System (ICS) Road Map for 2018/19 and 2019/20, encompassing prevention, primary care, urgent and emergency care, planned care, diagnostics, cancer, mental health and community-based care.

**Prevention**

The SEL STP has committed to developing concrete plans to enhance our prevention offer. The aim is to ensure our prevention offer is systematically rolled out and embedded within each and every level of our ICS development and delivery work. This will include the early identification of risk and targeted intervention to improve population health, reduce disease burden and health inequalities across the SEL population.
There is significant work being undertaken to tackle the wider determinants of health – the SEL CCG commissioning intentions concentrate on NHS interventions to identify and manage risk. In addition, there is work on going to develop a SEL wide prevention framework and strategy as part of the STP Prevention Programme.

**Primary Care**

Objectives for this area include support for increased resilience and innovation in our primary care offer – to enable a consistent and high-quality offer that provides accessible, proactive and preventive care – through a more explicit articulation of our core and enhanced service offer, working to reduce unwarranted variation.

**Urgent and Emergency Care**

The STP has identified U&EC as a key area for the further development of our borough-based ICS model recognising that effective U&EC provision is dependent upon whole system working across health and social care to deliver an integrated offer supporting optimal patient outcomes and pathway efficiency.

**Planned (Elective) Care**

Demand and capacity planning and optimised utilisation of available capacity to support Referral to Treatment (RTT) recovery is a key underpinning requirement and priority for 2019/20 to ensure that we agree approaches that support equity of access of patients across SEL through joint approaches to waiting list and capacity management.

**Diagnostics**

Sustainable delivery of diagnostic targets plus diagnostic turnaround times will support the delivery of wider planned care and cancer waiting times targets; agreed mechanisms for managing demand and capacity effectively and collaboratively across SEL.

**Cancer**

To continue to make progress in implementing our STP cancer plan – focus on improved early detection and diagnosis of cancer as well as improved cancer survivorship and recovery care and support. Our key focus for 2019/20 however remains securing pathway improvements across SEL to support the treatment of patients suspected of having and diagnosed with cancer in line with national waiting times standards.

**Mental Health**

Mental health services will form an essential element of our Integrated Care System. Similarly, acute networked provision, with the three south London providers working collaboratively, will be an essential component of our integration work in south-east London.

**Community-based Care**

Along with Bexley and Greenwich CCGs, in Lewisham the priority will be on the agreement and production of a community services development plan that supports a more systematic,
consistent and core community offer that is focussed around a shift to home based support for patients, with a priority focus on admission avoidance and supported discharge pathways.

5.1.6 Commissioning Intentions 2020/21

In line with the approach initiated last year, the Integrated Contract Delivery Team (ICDT) in the South East London Commissioning Alliance has been leading the development of commissioning intentions for our acute providers to ensure a consistent approach and ask of Guy’s and St Thomas NHS Foundation Trust, King’s College Hospital NHS Foundation Trust and Lewisham and Greenwich NHS Trust, as well as coordinate with local CCG commissioners for our main mental health providers of Oxleas and South London and Maudsley NHS Foundation Trusts on behalf of all 6 CCGs in SE London.

In overall terms, the Commissioning Intentions are a build on those introduced in 2019/20, with a heavy focus on areas for acute providers such as referral optimisation (planned care), ambulatory care (urgent and emergency care) and early detection and prevention (cancer). For mental health, the priorities of crisis and acute care, range of services for children and young people continue, along with the local development of our provider alliance. The commissioning intentions will be refreshed to ensure that they are in line with the requirements of the Long-Term Plan, noting that our intentions were broadly in line with national priorities, and will be communicated to NHS providers by the end of September 2019.
5.2 Procurement

<table>
<thead>
<tr>
<th>Procurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Designing Services</td>
</tr>
<tr>
<td>Shaping structure of supply</td>
</tr>
<tr>
<td>Planning capacity and managing demand</td>
</tr>
</tbody>
</table>

The key local commissioning priorities are Prevention and Early Action, Planned Care and Urgent and Emergency Care. In these commissioning areas the CCG has been working with service users to co-design and co-produce services which are more responsive to individual needs. Equality Analyses have been undertaken in many commissioning areas to demonstrate that due regard has been taken of the general duty under the Equality Act 2010 to eliminate discrimination, advance equality of opportunity and foster good relations between people from different groups, as summarised in section ‘Meeting the Public Sector Equalities Duties in 2019’.

5.2.1 Prevention and Early Action

Our strategic aim is to promote and facilitate health and wellbeing and prevent illness and dependence. This will require changes in the way prevention is commissioned and delivered, given the level of public sector resources available. It will also require whole system transformation across all sectors, not just health and care. The CCG aims to embed prevention in all our commissioned services to promote health and wellbeing (primary prevention) and to prevent the need for treatment and care (secondary prevention), that is evidence based or based on best practice, cost effective and sustainable.

Our local focus for our commissioning work in ‘Prevention and Early Action’ is:

- commissioning and supporting a range of holistic and whole system actions to make it easier to choose to live a healthier lifestyle.
- supporting people to live in their own homes safely and independently working with a range of voluntary and community sector organisations.
- commissioning a range of information, advice and care to support people with long term conditions to make it easier to self-manage their health, including self-management for diabetes, better psychological options.

5.2.2 Planned Care

Our aim is to commission services so that all people who need planned care have appropriate, timely access to high quality care and excellent patient outcomes. Our local focus for our commissioning work in ‘Planned Care’ is:

- improving the quality of hospital referrals and also patient experience of the appointment booking process through the Referral Assessment Service.
- Cancer, with a specific focus on Bowel cancer, Lung cancer, Prostate cancer, the 2 Week Wait pathway, living with and beyond cancer and inequalities.
• With Greenwich and Bexley CCGs, developing and implementing new clinical pathways including gastroenterology, cardiology, neurology & clinical haematology, diabetes model of care
• developing services closer to home, supported by specialists, to enable the management of people with more complex health and care needs out of hospital
• Testing a model of care (“caseloading”), which combines pre-term birth surveillance with a continuity of care pathway from pregnancy through to postpartum period; this will particularly benefit women with risk factors for preterm birth from BME groups.

5.2.3 Urgent and Emergency Care

Our aim is to commission urgent and emergency services across the whole system which are coordinated, consistent, clear and affordable, helping people to get the right advice and care in the right place first time, particularly for those with urgent or emergency physical and/or mental health needs.

Our local focus for our commissioning work in ‘Urgent and Emergency Care’ is:

• commissioning a range of information, advice and care to support people with longterm conditions to make it easier to self-manage their health, including self-management for diabetes, better psychological therapies and Dementia and Information Service
• Implementing a range of community-based services which may help to avoid or reduce the need for emergency admissions including the Ambulatory Care Service, Integrated Primary and Urgent Care service, the Rapid Response Teams and the GP Extended Access Service.
• The work on Primary Care access for homeless people as part of the consideration of the review of the NHS Walk in Centre and improving the provision and access to primary care.
• working with partners to improve the Emergency Care provided in Lewisham, including improving the emergency care pathway and the interface with mental health services, developing further Supported Discharge Services so that discharge planning is consistent and begins as early as possible to facilitate early discharge from hospital and reduce avoidable admissions into hospital.

5.3 Contract Monitoring

<table>
<thead>
<tr>
<th>Contract Monitoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supporting Patient Choice</td>
</tr>
<tr>
<td>Managing Performance</td>
</tr>
<tr>
<td>Seeking Public and Patient Views</td>
</tr>
</tbody>
</table>

A key aspect of commissioning is to monitor the contract and services the CCG has commissioned to ensure that these services deliver high quality care for all. One of the key challenges Commissioners are addressing is the availability of robust data to monitor and evaluate whether commissioned services are being accessed and provided appropriately for the nine specific areas (or protected characteristics) which are covered by equality and diversity guidelines and legislation. Generally, monitoring data is available for age, sex and
partially race. The CCG is working with the local Public Health Department to identify the priority areas where more comprehensive JSNA data is required to find out the actual impact of current services on differing groups of people.

In Lewisham CCG, the Integrated Governance Committee, a subcommittee of the Governing Body, is responsible to provide assurances that current contracted services are monitored appropriately and to ensure that the Equality Act 2010 general duties are being met.
6. **Meeting the Public Sector Equality Duties in 2019**

The Equality Act 2010 requires the CCG to pay due regard to the three aims of the general duty of the Act. The three aims are 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.

The CCG carries out Equality Analysis to highlight positive and negative impacts on protected characteristics and other local disadvantage groups, giving an opportunity to mitigate any negative impacts. Also, Equality Analyses are used to inform decision making.

Below are examples of the Equality Analyses carried out in 2019:

- Integrated Respiratory Service (EA Screening)
- GP Practice Merger - Sydenham Surgery & Sydenham Green (EA Screening)
- GP Practice Merger - Waldron Family Practice and New Cross Health Centre (EA Screening)
- GP Practice Merger - Brockley Road & Hilly Fields (EA Screening)
- Vietnamese LES_EA screening Lewisham
- St Christopher's and Marie Curie Rapid Response Service (EA Screening)
- Advancement of IT in Care Homes (EA Screening)
- COPD Plus Pilot Lewisham (EA Screening)
- LSL ITS (Lambeth, Southwark and Lewisham Interpreting and Translation Services) (EA screening)
- St Johns Patient Transport Winter Scheme (EA Screening)

### 6.1 Eliminating Discrimination and Advancing Equality of Opportunity

#### 6.1.1 Community Specialist Palliative Care (St Christopher’s (read the full Case Study in section 9))

The service was developed during 2016-17 when there were previously three providers. Since July 2018 St Christopher’s has been the sole provider.

The 38-bed service is for people facing the final weeks/months/year of their life and works towards the six ‘Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020’.

Traditionally, end of life care services have been orientated towards cancer care, however people with a whole range of other conditions including cardiovascular, respiratory, and neurological disorders and dementias should also be accommodated.
This service was reviewed as part of the 2019 Equality Delivery System EDS2 process.

6.1.2 Core24 Mental Health Liaison Service (read the full Case Study in section 9)

Core 24 Service is designed to meet the needs of people aged 18 and above who attend University Hospital Lewisham Emergency Department with a mental health issue.

This service sees approximately 80% of the patients attending A+E with a mental health issue (August 2019) within the first hour of their attendance.

The additional resources for the Core 24 was the result of an NHS England (NHSE) Transformational programme to expand the provision of mental health liaison in Hospitals across England and Wales. Core 24 will ensure that people with a mental health issue attending A&E will receive a comprehensive assessment outlining the appropriate treatment to address their mental health need.

This service was reviewed as part of the 2019 Equality Delivery System EDS2 process.

6.1.3 Extra Support Service (ESS) (formerly known as the High Intensity Users Services and Interventions (read the full Case Study in section 9)

The Lewisham Extra Support Service (ESS) is commissioned from the local GP Federation (One Health Lewisham Ltd) and commenced in 2018. The Federation met with UHL (University Hospital Lewisham) consultants and identified the cohort of 75 patients to ensure no duplication with the Mental Health CQUIN.

The service has achieved a 32% reduction in avoidable admissions for the selected cohort of patients.

This service was reviewed as part of the 2019 Equality Delivery System EDS2 process.

More case studies that cover the following areas can be found in Section 9 of this report:

CYP – Children & Young People
• Lewisham i-THRIVE
• Lewisham CAMHS Deep Dive July 2019
• BAMER health inequalities in CAMHS
• Public Health Approach to reducing violence – Trauma Based Approach to Young Offenders
• Teenage pregnancy in Lewisham

Reducing Health Inequalities – NHSE and University of York research / Lewisham CCG’s Initiatives and investments during 2014-19

Review of Primary Care Interpreting and Translation Service across Lambeth, Southwark and Lewisham (LSL ITS)

GP led Primary Care Homeless services in Lewisham
6.2 Fostering Good Relations

6.2.1 Lewisham CCG Public Engagement Network

During 2019 we have continued to extend our contacts with Lewisham residents and community groups. We have used festivals and local initiatives to promote the work of the CCG, and attended specific groups (carers, Lewisham BME Network, Neighbourhood Community Partnership Development meetings) to have a direct conversation, offering the opportunity to learn about our engagement options. Lewisham community and voluntary sector organisations provide continuous and invaluable support extending our reach into seldom heard communities.

We have offered support disseminating and/or participating in other events organised by our Lewisham collaborators. Examples of this are Lewisham Pensioners Forum Health Fair, Falls Prevention event organised by Lewisham and Greenwich Trust, Lewisham Library Health Talks series, Job Fair by the DWP and a meeting for Carers organised by South London and Maudsley. We also joined forces with partner organisations for a more efficient engagement, such the Fresher’s Week in Goldsmith University, where we talked to students supported by Lewisham Healthwatch and Africa Advocacy Foundation.

Lewisham CCG is also part of Lewisham Health and Care Partners (LHCP). LHCP is a partnership of the main health and care commissioners and providers in Lewisham that supports system wide leadership, strategic direction and a collective view on the transformational change required in health and care across Lewisham. The partners include Lewisham CCG, Lewisham Council, One Health Lewisham, South London and Maudsley NHS Foundation Trust and Lewisham and Greenwich NHS Trust.

6.2.2 Lewisham CCG Public Reference Group (PRG)

The Public Reference Group (PRG) was set with a range of local people who reflect the Borough’s diversity. The first cohort 2016-18 set a strong platform of engagement. An Evaluation Report with the contribution of the first cohort can be found [here](#). A new group was recruited during 2018. The selection of four transition members has enabled a smooth conversion between the two groups. The new PRG, with 13 members has been fully functional from January 2019, and continues to:

- Ensure that public engagement is integrated into the commissioning cycle.
- Act as a ‘critical friend’ across all commissioning services in respect of patient and public engagement.
- Support the CCG in engaging and communicating more widely with the public to gather their views, and to inform the public of the challenges facing the NHS and any proposed changes to services.

Some of the work of the PRG during 2019 includes the participation on the development of Lewisham Mental Health Alliance, involvement in the CCG’s 2019 Equality Delivery System process, support on specific leaflet design (HIV poster by One Health Lewisham, Lewisham Integrated Medicines Optimisation Service (LIMOS) patient information leaflet) and discussion and suggestions for the four main CCG priorities – Frailty, Mental Health, Respiratory and Diabetes. Members of the group joined our engagement team during local festivals such Phoenix Festival (May), Downham Celebrates (June), and Evelyn Multicultural Festival (July)
where we had the opportunity to sponsor the PRG role and promote our health messages to residents of all ages and backgrounds.

6.2.3 Readers panel

The CCG Readers panel is a voluntary group of Lewisham local people who supports the CCG to ensure our written materials provide clear, relevant and understandable information for the public.

In 2019 the group has newly supported the CCG in the preparation of the CCG Annual Report 2018-19, where they provided suggestions to improve and make the Performance Overview section easy to understand.

6.2.4 Engagement email list

Lewisham CCG want to keep an open dialogue with residents and community groups to easily communicate and disseminate health events and campaigns. By joining our engagement list residents can be informed of opportunities to get involved in focus groups, surveys, events and discussions about shaping health services in Lewisham. Residents can register through our [page](#).

We send regular updates promoting our events. We also highlight activities and information from collaborators and groups in Lewisham that support health and wellbeing for residents of all ages: from pop up exhibitions, roadshows and healthy walks to festivals, specific groups or apps to inspire and motivate exercise.

6.2.5 Public forum sessions at Governing Body meetings

All CCG’s Governing Body meetings take place in public. We run a public forum session prior to each meeting where members of the public are able to ask questions. These are well attended and the notes are published on our website: [http://www.lewishamccg.nhs.uk/about-us/Who-we-are/Pages/Governing-body-meetings.aspx](http://www.lewishamccg.nhs.uk/about-us/Who-we-are/Pages/Governing-body-meetings.aspx)


The Governing Body receives a summary of the Public Engagement and Equalities Forum (PEEF) meetings. PEEF ensure Lewisham CCG achieve a high level and quality of patient and public engagement and that its approach to engagement promotes equality and diversity and the reduction of health inequalities.

6.2.6 Other Public Engagement

<table>
<thead>
<tr>
<th>Summer Festivals 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>This year we have been present in several events covering and reaching residents of all ages from different areas in Lewisham. We tailored our activities following the specific themes on each festival and aligned with national campaigns.</td>
</tr>
</tbody>
</table>

**Sun Awareness Week at the Phoenix Festival**

On the 11 May we joined the Phoenix Festival 2019 edition held at Foster Memorial Park, SE6 2BL from 12 till 5 pm. This free event was organised by the Phoenix Community Housing, a not-for-profit resident-
led Housing Association in the Bellingham, Whitefoot and Downham areas of Lewisham. The festival was open to all Phoenix residents and the wider community to attend so it was a great opportunity for us to meet you all.

Our engagement team, supported by Public Reference Group members, joined the fun on the day and talked to local residents about health services in Lewisham. We have some activities to support the Sun Awareness Week. For the occasion, we created a Mole Doctor game that proved to be a great way to engage with young and older visitors in our stall. The game explains the ABCDE rules to look for changes in moles that may become malignant:

A for asymmetry, B for border, C for colour, D for diameter, and E for Elevation or Enlargement.

Our visitors tested their knowledge straight away answering our ‘moles quiz’. The game offers links to additional information from the Primary Care Dermatology Society and to explore a virtual laboratory to perform biopsies on skin tissue.

We also had a drawing competition on ‘How to stay safe in the sun’ for the children, leaflets to Stay Safe in the Sun by Cancer Research UK, and hats, sunglasses and sun cream to bring the sun safety prevention to life!

We provided CCG Health Packs with information for everyone (GP Extended Access, Use the Right Service, NHS Ask app, Social Prescribing, Healthy Start and Vitamin D) and supported Stroke Awareness Month with information.

Engaging at Downham 2019

We joined local residents to celebrate this year’s annual summer festival, ‘Downham Celebrates’ on Saturday 8 June, from 11am to 4pm at Downham Health and Leisure Centre.

The theme of the event was ‘Downham through the ages’, which incorporated a fascinating look back at the many changes this leafy area of Lewisham has undergone over the years. After the First World War there was an urgent need to reduce overcrowding in metropolitan areas, so the Downham Estate was developed towards the end of the 1920s. We displayed a selection of historical photographs, inviting festival-goers to play our fun ‘Guess the location’ quiz. The quiz also had an important message. We used the opportunity to highlight how the area has changed over the years and what we can all do to stay healthy and improve the environment that we live in.

In preparation for ‘Love your Lungs Week’ and ‘Breathe Easy Week’, 17-23 June, we showed where and how to access and how to use the Lewisham Air app to see live air quality news and find low-pollution routes, and had information on respiratory conditions.

We also displayed information on Diabetes 1 and 2 to celebrate ‘Diabetes Week 2019’.

Lewisham CCG engaging with the community at Evelyn Multicultural Festival

Despite the torrential rain, the enthusiasm of local people at the Evelyn Multicultural Festival in Deptford wasn’t dampened as they turned up for a day of free music, dance, food and snacks on Saturday 20 July.

But the day also provided Lewisham people with the chance to find out more about healthcare in the area – and how the community can get involved. We provided leaflets with advice on healthy eating, drinking and smoking cessation. The team also promoted the NHS Long-Term plan survey.

We brought information on how to stay well in summer, including Kooth information on how young people can access mental health support during the summer months. Information was also made available on how people can stay safe in the water.

People at the festival were also told how they could access the ASK NHS GP app – the new app commissioned by NHS Lewisham Clinical Commissioning Group (CCG) to help patients get the right healthcare they need at the right time.

The day was a great opportunity to promote the importance of vaccination, including visual displays.

General feedback
Summer festivals are the best way to reach community members who do not normally attend other more formal meetings. During these events the CCG gets agile and moves its engagement headquarters to the park or community centres. We think of an offer that would attract members of the public with different ages and interests. For example, by organising an activity for children we create opportunities to have conversations with other members of the family.

As an example, after the Downham Celebrates festival, our PRG member said: ‘We worked together to operate a lively stall in the marquee which during heavy bursts of rain became rather hectic. Main health messages for the children were healthy eating and exercise and the children enjoyed the art tables where they made Father’s day cards and drew pictures with enthusiasm for the keeping healthy picture competition. This was a well-attended local community event with a good representation of health providers in Lewisham present.’

Additional feedback to organisations involved on the day, Dr Helen Tattersfield, Chair of Downham Nutrition Partnership said ‘Downham Celebrates tries to bring the whole of Downham together. Thank you all for your contribution to the ‘Healthier, Happier, Downham’ Marquee on Saturday. Together with you we delivered a health event that was engaging and active due to your hard work and personal involvement. Apart from the real changeable weather we had a great festival and helped us to deliver over 300 fruit kebabs and 100 tomatoes plants. But the big thing was the smiles and families that we engaged with.’

Equalities
We talked to more than 400 residents during our summer festivals engagement. By holding a variety of activities, we interacted with children and young people, young families, adults and older adults from different backgrounds. The events were held in North (Evelyn) and South (Downham/Whitefoot) Lewisham, areas that currently show higher level of deprivation. We were pleased to bring health messages in a fun and creative manner, accessible to all, and to connect to the local community in these areas of the borough.

NHS Long Term Plan engagement in Lewisham

In January 2019, the NHS set out its plans for the next 10 years across the whole of England. OHSEL commissioned Kaleidoscope to deliver a series of engagement events in SEL to understand how we can improve our services and make a healthier south east London. The engagement ‘Help us to shape the future of the NHS in South East London’ focused on six specific areas, from how we work with charities to improving access to care.

Kaleidoscope, supported by CCG local engagement teams, ran twelve public engagements events across the six boroughs focusing on both borough-wide discussions and specific topics that are important to the future of the NHS in south east London.

Engagement in Lewisham
In Lewisham the events were held on the 16 July in Laurence Centre:

1. Topic specific – Getting the best start in life. 16 July 12-2pm
The event was attended by 23 members of the public and had opening perspectives from Vicky Scott (Chief Operating Officer at OHSEL), who introduced the aims to improve the health of individuals in SEL through creating a sustainable future for NHS services, and Martin Wilkinson who spoke about the importance of prevention and building integrated services for children with long term conditions such as diabetes and asthma.
Reflecting on these messages, attendees concluded some of the key challenges we face in helping children to get the best start in life include:
  - a lack of understanding who is responsible for children’s services - the NHS, schools or local
Attendees felt that we should focus on a holistic, whole-child approach when trying to improve health, which means understanding the impact of housing, the social environment and poverty. Here is the summary for getting the best start in life.

2. Borough-wide discussion, 16 July 5-7.30pm
This public event in Lewisham was held to discuss how we can improve our services and make our community healthier. It was attended by 43 residents, who heard introductions from:
- Faruk Majid, GP and Chair of Lewisham Clinical Commissioning Group
- Folake Segun, Director of Healthwatch Lewisham
- Tom Brown, Director of Adult Social Services, Lewisham Council
- Catherine Mbema Director of Public Health
They discussed the NHS Long Term Plan, and its impact on the community and the wider public sector. There was a range of discussions about health and services in Lewisham. The attendees:
- were pleased we are focussing on getting services to work better together, but they had concerns about changes to CCG structures
- had questions about whether there is enough funding and time to achieve all the plans

Find our Lewisham summary here

3. Lewisham NHS LTP outreach activities
To gain a wide range of perspectives a series of conversations with Lewisham seldom heard community groups were held during July.

<table>
<thead>
<tr>
<th>Group</th>
<th>Date</th>
<th>Number of attendees</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 July BME Mental Health Carers Forum</td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>19 July Asian Elderly Group at the Calasbash Centre</td>
<td></td>
<td>16</td>
</tr>
<tr>
<td>25 July BME Lewisham Network</td>
<td></td>
<td>20</td>
</tr>
<tr>
<td>30 July Lewisham Mental Health Carers Forum</td>
<td></td>
<td>10</td>
</tr>
</tbody>
</table>

Feedback
What we have learned across south east London:
Throughout our discussions, we asked people what they thought about the main priorities in the NHS Long Term Plan. Here are the five key themes we heard:
1. They liked that there is and will be more joined-up working between different services.
2. They liked that the public is being involved in south east London's response to the NHS Long Term Plan.
3. They are concerned about whether there is enough funding available to deliver these changes.
4. They are concerned about whether there are enough healthcare professionals in the workforce to deliver these changes.
5. They are concerned that the NHS isn't making the most of the resources that exist already, especially organisations in the voluntary, community and social enterprise (VCSE) sector.
The full summary can be found here
The Healthwatch LTP engagement report can be found here

Equalities
OHSEL is committed to reducing health inequalities, promoting equality of access to services and involving patients and the public in supporting us to make decisions about local health services. OHSEL is currently working on a review of the engagement carried out in south east London, where we’ve heard from over 1600 people, with the support of south east London Healthwatch organisations. The review is
based on the [national Long Term Plan EIA](#) that provides an overarching assessment of the equality impacts.

In Lewisham we focused our local outreach on two Mental Health Carer Forums, Asian Elderly group at the Calabash Centre and Lewisham BME Network.

---

**Mental Health Stakeholders Day ‘Me and My community – October 2019**

In July 2018 the [Lewisham Health and Wellbeing Board](#) agreed Health Inequalities as the main areas of focus, and as an initial priority Black, Asian and Minority Ethnic (BAME) communities Health. As a result, a [summit](#) to engage local community members in an ongoing dialogue to explore ways to tackle BAME health inequalities around mental health was held on the 8 October 2018. To follow on the Mental Health conversation with the BME community and other groups in Lewisham the CCG and Lewisham Council organised a stakeholder event on the 14 October 2019: ‘Me and My community.

Cllr James Rathbone, Lewisham Mental Health Champion, opened the event, introducing talks covering Lewisham Mental Health Alliance, Health Inequalities and Carers in Lewisham. The presentations were followed by a lively Q&A session.

The programme offered a selection of discussions and a market place where organisations provided information on health services and support in Lewisham. The discussions were organised in three sessions with a total of 12 workshops ranging from Care information, Prevention, Mental Health in Schools, 5-Ways to Wellbeing, to themes including Social Inclusion Recovery Services, Help in a mental health crisis, and additional conversations on how to improve BAME groups equality for access and experience of mental health services.

The event had more than 170 participants: commissioners, providers, carers and representatives from a variety of community groups and members of the public.

"Mental health is one of our priorities," said Dr Charles Gostling, Senior Clinical Director of Lewisham CCG. "Not everyone knows where to get the best advice and support – for themselves or a loved one. And if you’re unfamiliar with the NHS and its mental health services – particularly during a period of change – the system can sometimes appear daunting.

**Feedback**

We received a total of 91 feedback forms. On the day, 96% of attendees agreed/strongly agreed the day was well organised, informative and interesting, with information at the right level and with the ability to make a contribution. The attendees praised the morning presentations and Q&A, the variety of topics covered in the workshops and opportunities for networking and interactions during breaks and marketplace.

**Equality Data**

<table>
<thead>
<tr>
<th>Age</th>
<th>Number and Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;25 (4.2%)</td>
<td></td>
</tr>
<tr>
<td>25-29 (5.5%)</td>
<td></td>
</tr>
<tr>
<td>30-44 (34.2%)</td>
<td></td>
</tr>
<tr>
<td>45-59 (41.1%)</td>
<td></td>
</tr>
<tr>
<td>60-69 (9.6%)</td>
<td></td>
</tr>
<tr>
<td>70-79 (5.5%)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Disability</th>
<th>Number and Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deafness</td>
<td>4%</td>
</tr>
<tr>
<td>Blindness</td>
<td>4%</td>
</tr>
<tr>
<td>Loss of sight</td>
<td>1.3%</td>
</tr>
<tr>
<td>Learning Disability</td>
<td>6.7%</td>
</tr>
<tr>
<td>Development Disorder</td>
<td>1.3%</td>
</tr>
<tr>
<td>Mental ill Health</td>
<td>16%</td>
</tr>
<tr>
<td>Long term illness or condition</td>
<td>10.7%</td>
</tr>
<tr>
<td>Physical disability</td>
<td>5.3%</td>
</tr>
<tr>
<td>Other (5.3%)</td>
<td></td>
</tr>
<tr>
<td>No disabilities (49.3%)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th>Number and Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female (74%)</td>
<td></td>
</tr>
<tr>
<td>Male (26%)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender reassignment</th>
<th>Number and Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>No (90%)</td>
<td></td>
</tr>
<tr>
<td>Prefer not to say (5%)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Religion</th>
<th>Number and Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Christian (53.7%)</td>
<td></td>
</tr>
<tr>
<td>No Religion (26.9%)</td>
<td></td>
</tr>
<tr>
<td>Prefer not to say (4.5%)</td>
<td></td>
</tr>
<tr>
<td>Other (9%)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sexual orientation</th>
<th>Number and Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heterosexual (86.1%)</td>
<td></td>
</tr>
<tr>
<td>Bisexual (2.8%)</td>
<td></td>
</tr>
<tr>
<td>Gay (2.8%)</td>
<td></td>
</tr>
<tr>
<td>Lesbian (1.4%)</td>
<td></td>
</tr>
<tr>
<td>Prefer not to say (8.3%)</td>
<td></td>
</tr>
</tbody>
</table>
Pride in Practice

Pride in Practice trains practitioners to meet the needs of their lesbian, gay, bisexual and transgender (LGBT) patients, from making a practice more welcoming to ensuring that patients are addressed in an appropriate way. It has been developed by the LGBT Foundation and funded by the Government Equalities Office. The programme package includes myth-busting training, support to deliver effective active signposting and social prescribing for LGBT communities, and ongoing support.

In Lewisham more than 60% of GP services have already registered with the programme. In October, one of the GP practices, Woolstone Medical Centre, received the Pride in Practice 'Gold Award' for delivery a fully inclusive healthcare service to their LGBT patients. Minister for Equalities, Baroness Williams, and the Mayor of Lewisham, Damien Egan congratulated the practice on receiving the award. On the day, Baroness Williams said "It is vital that LGBT people are able to access appropriate healthcare and are treated with respect. I would like to congratulate Woolstone Medical Centre on achieving the Gold Award for the Pride in Practice programme, showing a real commitment to ensuring they serve LGBT people in a supportive and respectful manner."

Dr Seb Kalwij, CCG Clinical Director with lead responsibility for Equality and Diversity, said: "The feedback from those who have taken part in Pride in Practice has been overwhelmingly positive, with many reporting that it's been informative, interesting and made a tangible difference."

The Pride in Practice programme is endorsed and informed by the Royal Pharmaceutical Society, Royal College of General Practitioners, Care Quality Commission, and the Government Equalities Office.

Bexley, Greenwich and Lewisham (BGL) Learning Disabilities Big Health Day 25 October

We celebrated the first BGL Learning Disabilities Big Health Day on the 25 October. Following an original idea from Ian Ross, Associate Director of Planned Care & Cancer at Lewisham CCG, and thanks to funding from the South East London Cancer Alliance (SELCA) the event was designed to be a cancer awareness and health information day for people with learning disabilities – and their friends and family – from Bexley, Greenwich and Lewisham.

The day was held at Thomas Tallis School in Kidbrooke and the event organisation took place across the three south London boroughs.

More than 340 people attended the day and have given positive feedback of their experience. During the event there were an array of activities, including a ‘market place’ with 27 health information stalls plus exercise classes, smoothie bikes, a huge ‘inflatable colon’ and Thomas the therapy dog. The Baked Bean Theatre Group and local choirs performed throughout the day and the Magpie Dance Group offered rhythmic lessons.

There were also separate classrooms for health checks, health information and yoga, and more than 40 volunteers from a cancer and learning disabilities background to helped out on the day. Of those who attended the event, nearly 100 people received mini-health checks.

Three stalls in particular proved to be popular:

• The three-metre long ‘inflatable colon’, with its contained cancer messages.
• The ‘three Cs’ stall, which supported people with a learning disability to have control over their
choices.
• The Cancer Research UK cancer prevention and early diagnosis information stall.

Dr Appleby said: “People with learning disabilities suffer so many inequalities in health and many other areas during their life. We want to change this. The aim of the day was to provide helpful information on staying healthy and active. But we also wanted everyone to have fun. The feedback that we received was terrific, with our survey showing that all the representatives from the organisations and people present said they would like to be invited to future, similar events. Many people said they hoped it would become an annual event.” 41 people who attended signed up and gave contact details to be involved in future engagement activities.

Feedback and Equalities
Easy Read forms were designed to capture information on the day.
Evaluation Form
Health Check Form Man
Health Check Form Woman

Some of the comments of the attendees on the day were:
- I learned to look after ourselves, keep healthy
- A lot of interesting things. I had a health check, I learnt about blood pressure
- I learned about a social group that takes place near my home

Attendees (residents and stalls holders) were happy with the event, and provided feedback on how to improve future events, such clearer signage and directions for the activities and close proximity of different performances to facilitate access.
An overview of the day can be found here and a summary of the evaluation here.
7. Lewisham CCG’s Equality Objectives Progress in 2019

**Objective 1** – Ensure better data collection through the referral process to enable improved understanding regarding the people who use services, their outcomes and access and experience, focused on those with long-term conditions (diabetes). *(2017-21)*

The focus of the work under this objective area has been to agree the parameters to improve Provider collection of equality monitoring data focused on the diabetes pathway.

*[Further update to be added (VR)]*

**Objective 2** – To cultivate an organisation that is inclusive, free from discrimination with all able to fulfil their potential. *(2017-21)*

The CCG put in place a workshop programme on ‘Dignity and Respect in the Workplace’ to provide common understanding and shared expectations about appropriate and inappropriate workplace behaviours. The workshops covered strengths and good practice, unconscious bias, defining respect and dignity at work, staff support, the legal context, defining bullying and harassment, the acceptable/not acceptable continuum, taking responsibility to challenge, and equality monitoring.

Monitoring and reporting is in place to ensure everyone has an annual personal development plan, and also receives regular feedback and support throughout the appraisal cycle, particularly at the end of year review, to provide the opportunity to reflect and improve on their performance and areas of development. Where vacancies arise in the CCG these are highlighted to staff internally, as well as being advertised externally so that they are accessible to our local population.

The organisational change process being implemented with the merger of the south east London CCGs has incorporated support to staff and managers, and in particular has included mandatory training on unconscious bias particularly for those who may be part of recruitment panels. An equalities analysis was part of the CCG merger application.

**Objective 3** – Ensure Governing Body members and senior leaders maintain equality and diversity as a core element of the organisation’s vision, values, strategies. *(2017-21)*

The Governing Body participated in an equalities workshop in December 2018 as part of the Strategy & Development Workshop Programme, which enabled the members to receive updates on how the organisation is meeting the public sector equality duties. New governing body members are being supported to review their contribution and activity records of their leadership contribution in this area, for instance to provide input and to seek assurance that proposals and reports that come before the Governing Body and committees are addressing equalities considerations.
A seminar to look at the wider determinants of health was held in April 2019. The presentation led by the Director of Public Health covered the wide range of social, cultural, political, economic, commercial and environmental factors that shape the conditions in which people are born, grow, live, work and age.
8. Lewisham CCG’s Equality Delivery System Performance in 2019

The EDS enables the CCG to:

- Analyse its performance against the EDS Goals and Outcomes
- Identify any gaps or areas that require improvement
- Identify any high risk areas as priorities for setting objectives

The EDS has four Goals:

1. Better health outcomes
2. Improved patient access and experience
3. A representative and supported workforce
4. Inclusive leadership

An NHS organisation might decide to focus on people (with particular protected characteristics) most at risk, and/or for whom considerable progress has been made. The key question of EDS2 is: how well do people from protected groups fare compared with people overall?

Lewisham CCG chose to focus the EDS2 on their commissioning responsibilities for:

- **Community Specialist Palliative Care (St Christopher’s)**
  The service was developed during 2016-17 when there were previously three providers. Since July 2018 St Christopher’s has been the sole provider. The 38-bed service is for people facing the final weeks/months/year of their life and works towards the six ‘Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020’.

- **Core24 Mental Health Liaison Service**
  Core24 Service is designed to meet the needs of people aged 18 and above who attend University Hospital Lewisham Emergency Department with a mental health issue. This service sees approximately 80% of the patients attending A&E with a mental health issue (August 2019) within the first hour of their attendance.

- **Extra Support Service (ESS) (formerly known as the High Intensity Users Services and Interventions)**
  The Lewisham Extra Support Service (ESS) is commissioned from the local GP Federation (One Health Lewisham Ltd) and commenced in 2018. The aim of the service is to identify the top 100 high intensity users of Lewisham Hospital A&E and determine reason for attending then to effectively manage, co-ordinate and signpost frequent attenders.

During 2019, engagement was carried out with local stakeholders and staff in order to verify the process.

In October 2019 an EDS2 Stakeholder panel considered the evidence prepared by CCG commissioners and the service providers and awarded EDS grading for the services.

The EDS2 Grading External Stakeholder Panel reviewed three services:

- Community Specialist Palliative Care (St Christopher’s)
- Core24 Mental Health Liaison Service
• Extra Support Service (ESS) (formerly known as the High Intensity Users Services and Interventions)

All three services reviewed are delivering good quality services. One of the services was able to demonstrate (with data) that more than three or four of the nine protected characteristics is being collected and being analysed to provide assurance that there is not a group of patients with a particular protected characteristic:

- who are not accessing the service,
- or who are able to access the services
- or what has been the experience of the patients who have these protected characteristics.

Therefore, one service was graded as ACHIEVING and two services were graded as DEVELOPING.

The CCG is developing an Equality Objective that will work with partners to improve the quality and collection of equality monitoring data.

EDS2 Grades for Lewisham CCG in 2019 to date are as follows:

<table>
<thead>
<tr>
<th>EDS2 Goals</th>
<th>Grading achieved In 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – Better health outcomes</td>
<td>DEVELOPING</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>To be confirmed</td>
</tr>
<tr>
<td>4 – Inclusive leadership</td>
<td>To be confirmed</td>
</tr>
</tbody>
</table>

A staff survey that contains some of the same outcomes of EDS2 Goal 3 that focuses on whether the workforce is representative and supported has been carried out. The results together with staff engagement on the results of the survey will take place in February 2020.

The CCG has started the process of collecting data for EDS2 Goal 4 Inclusive Leadership and aiming to complete the process in February 2020.

The grades and improvement plans for all four goals will be published on the CCG’s website by March 31, 2020. They will be used to inform the CCG’s operational and organisational development plans.
9. Lewisham CCG’s Equality Case Studies

Case Study: Community Specialist Palliative Care (St Christopher’s)

The service was developed during 2016-17 when there were previously three providers. Since July 2018 St Christopher’s has been the sole provider.

During development of the new service, several engagement events were held where members of the public, carers, and delegates from organisations representing patients were invited to feedback on a proposed service specification and to give input into the development of questions that would be put to organisations tendering to provide the new service. The feedback from the events was used directly in the development of the final version of the Service Specification, KPIs and the questions included in the tender documents.

Description of the service:

| 38 beds including young adult group 18-28 years | Range of stay between 60-170 days |

The service is for people facing the final weeks/months/year of their life and works towards the six ‘Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020’, as follows:

- Each person is seen as an individual;
- Each person gets fair access to care;
- Maximising comfort and wellbeing;
- Care is coordinated;
- All staff are prepared to care;
- Each community is prepared to help.

Traditionally, end of life care services have been orientated towards cancer care, however people with a whole range of other conditions including cardiovascular, respiratory, and neurological disorders and dementias should also be accommodated. The 2019/20 Joint Strategic Needs Assessment for Lewisham shows that 73% of deaths in Lewisham were non-cancer.

Each person is unique and St Christopher’s tailors their care to meet social, emotional and spiritual needs, as well as manage physical symptoms. Every year they provide care and support to over 6,500 people across south east London, both at home and in the hospice.

The Community Specialist Level Palliative Care (SLPC) MDT (Multidisciplinary Team) works with the person to develop their individualised plan of care, including where they prefer it to be delivered. This plan is regularly reviewed to reflect the changing needs of the person and to ensure that care is provided by the most suitable health or social care professional(s)

Referrals - for adults 18 years+ registered with Lewisham GP

Patients are referred on a generic referral form which is triaged by the Single Point of Contact team. At the first face to face holistic assessment, the patient, their carer or LPA is asked to complete our E&D form, and assessed for their physical, psychosocial (including mental health) and spiritual needs. Any carer is invited to complete the Carers Support Needs Assessment Tool which is reviewed by the Social Worker Team and appropriate support offered.
Communications & Engagement
- St Christopher's uses a goal-based approach to care ensuring that each patient is able to vocalise goals they are aiming to achieve with a clear plan on how the organisation can support them.
- For people who lack capacity, decisions can be made in their ‘Best Interests’ and policies are in place to support this. The psychosocial team are experts in the assessment of mental capacity and support all people who are uncapacious.
- St Christopher's has produced a range of leaflets that are available to patients and carers in the hospice. There are also posters advertising the carers’ service which have been sent to all Lewisham GP Practices.
- Patients are provided with relevant literature in relation to accessible services or support they may need.
- St Christopher’s also provides a wide range of information on their website in the “Advice and Resources” section at: https://www.stchristophers.org.uk/advice-resources/
- On discharge from services, patients and their carers are made aware of how to re refer themselves if they are concerned or their condition changes. Patients or carers can re refer themselves instead of waiting for a professional referral. A third of all referrals are now re-referrals. 14% are self-referrals (or from a carer/ NOK).

Successes of the service
- Following the launch of the re-commissioned Community Specialist Palliative Care service in July 2018, preliminary data shows that the number of deaths in hospital in Lewisham has reduced by over 2%. This is significant change noted in the first year of the new service.
- 87% of 124 responses to their VOICES questionnaire stated they were likely or extremely likely to recommend St. Christopher’s to family and friends.

Equality Monitoring Data
At the EDS2 External Stakeholder Panel event on 1 October 2019
- The service provided data on the following protected characteristics:
  - Age, Disability (Sensory impairment), Gender, Ethnicity (Race), Religion

Case Study: Core24 Mental Health Liaison Service
Core 24 Service is designed to meet the needs of people aged 18 and above who attend University Hospital Lewisham Emergency Department with a mental health issue. This service is seeing approximately 80% of the patients attending A+E with a mental health issue (August 2019) within the first hour of their attendance.

The additional resources for the Core 24 was the result of an NHS England (NHSE) Transformational programme to expand the provision of mental health liaison in Hospitals across England and Wales. Core 24 will ensure that people with a mental health issue attending A+E will receive a comprehensive assessment outlining the appropriate treatment to address their mental health need.
This funding was made available directly to the provider from NHSE and the allocation was determined on the size on the Acute Hospital.

**Description of the service:**

**Established in 2016**

- Lewisham Core 24 Mental Health Liaison Team (MHLT) is a 24 hour, all age service (16 years and above), which operates 365 day a year providing assessments, consultation and mental health liaison service.
- The Core 24 MHLT also receives referrals from other departments and wards within UHL for patients with a mental health issue.
- The MHLT will endeavour to undertake an assessment within 1 hour of referral from A&E.
- If the outcome of the assessment is for ongoing mental health inpatient treatment, the MHLT will make a referral to the appropriate inpatient unit.

**Aims of the service:**

- To provide a comprehensive assessment and liaison service to people who are experiencing mental health difficulties who attend UHL A&E and other departments/wards
- To provide assessments to people who present with co-morbid presentations of either substance misuse or physical issues, and mental health difficulties in the Emergence Department (ED) and other departments/wards.
- To recommend and set up discharge plans and enable users to access appropriate ongoing care or treatment from community services.
- To provide advice and collaborative management plans on issues involving mental health to UHL ED and ward staff.
- To support UHL colleagues in carrying out complex capacity assessments.
- To promote mental health awareness and develop links with other non-mental health services within UHL
- To participate in local clinical governance structures to improve clinical outcomes attending UHL A&E.

**Successes of the service**

- The Service has averaged 70% for 1-hour response times and 80% for 24-hour response times. Response times compared favourably with other MHLTs in SLaM. (The national target is 95% of patient seen in 1 hour (Emergency) and 24 Hour (Urgent) referral.)
- During 2017/2018 zero complaints were received. We consistently scored highly regarding whether patients felt they were treated with dignity, empathy and respect (over 90% scores).

**Challenges**

- Key Performance Indicators - responding within 1 hour and discharging patients within 4 hours from ED attendance. A&E has seen a significant increase in the number of comorbid mental health patients, where both their physical/mental health needs should be addressed within this time period.
- There has also seen an increase in the demand for inpatients beds which as resulted in more people waiting in A&E for an inpatient bed.

**Equality Monitoring Data**

At the EDS2 External Stakeholder Panel event on 1 October 2019
Case Study: Lewisham Extra Support Service (ESS) (formerly known as the High Intensity Users Services and Interventions)

The Lewisham Extra Support Service (ESS) is commissioned from the local GP Federation (One Health Lewisham Ltd) and commenced in 2018. The Federation met with UHL (University Hospital Lewisham) consultants and identified the cohort of 75 patients to ensure no duplication with the Mental Health CQUIN.

Principles of the service:

- **Identify** – The top 100 high intensity users of Lewisham Hospital A&E and determine reason for attending. Exclusions include those with sickle cell disease, aged above 70, children under 18, care home patients etc.
- **Personalise** – Contact the top 75 patients directly to focus on their issues, identifying and de-medicalising their needs to uncover the ‘real’ reason for calling 999 or attending A&E.
- **De-escalate** – Offer immediate access to an appropriate listening support service between 9am-5pm weekdays. Local referrals to support services that may address housing problems and social care difficulties.
- **Discharge** – Many clients, following initial support from the ESS are discharged without the need for follow up.
- **Manage relapse**. If relapse occurs clients can contact the service directly which will immediately pick up their crisis and helps them navigate through the difficult time rather than the need to return to their old behavior of attending A&E.
- **Quality of intervention** – Higher quality more personalized and effective interventions will create robust connections and positive outcomes for clients and deliver financial savings to the system. The impact of these interventions will be assessed by the service in terms of reduced usage of A&E.

Aims of the service are to:

- Effectively manage, co-ordinate and signpost frequent attenders at A&E
- Effectively manage and co-ordinate the chaotic and demanding nature of the patient group through use of multi-agency support and the voluntary sector
- Reduce activity frequent attenders have on A&E
- Support patients to access appropriate projects/services and sign-posting referrals and partnership working

Successes of the service

The service has achieved a 32% reduction in avoidable admissions for the selected cohort of patients. 111 patients supported in 2018/19.

Equality Monitoring Data

At the EDS2 External Stakeholder Panel event on 1 October 2019

- The service provided data on the following protected characteristics:
  - Age, Gender, Ethnicity (Race)
Case Study: Lewisham i-THRIVE

This case study sets out how Lewisham CCG and partners are locally implementing the i-THRIVE framework that the NHS Improvement recommends as an approach to improve access to and delivery of CAMHS.

Background

The THRIVE Framework for system change (Wolpert et al., 2019) is an integrated, person centred and needs led approach to delivering mental health services for children, young people and their families that was developed by a collaboration of authors from the Anna Freud National Centre for Children and Families and the Tavistock and Portman NHS Foundation Trust.

As a response to the NHSI (NHS Improvement) recommendations, in 2019 Lewisham CCG Clinical Directors agreed to locally adopt the national i-Thrive framework, to support clinical pathways, interface between providers and access to services. The model focuses on 5 key concepts: thriving; getting advice and signposting; getting help; getting more help; and getting risk support. Lewisham partners convened a large scale i-THRIVE event in October 2019, this was attended by 80 cross sector partners including representatives from the CCG Public Reference Group, clinical leads, local VCS organisations.

The THRIVE Framework provides a set of principles for creating coherent and resource-efficient communities of mental health and wellbeing support for children, young people (CYP) and families.

It aims to talk about mental health and mental health support in a common language that everyone understands.

The i-THRIVE framework will enable commissioners to map services, identify gaps and target health inequalities.

Change in terms of improved outcomes for different population groups

In order to increase the provision of psychology minded interventions to the most vulnerable
CYP in Lewisham, a re-focused service specification for Youth Services will ensure that youth workers are fully engaged in the i-THRIVE framework of practice. Youth workers will also be contractually bound to access mental health and emotional wellbeing training, such as Youth Mental Health First Aid. With a large percentage of BAMER (Black, Asian, Minority Ethnic and Refugee) CYP attending youth services, this will have a positive impact on this particularly vulnerable cohort of CYP.

Work is under way to establish a 'pathway project' structure with representatives from service users and providers to identify and address gaps in provision. This long – term work programme will ensure that CYP can move seamlessly across pathways that address the wide range of needs. A cross sector mapping and consultation process, via the i-THRIVE framework, will enable this element of the Improvement Plan.

**Planned Improvements in access to service by different protected groups**

An initial mapping exercise has been undertaken of services available to support transition for 14-25-year olds, across a range of service areas including mental health, housing, SEND (special educational needs and disability) and learning disabilities, substance misuse, youth justice and care leavers.

These services have been mapped against the national i-Thrive framework. Findings will be used to highlight service gaps, with the aim to identify potential new areas of commissioning needed within transition and preparing for adulthood. BAMER access to mental health services has been identified as one of nine key priorities within the refreshed CAMHS Transformation Plan 2019 and the CYP MH and EW Pathway Improvement Plan (e.g. i-Thrive implementation)

CYP mental health commissioners and providers are beginning to consider with adult mental health colleagues and other system partners how to better meet the needs of 18-25 year olds: A desk top mapping exercise identified a range services and interventions, for CYP aged 14-25, against the i-THRIVE model (creating an in-year baseline of current activity for 18-25 year olds), the new transition post, the inaugural i-THRIVE event, that was attended by CYP and adult colleagues and the joined up approach to Transforming Care all serve as examples of this. This activity links to the NHS Long Term Plan to deliver a comprehensive 0-25 support offer by 2023/24.

In order to promote service coherence and coordination, early help providers are engaged in the process of implementing Lewisham’s i-THRIVE framework.

**Outputs, Impact & Outcome – what was learned**

- The inaugural i-THRIVE event took place in October 2019
- A series of co-production events have been scheduled for Q4 including work with CYP with SEND, those engaging in the YOS etc
- Joint CYP commissioners maintain strong links with the CCG Public Reference Group, which provides members of the public the opportunity to feed into the development of local services. The Public Reference Group (PRG) consulted on the 2019 CAMHS Transformation Plan, several members of the PRG attended the inaugural i-THRIVE event, and the PRG have agreed to help shape a menu of evidence based pathways for CYP mental health and emotional wellbeing in the coming year. Latterly, the PRG consulted on i-THRIVE definitions, and influenced the shape of this emerging agenda.
- The i-THRIVE implementation is at an embryonic stage, though the expected outcomes are as follows:
  - CYP Joint Commissioners were advised to implement a 'conceptual model' (i-THRIVE) to inform and organise the system while allowing individual services to use their own delivery models e.g. Trauma-informed, Signs of Safety. i-THRIVE is a national, conceptual framework, which was developed by a collaboration of authors from the Tavistock and Portman NHS Foundation Trust and the Anna Freud National Centre in 2014. The National i-THRIVE Community of Practice now covers over half (62%) of all children and young people in England and the key principles include a common language, shared decision making and outcome informed practice.

**How the CCG is holding providers to account for equality and diversity**

- i-THRIVE is being adopted within the Early Help Approach, it will therefore be incorporated into upcoming contracts. As an example of this, the newly formed service spec for the Youth Service, which is currently out to tender, features the i-THRIVE framework of support.

- i-THRIVE will continue to be implemented in conjunction with CAMHS Transformation Planning and service design, ensuring that we meet the needs of the most marginalised CYP and those that may experience barriers to accessing services. The upcoming Mental Health Support Trailblazer Teams, based in schools and coming on stream in January 2020, will focus on three health inequalities
  - Poverty and crime
  - School Exclusion
  - Targeting and Tailoring Services to BAMER CYP
- These teams, which are funded by additional resource from NHSE, will complement the existing i-THRIVE provision.

**Case Study: Lewisham CAMHS Deep Dive – July 2019**

This case study is a report on the deep dive of Lewisham CAMHS that were reported to the CCG Governing Body in July 2019.

**Background**

Since 2015, the children's mental health agenda has continued to be a national area of focus. Additionally, the 2015 government committed to implementing the recommendations made in the 'Five Year Forward View for Mental Health'[1] (February 2016), which includes specific objectives to improve access to ‘evidence based’ treatment for children and young people by 2020/21. Five Year Forward View sets out an indicative trajectory to achieve the ambition that by 2020/21, 70,000 additional children and young people (CYP) will access community mental health services each year (increasing the percentage from 25% to 35%). The NHS Long Term Plan 2019 (January 2019) contains a set of expectations regarding children and young people’s mental health services. There is an ongoing requirement to increase access to evidence based mental health support for children and young people (CYP).

**Change in terms of improved outcomes for different population groups**

Based on local data returns between April and October 2019, the six south east London boroughs are now projecting to meet the 34% CYP MH access standard this year at 34.3%,
an improvement from our last forecast. Lewisham has risen to achieve 31.6% in October and is confident that this will increase by March 2020.

**Planned Improvements in access to service by different protected groups**

Since 2015/16, there has been an NHSE requirement for CCGs to submit an annual local CAMHS Transformation Plans (LTP), to indicate how local areas would work together when delivering against the national agenda. The Plan was refreshed and published in November 2019. Key priorities within the current plan include nine priorities, all of which focus on protective characteristics:

- Increase participation and co-production
- Promote fair, timely and equitable services for Black, Asian, Minority Ethnic and Refugee (BAMER) CYP
- Promote universal prevention Strengthening our work in schools and responding to the 2017 Green Paper, with a focus on BAMER / excluded groups
- Strengthening our work in schools and responding to the 2017 Green Paper, with a focus on BAMER / excluded groups
- Prioritise access to ‘evidence based’ mental health interventions and reduced CAMHS waiting times
- Strengthen and streamline mental health and emotional wellbeing provision for Looked After CYP
- Implement the CYP Mental Health and Emotional Wellbeing Improvement Plan
- Strengthen the graduated response to CY with Special Educational Needs and Disabilities and mental health difficulties
- Enhancing preventative and integrated support for Perinatal Mental Health and more targeted interventions that support a Public Health Approach to reducing violence in Lewisham, including psychological approaches within the community

**Outputs, Impact & Outcome – what was learned?**

- A Health and Wellbeing Board was jointly written by public health, adult and CYP commissioning and involved data cleansing of SLAM ethnicity data and deep dive analysis of BAMER access data for non-statutory services.
- Data analysis has highlighted proportionate BAMER access in community focused mental health provision (e.g. voluntary providers and low level mental health support (children wellbeing practitioners)). We have therefore focused on community facing services within our latest investment standard proposal
- The service user group ‘Alchemy’ works with BAMER CAMHS service users. The group meets monthly and recently designed and delivered cultural awareness training for CAMHS staff
- We are working with SLAM, NHSI and Public Health to develop a KPI that considers BAMER access in relation to individual minority ethnic groups
- There is an appetite to research areas of best practice in this area (something that Public Health will support with)
A recent ‘easy read’ guide of the recently published CAMHS transformation plan, is now available on line and aims to engage more families and professionals in this agenda.

**How the CCG is holding providers to account for equality and diversity**

- Commissioners continue to work with providers to ensure relevant data is captured to support the CAMHS access targets.
- Monthly STP access meetings with SLaM and Oxleas to oversee the risk.
- Implementation of NHSI recommendations to ensure that providers strengthen governance and sign off processes related to reported data.
- The 2019 NHS Lewisham CAMHS Transformation Plan was refreshed and published in early November 2019 and ‘improvement against the CAMHS access target’ has been incorporated as one of the key priorities.
- Lewisham’s NHS CAMHS provider, SLaM, are taking a number of actions to manage waiting lists and increase access. The ongoing delivery of twice monthly Saturday clinics (planned until March 2020) are helping to engage more families from a range of backgrounds.
- Newly established monthly commissioner meetings with SLaM has resulted in more focus on data to support equality and diversity.
- 4 borough data meetings with SLaM have been established and have resulted in the implementation of a monthly performance dashboard since October 2019.

References:


**Case Study: Bamer health inequalities in CAMHS**

This case study describes how Lewisham CCG and partners investigated the presence of Bamer (Black, Asian, Minority Ethnic and Refugee) communities health inequalities in the CAMHS services through improved data collection and analysis.

**Background**

The joint Children and Young People Select Committee and Healthier Communities Select Committee (July 2019) made a presentation to the Health and Wellbeing Board (HWB) recommending:

- That HWB investigates the lack of robustness and possible inaccuracies with CAMHS ethnicity data and provides details of how and when this deficiency will be addressed and remedied.
- That HWB considers a dedicated programme, with additional funding and other resources, based within community and third sector partner organisations that already have expertise and the trust of Bamer (Black, Asian, Minority Ethnic and Refugee) communities, on whose cooperation public consultation and co-production will rely.

**Change in terms of improved outcomes for different population groups**

Extensive work has been undertaken over the last three months by the Lewisham CAMHS
service alongside SLaM (South London and Maudsley NHS Foundation Trust) data analysts to improve the accuracy and comprehensiveness of ethnicity data for Lewisham CAMHS.

Data shows a much-improved position for 2019/20 where the number of 'unknowns' for ethnicity has been reduced to 9%, meaning that the data is far more meaningful and accurate.

This more accurate and comprehensive data shows that although access for BAMER children and young people is better than we originally thought, there is still an issue of disproportion, when measured against Lewisham’s demographics. There is more work to be done to understand the level of disproportionality particularly for specific ethnic groups and gender.

Alongside this work to improve the Lewisham CAMHS data, commissioners for children and young people have also undertaken analysis of reach and ethnicity data across the wider commissioned mental health and emotional wellbeing pathway for children and young people. Early findings have been positive, with BAMER access being around 55-60% for most non-statutory/community-based services.

Any improvements in access to service by different protected groups

SLaM’s Children Wellbeing Practitioner (CWP) Programme has been established to develop the CYP mental health workforce by allowing trainee mental health practitioners, with robust clinical supervision, to deliver evidence – based interventions to children and families with mild to moderate needs. This proven, community and evidence-based approach has doubled in size over the past year. Whilst it is still a small resource, with approximately four WTE practitioners and two trainees, data shows that it has achieved 57% BAMER access against a total figure of 63.4% of 0-19 year olds that identified as BAMER in the Census 2011.

In 2019, Lewisham was successful in securing funding to implement two Trailblazer Mental Health Support Teams (MHST), as set out in the Transforming Children and Young People’s Mental Health: A Green Paper. Much like Children Wellbeing Practitioners, Education Wellbeing Practitioners (EWP) will allow a new cohort of trainees to join the local workforce in delivering evidence-based interventions in community settings. This proven, community and evidence-based approach is hoped to mirror CWP’s success in delivering proportionate BAMER access.

Outputs, Impact & Outcome – what was learned?

Positive progress has been made in improving the availability and quality of data on the ethnic origin of children and young people accessing statutory and non-statutory mental health and emotional wellbeing services. This data shows a mixed picture with room for improvement, particularly for statutory services. Action being taken is therefore as follows:

- Given the ethnic composition of the Lewisham CYP population, BAMER access to mental health services has been identified as one of nine key priorities within the refreshed CAMHS Transformation Plan 2019. Baseline information will be reported with clear actions attached, which will be monitored and reviewed over the course of the coming year.

- As part of wider performance management systems, equality of access to services will
remain a priority for SLaM, ongoing work will be undertaken to ensure that the ethnicity of services users is recorded and any anomalies are addressed.

- Additional resource, such as the Mental Health in Schools Trailblazer will be targeted to meet the identified needs of our community, by focusing on BAMER access as a key priority.

- We will build on the well-established BAMER participation networks, such as Alchemy, that we already have in place. Alongside public health, we will work with the London Borough of Lambeth to learn from best practice in this area.

- A range of training programmes will continue to be offered to professionals across CAMHS and non-NHS providers such as unconscious bias and cultural awareness, with an expectation that this will be taken up by all relevant practitioners.

- We will continue to build on successes achieved through co-location of services and integration of statutory mental health provision with local non-NHS providers, but currently resourcing is a real constraint.

- We will actively seek to increase resources available for this area of work. The CCG are recognising the historical financial position and there are opportunities for improvement under the NHS Investment Plan.

- Ongoing work will continue with SLaM and other agencies, building on the successes in community-based services and addressing the continued improvement agenda for SLaM CAMHS. Where possible we will work alongside adult’s services, when supporting the commitment to a ‘provider alliance’ across children’s services.

**How the CCG is holding providers to account for equality and diversity**

- Commissioners continue to work with providers to ensure relevant data is captured regarding ethnicity and diversity

- Implementation of NHSI recommendations to ensure that providers strengthen governance and sign off processes related to reported data

- The 2019 NHS Lewisham CAMHS Transformation Plan was refreshed and published in early November 2019 and ‘improved access for BAMER groups’ has been incorporated as one of the key priorities.

- Lewisham’s NHS CAMHS provider, SLaM, are taking a number of actions to manage waiting lists and increase access. The ongoing delivery of twice monthly Saturday clinics (planned until March 2020) are helping to engage more families from a range of backgrounds

- Newly established monthly commissioner meetings with SLaM has resulted in more focus on data to support equality and diversity

- 4 borough data meetings with SLaM have been established and have resulted in the
Case Study: Public Health Approach to Reducing Violence - Trauma Based Approach to Young Offenders  [Await confirmation on additional content]

This case study describes the initial stages of Lewisham Council, Lewisham CCG and partners working together to reduce violence in the borough.

Public Health Approach to Reducing Violence

- Is a science-driven, population-based, interdisciplinary, across sector approach which emphasises primary prevention. Rather than focusing on individuals, the public health approach aims to provide the maximum benefit for the largest number of people, and to extend better care and safety to entire populations.

- Is interdisciplinary, drawing upon knowledge from many disciplines including medicine, epidemiology, sociology, psychology, criminology, education and economics. Because all forms of violence are multi-faceted problems, the public health approach emphasises a multi-sectoral response.

- Considers that violence, rather than being the result of any single factor, is the outcome of multiple risk factors and causes, interacting at four levels individual, close relationship/family, community and wider society of the Social ecological model.

Lewisham is taking a public health approach to reducing violence which means:

- Understanding the extent of all violence, where and how it happens and who is affected to better inform including youth violence, domestic abuse, and sexual violence.

- Understanding that violence damages physical and emotional health and can have long-lasting negative impacts. It increases individuals’ risks of a broad range of health damaging behaviours – including further violence – and reduces their life prospects in terms of education, employment and social and emotional wellbeing.

- A wide range of factors relating to individuals, their relationships, and the communities and societies in which they live can interact to increase or reduce vulnerability to violence. Issues such as Adverse Childhood Experiences (ACEs) can have significant impacts on families.

- There are a wide range of strategies that can be used to address risk factors for violence and promote protective factors across all ages. Some can be implemented universally and others are targeted specifically. Using evidence-based models will shape impact.

- Working with the strengths that exist in communities to listen and collaborate on designing solutions together.

The Aim is to:

- Reduce the impacts and actual violence across Lewisham

- Identify the causes of violence in Lewisham, and act to deliver short and longer term
Public Health in Lewisham has developed a framework to deliver the Public Health Approach to Reducing Violence. Lewisham Council is leading on this initiative working with its partners including Lewisham CCG.

A key strand of work that forms the framework approach is:

- Supporting workforce resilience and creating Trauma informed restorative aware organisations

In November 2019 Lewisham CCG senior managers took part in a Systems Leadership in Trauma-informed, Restorative Practice workshop.

The workshop gave participants the opportunity to learn and/or gain greater understanding of the equality aspects of the framework including:

- Formative developmental; experiences
- Compromised attachment in early childhood
- The effects of Trauma and vicarious traumatisation
- The seven-piece jigsaw puzzle of 'Developmental Trauma' and adverse childhood experiences (ACES)
- Understanding unconscious bias and its various forms
- Steps to challenge unconscious bias
- Racisms, mental health and well being
- Individual and systemic racism
- Race-based traumatic stress
- Childhood traumatic stress and ACEs
- Historical group trauma

**Change in terms of improved outcomes for different population groups**

**Planned Improvements in access to service by different protected groups**

**How will success be measured?**
This case study describes how Lewisham CCG and partners have reduced the rate of teenage pregnancy in the borough through targeted commissioning and interventions.

### Background

Lewisham’s under 18 conception rate has declined by 70% since 2006 and in 2017 was similar to the national average though remains significantly higher than the London average.

### Under 18 conception rate in Lewisham compared to similar London boroughs

<table>
<thead>
<tr>
<th>Borough</th>
<th>Rate/1000 females aged 15-17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barking &amp; Dagenham</td>
<td>25.1</td>
</tr>
<tr>
<td>Greenwich</td>
<td>24.7</td>
</tr>
<tr>
<td>Lambeth</td>
<td>24</td>
</tr>
<tr>
<td>Lewisham</td>
<td>20.8</td>
</tr>
<tr>
<td>Southwark</td>
<td>20.5</td>
</tr>
<tr>
<td>Haringey</td>
<td>20.2</td>
</tr>
<tr>
<td>Croydon</td>
<td>20</td>
</tr>
<tr>
<td>Hackney*</td>
<td>19.4</td>
</tr>
<tr>
<td>Waltham Forest</td>
<td>18.1</td>
</tr>
<tr>
<td>England</td>
<td>17.8</td>
</tr>
<tr>
<td>London</td>
<td>16.4</td>
</tr>
<tr>
<td>Wandsworth</td>
<td>15</td>
</tr>
<tr>
<td>Brent</td>
<td>13.8</td>
</tr>
</tbody>
</table>

*Hackney & City of London combined

Source: Office for National Statistics (ONS)
Lewisham’s under 18 conception rate is 4th highest in London.

**Chart 3: Rate of abortions per 1000 females aged 15-17, 2018**

<table>
<thead>
<tr>
<th>Location</th>
<th>Rate/1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southwark</td>
<td>16.4</td>
</tr>
<tr>
<td>Lambeth</td>
<td>14.4</td>
</tr>
<tr>
<td>Hackney</td>
<td>12.2</td>
</tr>
<tr>
<td>Lewisham</td>
<td>11.8</td>
</tr>
<tr>
<td>Barking &amp; Dagenham</td>
<td>10.5</td>
</tr>
<tr>
<td>Greenwich</td>
<td>9.4</td>
</tr>
<tr>
<td>Haringey</td>
<td>9.3</td>
</tr>
<tr>
<td>Croydon</td>
<td>8.5</td>
</tr>
<tr>
<td>London</td>
<td>8.5</td>
</tr>
<tr>
<td>England</td>
<td>8.1</td>
</tr>
<tr>
<td>Wandsworth</td>
<td>7.8</td>
</tr>
<tr>
<td>Waltham Forest</td>
<td>7.0</td>
</tr>
<tr>
<td>Brent</td>
<td>6.5</td>
</tr>
</tbody>
</table>

**Source: Department of Health (DoH)**

Lewisham’s under 18 abortion rate is not significantly higher than London but is significantly higher than the England rate.

Since 2006, Lewisham has achieved dramatic decreases in teenage conceptions, however, the under-18 conception rate remains one of the highest in London. Teenage pregnancy is more likely to end in abortion than other age groups, and approximately two-thirds of under-18 conceptions in Lambeth, Southwark and Lewisham are terminated.

**Planned improvements in access to service with expected outcomes in this protected group**

The higher rate of under-18 conception in Lewisham reflects Lewisham’s higher starting point and prevalence of risk factors and may suggest an unmet need in contraception care.

Operating within the constraints of reducing public health budgets, publicly funded contraception to prevent unintended pregnancy is extremely cost-effective and is one of the highest value public health interventions. While NHS and local authority spending on contraception totalled £246.1m in 2016, new analyses in England suggest that every £1 invested in contraception saves these public services £4.64 over a four year period, and £9.00 over 10 years.

**Prevention of unwanted teenage**

- From September 2020, Relationships and Sex Education (RSE) will be compulsory subjects in schools. Work is in progress for schools to develop – alongside health professionals –

---


2 DfE. ‘Relationships and Sex Education (RSE)’ 2019
| conception and pregnancies | comprehensive, relevant lessons which will have an emphasis on knowledge, confidence and skills for safe, healthy and fulfilling relationships.  
- Long Acting Reversible Contraception (LARC) methods do not depend on daily concordance and have been proven more effective than oral contraception at only one year of use. The Lambeth, Southwark and Lewisham Sexual Health Strategy aims to develop, ‘young people friendly services,’ that increase knowledge of, choice and access to a range of contraceptive methods.  
- New models of practice include leveraging the accessibility, ease and anonymity of pharmacies, and increasingly incorporating an online aspect to contraceptive services (for low risk individuals).  
- The condom distribution scheme, ‘Come Correct’ has been popular locally and has capitalised on non-traditional settings (e.g. leisure centres and libraries) to distribute condoms to young people.  
- The strategy undertakes to ensure that there are high quality abortion services available to all young people in LSL. |
| Services to teenage parents who choose to continue their pregnancies |  
- Lewisham and Greenwich Trust (LGT) have a specialist midwifery team called ‘Indigo’ that provides continuity of carer during pregnancy and the postnatal period for teenage mothers and vulnerable women, recognising that chronological age is not always indicative of vulnerability. In the post-natal period, contraception is discussed and LARC can be arranged on the postnatal ward if the women consent.  
- The Family Nurse Partnership (FNP) continues to operate within Lewisham, providing continuity of carer from FNP nurses in pregnancy and for the first 2 years of the child’s life. The Lewisham caseload is particularly vulnerable compared to national FNP, despite which they have demonstrated improved outcomes in maternal smoking, breastfeeding, A&E attendances and LARC use.  
- The rate of subsequent unwanted pregnancies has increased in the FNP over the last year. Clients are now fast-tracked for contraception and staff prioritise contraception as a health and social issue with clients. The action plan for 2019/20 will include better linking with pharmacies and young person’s sexual health services.  
- LGT Indigo team, maternity services and FNP continue to have close links with ‘Future Men’ which can provides support to fathers but can also offer specialist support and work with young fathers. |
How the CCG is holding providers to account for equality and diversity

The partnership work required to effect the changes described in this case study will be monitored in a number of different ways involving a variety of professional groups. The Public Health team work closely with the CCG and changing trends and updated data are reported on a regular basis.

However, one of the key Boards overseeing this work will be the Maternity Commissioning group for LGT and the FNP partnership board both of which are either chaired by CCG representatives or have CCG as core members.


Case Study: Reducing Health Inequalities – NHSE and University of York research / Lewisham CCG’s Initiatives and investments during 2014-19

The case study describes the collaborative research work carried out by NHS England and the University of York to identify lessons for the NHS about reducing inequalities in emergency admissions for ambulatory care sensitive conditions – the main health inequalities indicator in the CCG Improvement and Assessment Framework (CCGIAF). Lewisham CCG was identified as an area that experienced consistent and significant (positive) changes in this indicator in recent years. During the timeframe of the research 2015-18 – Lewisham CCG developed and commissioned services that would have impacted the level of avoidable admissions.

Below are extracts from the research paper and evidence of the CCG’s initiatives and investments during 2014-19.

A) NHSE and University of York research paper extract (part 1)

Background

In December 2018, NHS England published a new Health Inequalities RightCare pack based on inequalities in Ambulatory Care Sensitive and Urgent Care Conditions for each Clinical Commissioning Group (CCG). The pack included the Absolute Gradient of Inequality (AGI) for Ambulatory Care Sensitive and Urgent Care Conditions, which is a measure of socio-economic inequalities in avoidable emergency admission rates. Over the past 3-4 years, some CCGs have experienced a widening of health inequalities based on this measure, while others a narrowing, but the determinants of these trends are unclear.

The University of York conducted interviews with CCG staff and providers to identify potential determinants.

Findings

The Research Team did not find a simple clear-cut explanation of any of the increasing or decreasing trends in the five CCG sites, and none of the CCGs had specifically designed a large-scale package of reforms with the explicit aim of reducing socio-economic inequalities in avoidable admissions. The Research Team did however find several potential contributing factors which may partially explain the observed trends. Most of these related to either primary and community care or the commissioning process. Key primary care factors were changes in (i) workforce, (ii) exception reporting and case
finding, (iii) proactive care, and (iv) access and quality in socio-economically deprived areas. Key commissioning factors were (i) leadership on inequalities, (ii) use of data and incentives and (iii) targeting of services to more deprived areas. Other factors included changes in care home services, national A&E targets, and wider non-care factors such as financial constraints on public services, residential gentrification, and shifting health care expectations within the population.

B) Lewisham CCG contributions to reduction in inequalities in avoidable admissions / AGI

Between 2014-19 Lewisham CCG developed and commissioned services that would have impacted the level of avoidable admissions:

1. **Primary Care**

Interventions in Primary Care focused on early detection and management, which ultimately supports reductions in acute activity. Lewisham CCG commenced investing additional funding (above and beyond the core contract and any associated premiums) in primary care through locally enhanced incentive schemes and then commissioned and contracted at scale neighbourhood and borough federations.

<table>
<thead>
<tr>
<th>Year</th>
<th>Intervention/Service</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014/15</td>
<td>Lewisham Neighbourhood Primary Care Incentive Scheme (Locally Enhanced Service) AIMS:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>· Increasing self-management</td>
<td>GP Practices</td>
</tr>
<tr>
<td></td>
<td>· Improving person centred care planning, where plans are drawn up collaboratively by clinicians with patients</td>
<td></td>
</tr>
<tr>
<td></td>
<td>· Encourage practices to work together</td>
<td></td>
</tr>
<tr>
<td></td>
<td>· Reducing unplanned admissions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>· Reducing variation between practices</td>
<td></td>
</tr>
<tr>
<td>2015/16</td>
<td>Lewisham Neighbourhood Primary Care Scheme (Locally Enhanced Service) AIMS:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>· Increase self-management for people with long term conditions</td>
<td>GP Practices</td>
</tr>
<tr>
<td></td>
<td>· Build on the collaborative working within Neighbourhoods in Lewisham</td>
<td></td>
</tr>
<tr>
<td></td>
<td>· Reduce variation in primary care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>· Improve the health outcomes for people with Long Term Conditions in Lewisham</td>
<td></td>
</tr>
<tr>
<td></td>
<td>· Provide a platform for the delivery of population-based care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>· Reduce the number of emergency admissions</td>
<td></td>
</tr>
<tr>
<td>2016/17</td>
<td>Co-ordinated Care Service – Reducing Variation. Two-year contract awarded to the local GP Federations to provide at scale primary care prevention and intervention. OUTCOMES:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>· Increasing prevalence: Finding those with undiagnosed;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>i) diabetes ii) COPD and iii) hypertension</td>
<td>Four Local GP Neighbourhood Federations</td>
</tr>
<tr>
<td></td>
<td>· Reducing variation between practices and improving clinical outcomes for patients with diabetes, hypertension</td>
<td></td>
</tr>
<tr>
<td>2017/18</td>
<td>Merged local GP Federation (One Health Lewisham Ltd)</td>
<td></td>
</tr>
</tbody>
</table>
and COPD
  · Supporting newly diagnosed COPD patients to stop smoking
  · Increasing uptake of self-management programmes for diabetic and COPD patients
  · Follow-up of patients with high Cardiovascular (CVD) ‘risk scores’ following NHS Health Checks
  · Proactively managing patients at risk of emergency admissions
  · Improving flu & pneumococcal vaccination rates
  · Improving childhood immunisation rates

2. Community Services & Long Terms Conditions

Respiratory diseases and Diabetes have been ongoing commissioning priorities for the CCG over several years.

(a) COPD Pathway: This programme was jointly led by our then Director of Public Health, Dr Danny Ruta, Dr Hilary Entwistle, GP and Dr Tudor Toma (Respiratory Consultant, LGT);

(b) Diabetes Pathway included:
  • Lewisham CCG Diabetes Strategy 2015/17
  • HeLP-Diabetes (Healthy Living for People with type2 Diabetes)
  • Tailored Self-Management Support for People with Long Term Conditions

(c) Lewisham Winter Assessment Team: 2015/16
  • Lewisham Winter Assessment Team (Pilot) 2015/16
  • Enhanced GP support to homeless hostels in Lewisham

<table>
<thead>
<tr>
<th>Year</th>
<th>Intervention/Service</th>
<th>Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014/15</td>
<td>Proactive Primary Care</td>
<td>CCG</td>
</tr>
<tr>
<td>2015/16</td>
<td>Lewisham Winter Assessment (LWAT)</td>
<td>Bromley</td>
</tr>
<tr>
<td>2015/16</td>
<td>• provided an immediate medical assessment service for housebound and care home patients</td>
<td></td>
</tr>
<tr>
<td>2016/17</td>
<td>• requiring an urgent assessment via a single point of access for GPs, Care Homes and extra care housing and received 988 referrals in the first 6 months.</td>
<td></td>
</tr>
</tbody>
</table>

C) NHSE and University of York research paper extract (part 2)

Gentrification contributing to improving AGI trend in Lewisham

Gentrification in Lewisham was one plausible contributing factor to the apparent reduction in inequalities.

Lewisham CCG has seen a consistent reduction in inequalities in avoidable admissions. On discussion with CCG staff and providers there was no clear healthcare-related reason to explain it. However, several individuals mentioned the potential role of gentrification in Lewisham.

Between 2015 and 2019 there is evidence that Lewisham has become less deprived when the Index of Multiple Deprivation is compared between 2015 and 2019 (see Figure 1 especially south west of the CCG). For example, in 2015, 4.7% of Lower Super Output Areas (LSOA) were in the most deprived 10% nationally, whereas in 2019, only 2.9% were
in the most deprived 10%.

Figure 1: Map of deprivation in Lewisham between 2015 and 2019

Source: Office for National Statistics 2019

House prices have also increased in Lewisham at a faster rate than the rest of England over the past 10 years and since 2014/15. The increase in house prices is likely to have led to a health migrant effect, where more affluent people have moved into the area, who tend to be healthier.

While it is conceivable that gentrification in certain parts of Lewisham has contributed to reduced inequalities through a healthy migrant effect, it is likely that there are several other interacting health service, community and population factors which have also contributed to reduction (see Section B) Lewisham CCG contributions to reduction in inequalities in avoidable admissions / AGI above)

Final Report

NHS England and the University of York are due to publish a final report on their research, findings and recommendations in early 2020.
This case study looks at the use of public, patient, carer and health care professional involvement in the review of the Primary Care Interpreting and Translation Service across Lambeth, Southwark and Lewisham. NHS Lewisham CCG is the host CCG for the service and led the review working with commissioning and engagement colleagues across NHS Lambeth CCG and NHS Southwark CCG.

Key Drivers for a review
- LSL commissioners outlined in their 2018/19 commissioning intentions to review the LSL ITS service.
- An EIA identified that the current model negatively impacts on a proportion of the service users that access LSL ITS.
- LSL CCGs liaised with their local Healthwatch organisations to seek intelligence collated with regards to access to primary care services for those patients for who do not speak English as a first language and/ or are visually/hearing impaired.
- The current service model does not meet the NHS England recommendations.
- Service User Experience of current service required to identify if the service meets the users needs.
- The current model is not operationally, contractually or financially sustainable

Engagement Approach
An engagement working group was established to develop an LSL and individual CCG engagement plans. Key messages for materials, webpages, presentations and reports were developed and translated into the ten most requested languages across LSL. An independent Interpreting provider was sourced to reduce conflict of interest throughout the process.

Example materials

In 2017/48 there were 29531 booking requests covering 73 different languages (including...
British Sign Language), reflecting the diverse ethnic and cultural mix of the three LSL boroughs.

Commissioners adopted a co-ordinated approach and agreed to actively engaged with the five most requested languages across each borough and actively inform those service users that request the top 6-10 languages.

Language requests across borough varied slightly between each borough however collectively across LSL the ten most requested languages are 1) Spanish 2) Portuguese 3) Vietnamese 4) Mandarin 5) Cantonese 6) Polish 7) Arabic 8) Turkish 9) Somali 10) French. Requests for these languages equated to approximately 76% of all language requests for 2017/18.

The engagement approach varied for each identified service user as outlined below.

How did we engage with service users?
Extensive service user engagement was undertaken between October 2018 and March 2019.

Engagement events were held with the patients, the public, carers and health care professionals to gain an understanding of their experience and satisfaction of the current service and also to gather their views on how the service could be shaped in the future to help inform commissioners of long term commissioning arrangements.

We liaised with 25 individual community groups across LSL as well as patient reference groups, local residents and health care professionals.
What did we do with feedback?
An in-depth evaluation of the findings was undertaken, reviewed by the Public and Patient Equalities forum in each LSL borough and published on the CCG webpages.

Along with the wider contractual, operational, financial review, the findings were incorporated into an options paper for commissioners to agree the long term commissioning arrangements. LSL Commissioners agreed to put the existing contract(s) out to tender with an aim to commission a new service from a single service provider by 1st April 2020.

A next steps presentation providing an overview of the engagement findings, an outline the new service proposals including a 'You Said, We Did!' summary and a mapping of the proposals against the NHS England recommendations was developed for commissioners to share with service users and stakeholders as identified in their communications and engagement plans.

The Service user feedback was used directly in the development of the Service Specification, KPIs and tender documentation.

How were these used in the procurement process?
Service user representation (Patient/community, Clinical lead, GP Practice Manager) are involved in the procurement process by fully participating in the tender scoring process-evaluating and submitting a score for the Technical and Quality Envelope and sitting on the Panel for the bidder presentation. The service users will also assist in providing their views and input into the development of any marketing materials produced.

The tender questions for bidders focused on some of the elements highlighted from the service user engagement to allow potential bidders to demonstrate how they would strive to meet the requirements if they were successful. These included (but not exhaustive);

- **Service User Experience**: How will this be captured, what approach would be taken, how would they meet the needs of the service users across a culturally and ethnically diverse population requiring interpreting support
- **Interpreter qualifications / experience**: experience and knowledge in medical terminology, safeguarding, cultural awareness, dignity and respect training.
- **Access**: Equitable response times for all booking request types regardless of users need
- **Marketing materials**: Development of materials that are visible, clear and available in multiple languages
- **Personalised approach**: Ensuring that each patient’s interpreting need is recorded and met accordingly.
- **Innovation**: Improve access through innovative means of technology to support service users needs

How will they be incorporated into the contract
A series of KPIs relating to our service users have been developed and will be included in the contract.

How will we feedback and monitor them?
These will be monitored during our quarterly monitoring meetings with the provider. Commissioners will provide updates to the Public and Patient Equalities Forum to inform them of service delivery including patient and public engagement findings in the contract and
in the new service provision.

**Next steps**

Procurement is currently in process and it is hopeful that a Preferred Bidder will be identified by 24th December 2019. Contract signing, mobilization and implementation will be undertaken between January – March 2020 with the new service to go-live on the 1st April 2020.

---

**Case Study: GP led Primary Care homeless services in Lewisham**

This summary provides details about GP led primary care services commissioned in Lewisham for the homeless population, current service delivery and planned next steps for long term commissioning arrangements.

a) Enhanced GP support to homeless hostels in Lewisham  
b) Rough Sleepers Pilot; Improving Access to Primary Care  
c) Evaluation of GP led primary care homeless services in Lewisham  
d) Lewisham Whole System Homeless Summit

### a) Enhanced GP support to homeless hostels in Lewisham

- In 2016 Lewisham CCG commissioned an enhanced GP service to homeless hostels in Lewisham to assist in addressing some of the challenges the homeless population face in accessing health care.  
- The service is delivered by 2 local GP practices within Lewisham who provide weekly in-reach clinics to 3 homeless facilities in Lewisham for single adults aged over 18.  
- There is a total of 113 units across the 3 hostel sites. 2 hostels provide 1st stage accommodation and are assessment centres (1 is a mental health assessment centre). The other hostel provides 2nd stage accommodation  
- The service aims to provide:  
  - Core general practice service to residents at the hostels.  
  - Referrals and liaisons with other health and homeless services  
  - End of Life Care  
  - Outreach Support  
  - Medicines management adherence support  
  - Advocacy e.g. rehousing, statutory benefits  
  - Collaborative multiagency working

<table>
<thead>
<tr>
<th><strong>Patient Demographics</strong></th>
</tr>
</thead>
</table>
| Patient’s age: 36-50 years (50%), 26-35 (29%), 26-35 (14%), 18-25 (7%)  
| 78% of patients accessing the service are male  
| 41% are white British |

<table>
<thead>
<tr>
<th><strong>Key findings</strong></th>
</tr>
</thead>
</table>
| The following findings provide a high level summary of service activity from one of the hostels at Hither Green (2nd stage accommodation hostel).  
| 70% of all available appointments are utilised (318/460)  
| Approximately 26 patients were seen within the GP practice (outside of clinic)  
| 54% have reported drug misuse, 27% alcohol, 12% both and 7% none. 25% had a respiratory condition (COPD (8%) or Asthma (17%))  
| Average number of monthly referrals to secondary care = 4. 18% referrals are to mental health services (CMHT) |
Common Challenges and Barriers

- Out of clinic correspondence with wider services, stakeholders and patients themselves is required but time consuming often requires chasing
- Patient engagement can be challenging at times to the patients complex needs and chaotic lifestyles.
- Follow-up of patients at clinics or within practice not always possible as patient does not attend (high DNA rate to multiple health and social care services)

What could be improved

- Improve accessible (local) Opportunities for networking and knowledge
- Closer work between commissioned GP Practices across SEL CCGs, HIT, homeless outreach Team (START). Pathway homeless team (Kings Health Partners), others
- Additional funded resources for increased MDT working
- Information sharing agreement with other Lewisham GP practices
- Improved IT resources at hostels

Patient and stakeholder feedback (Hither Green)

- In general, residents value the service and appreciate facilitated access to GP and nurses, e.g. no need to book appointments, needs promptly met (or discussed), close to them.
- Approximately 1 in 3 residents have seen a GP in the surgery or feel confident they are able to. The remaining 'would never' travel to the surgery due to perceived mental or physical impairment.

b) Rough Sleepers Pilot; Improving Access to Primary Care

The Rough Sleepers Pilot was commissioned in April 2018 as an 18 month pilot to deliver improved access to primary care for Rough sleepers in Lewisham.

Background Information

- During the consultation on the future of the NHS Walk-in Centre concerns were raised about the homeless in Deptford and New Cross and access to primary care
- An equality impact assessment identified that there could be a gap in services for Rough Sleepers in Deptford and New Cross accessing GP services.
- A multi-agency Homeless Summit was held on 18th October 2017 for local partners and agencies.
- The CCG committed to developing a GP led service for the Rough Sleepers in Deptford and New Cross.
- The CCG held a number of workshops with key stakeholders and undertook vast service user engagement with potential service users discuss the proposed service model for the Rough Sleepers Pilot to assist in service specification development.

Service Model

The service operates 2 weekly drop-in clinics offering 6 hours of primary care provision to Rough Sleepers in Lewisham aged 18 years and over. One clinic operates from a local GP practice and the other is delivered as an outreach clinic located at one of the homeless charities.

Patient Demographics
Activity

- 58% of available appointments across both sites was utilised
- Variation of utilisation across individual sites (Amersham vale 22% v 999 Club 86%)
- A high number of patients have alcohol (45%) and drug (18%) dependencies. 17% presented with respiratory conditions
- Referrals and attendance at other services included; UCC/ED (44%), emergency admissions (15%), outpatients (18%)
- 85% of patients reported becoming homeless within the last 12 months (13% in last month)
- 18% reported as rough sleeping, in which the same number reported as sofa surfing, 14% resided in a night shelter (patients can report more than one type of status in any one given period)
- 53% of patients were unregistered of which the majority registered at the AVP

Common Challenges and Barriers

- Intense workload outside of clinics (with both patients and stakeholders)
- Patient engagement – takes time to gain trust and confidence
- Patient compliance to medication and appointments (requires additional support)

What could be improved

- Improved access to primary care and health outcomes
- Continuity of care with clinicians and co-ordinated care with other stakeholders

Patient and stakeholder feedback

- General feedback about the GP service was positive & all responders (patients and stakeholders) felt having a GP working with 999 had the potential to improve the quality of healthcare for the homeless.
- 59% of patients reported seeing an improvement in their physical health and 13% in their mental health
- 50% of stakeholders had signposted their patients to the GP service
Given the high prevalence of chronic disease and co-morbidity amongst the population of people who are homeless, and the financial cost this has on the NHS, NHS Lewisham CCG has made a commitment to commissioning healthcare to work more proactively with people experiencing homelessness and the agencies that support them.

NHS Lewisham CCG works closely with its providers and wider stakeholders in the review, development and commissioning of primary care led homeless services and has held multiple homeless summits / workshops with wide representation from health, social and voluntary organisations.

Lewisham CCG has outlined in the 2019/20 corporate objectives to review primary care services for the homeless population. HealthWatch Lewisham has been commissioned by NHS Lewisham CCG to undertake the evaluation.

The evaluation will assist in providing a summary of existing service provision, service outcomes and benefits and outline recommendations for commissioners to consider when reviewing long term commissioning arrangements.

**Expected Outcomes**
- gain an understanding of the health care needs of the homeless population the services provide services to and the challenges it presents
- Identified areas of improvement when providing health care to this population including examples of good news stories/ clinical case examples
- Understand the requirements for collaborative and aligned service delivery with other providers and agencies,
- An estimated baseline of need and whether the needs are being met
- are equality goals being met
- Does the provider(s) understand the specification requirements and are able to demonstrate and evidence accordingly to provide assurance to commissioners.
- Recommendations for future service delivery and long term commissioning arrangements

The evaluation will be undertaken between October – December 2019. Commissioners will review the recommendations and draft options for future service delivery working closely with Local Authority colleagues to ensure primary care commissioned health services to the homeless populations are developed collaboratively with providers and key stakeholders and aligned to other commissioned services.

**d) Whole System Homeless Summit**

On 31st July 2019, the CCG in partnership with Lewisham Council organised a multi-agency Homeless Summit for local partners and agencies. It presented a unique opportunity where representative from agencies across the system providing services and support to the homeless came together

There was wide stakeholder representation from homeless charities (*Deptford Reach*, *999 Club*, *Bench Outreach*, *St Mungos*, *Thamesreach*, *Pathway*), Lewisham & Greenwich NHS Trust, South London & the Maudsley NHS Trust, Healthy London Partnership, GP Primary Care Providers.
I. The objectives of the summit was to;
   I. Stocktake of the ‘system commitments’ made at the joint CCG and local authority Homeless Summit on 18th October 2017;
   II. Review of the challenges facing our homeless population and current services;
   III. Consider guidance and policy changes, the implications and the development of a ‘whole system’ response?

I. 2017 Summit overview

<table>
<thead>
<tr>
<th>Whole system commitments</th>
<th>Did we achieve it?</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Lewisham CCG committed to working with local GP practices located in the Waldron Health Centre to develop an additional alternative service for the rough sleepers in New Cross and Deptford</td>
<td>YES</td>
</tr>
<tr>
<td>• Commissioned a Rough Sleepers pilot in April’18 • Delivered by Amersham Vale Practice • Service evaluation scheduled (Q3 2019/20)</td>
<td></td>
</tr>
<tr>
<td>Lewisham Council &amp; NHS Lewisham CCG committed to setting up a homeless redesign network, which would meet on a regular basis, which would consider;</td>
<td>PARTMET</td>
</tr>
<tr>
<td>• Signposting and inter-agency communication and information sharing  • Outreach Primary Care (including mental health) for Rough Sleepers  • Reviewing evidence of good practice (e.g. setting up an MDT panel)</td>
<td></td>
</tr>
<tr>
<td>• Rough Sleepers Steering Group set up in June 2019 (wide representation) • Outreach services include;  • rough sleepers service (CCG)  • Nurse led HITPlus pilot (CCG)  • DoTW mobile unit (OHL)</td>
<td></td>
</tr>
<tr>
<td>GAPS • Signposting and inter-agency communication and information sharing • Reviewing evidence of good practice</td>
<td></td>
</tr>
</tbody>
</table>

II. Challenges facing our homeless population

Homelessness can be a consequence as well as a cause of worsening health. People experiencing homelessness have significant needs in relation to physical health, mental health and substance misuse. These needs often go unmet and result in stark health inequalities, with an average age of death of 44 for men and 42 for women who are homeless.

The following provides a summary of the yearly comparison of the rough sleeper population in Lewisham.

<table>
<thead>
<tr>
<th>2015/16</th>
<th>2016/17</th>
<th>2017/18</th>
<th>2018/19</th>
<th>Change since 2017/18</th>
<th>Change since 2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>133</td>
<td>200</td>
<td>199</td>
<td>165</td>
<td>-34</td>
<td>32</td>
</tr>
</tbody>
</table>

Source: CHAIN (Combined Homelessness and Information Network)

The following provides a high level summary of homelessness across London;

<table>
<thead>
<tr>
<th>London Statistics</th>
<th>Demographics</th>
<th>Support needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 8,885 people sleeping rough in London (18% increase from)</td>
<td>• Diverse nationality profile of rough sleepers in London (126 nationalities) • % UK nationals has decreased</td>
<td>• 2/5 of rough sleepers did not have support needs assessment</td>
</tr>
</tbody>
</table>

---

5 Healthy London Partnership Commissioning Guidance for homeless health, March 2019
2017/18) with an increase in the number of new rough sleepers.
- November highest number of people and December saw the least (consistent pattern)

from 54% in 2017/18 to 49% in 2018/19
- Romanians are the largest non-UK national group (16%)
- 84% are male (consistent with 2017/18)
- 32% of rough sleepers were 36-45 years and 24% 46-55 years
- 63% were of white background (white British the majority 31%)

• Mental Health most reported support (50%)
• Majority accessed hostels and assessment centres but also private rented sector and local authority temporary accommodation

### III. Guidance and Policy Change

In March 2019, Healthy London Partnership (HLP) published commissioning guidance for London for Health care and people who are homeless. The guidance outlines 10 commitments and sub-commitments for commissioning services to the homeless population. The summary provides details about GP led primary care services commissioned in Lewisham for the homeless population, current service delivery and planned next steps for long term

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>People experiencing homelessness receive high quality healthcare</td>
</tr>
<tr>
<td>2</td>
<td>People with lived experience of homelessness are proactively included in patient and public engagement activities, and supported to join the future healthcare workforce</td>
</tr>
<tr>
<td>3</td>
<td>Healthcare ‘reaches out’ to people experiencing homelessness through inclusive and flexible service delivery models</td>
</tr>
<tr>
<td>4</td>
<td>Data recording and sharing is improved to enhance the safety of people experiencing homelessness, enhance best practice and facilitate outcome-based commissioning</td>
</tr>
<tr>
<td>5</td>
<td>Multi-agency partnership working is strengthened to deliver better health outcomes for people experiencing homelessness</td>
</tr>
<tr>
<td>6</td>
<td>People experiencing homelessness are supported to access to Primary Care</td>
</tr>
<tr>
<td>7</td>
<td>Mental Health Care Pathways offer timely assessment, treatment and continuity of care for people experiencing homelessness</td>
</tr>
<tr>
<td>8</td>
<td>People experiencing homelessness are discharged from hospital to suitable accommodation</td>
</tr>
<tr>
<td>9</td>
<td>Homeless Health advice and signposting is available within Urgent and Emergency Care Pathways and Settings</td>
</tr>
<tr>
<td>10</td>
<td>People experiencing homelessness receive high quality, timely and co-ordinated end of life care</td>
</tr>
</tbody>
</table>

Existing service provision across Lewisham was mapped against it to identify any gaps or opportunities in order to develop a ‘whole system’ approach going forward. This formed the basis of the group work discussions.

**Common themes:**
Three common themes were identified from the group discussions;
• **Eligibility:** There is a proportion of those that experience homelessness that are not eligible to access local services therefore presenting inequity and barriers

• **Population/ Demographic segmentation:** There is varying needs among the homeless population therefore there is a need for this to be considered as part of service delivery.

• **Shared common understanding:** There is a need for a shared common understanding across stakeholders with regards to homeless population including demographics, data, needs assessment outcomes, services available and information.

**Core Requirements**
Stakeholders were provided with an opportunity to outline their key priorities for homeless services in Lewisham that they feel would make improvements across the whole system. This formed the basis for some key commitments identified as priorities.

- Development of a homeless services induction video / e-resource pack across health and social care
- Develop one core forum across the whole system – focus on sharing information and outlining whole system strategy, priorities and planning
- Look at delivering emergency accommodation for ineligible rough sleepers
- Identify a Lewisham homeless health clinical lead
- End of Life (EoL) care awareness training (co-ordinate my care)
- Look at ways to improve collaborative working across teams – better use of resources and safer and better outcomes
- Identify ways to use pre-existing data platforms to populate with local data to share with / or stakeholders can access

**Next Steps**
Stakeholders committed to the following next steps;

- Develop a report of group findings and disseminate to stakeholders to ensure that there is a shared understanding of discussions, priorities and recommended next steps
- Commissioning arrangements. Outline the recommendations to the Health and Wellbeing board at a system level as opposed to an individual level
10. Our Partnerships

Lewisham CCG works in partnership with other commissioners to deliver high quality support and care. Lewisham CCG aims to work in partnership with the community in the commissioning of services. There is a good record of partnership working and strong relationships with:

- **South East London Clinical Commissioning Groups** - The six CCGs in South-East London, Lewisham, Lambeth, Southwark, Greenwich, Bexley and Bromley, have established collaborative arrangements to meet their shared and interdependent commissioning responsibilities.

- **Health and Wellbeing Board** - is a partnership that encourages local service commissioners and providers to work together to advance the health and wellbeing of the area.

- **July 2019**: In July 2018 Lewisham Health and Wellbeing Board (HWB) agreed that the main areas of focus for the Board should be tackling Health Inequalities, and identified as an initial priority; Black, Asian and Minority Ethnic (BAME) communities’ Health Inequalities. Mental health was chosen as the first theme through which to review BAME health inequalities. In July 2019 the HWB received reports on a variety of different work that has already been implemented and plans are in place for further work in 2019/20 and beyond. The longer-term aspiration is for the consideration of BAME health inequalities to be a routine consideration in all aspects of commissioning local services and programmes for the Lewisham population.

  *Please refer to Section 9 for details of the BAMER health inequalities in CAMHS and Adult Mental Health services.*

- **London Borough of Lewisham** - to jointly commission services for children and young people, learning disability, mental health, physical disabilities and emerging client groups, and older adults services

- **Lewisham Public Health** that transferred to LBL in April 2013

- **Lewisham Healthwatch**

- **Voluntary** and community organisations.

- **Healthcare providers** such as local acute, community and mental health hospital Trusts.

Please refer to the Partnership Commissioning Intentions in Section 5 and Case Studies in Section 9 that include examples of partnership working.

10.1 South East London Integrated Care System

As we described in section 5.1.1, the south east London Sustainability and Transformation Partnership (STP) is now working to become London’s first Integrated Care System (ICS), focused as a system on responding to and delivering the requirements of the Long Term Plan for the NHS (the LTP). The response will be finalised in January 2020.

Our draft priorities for LTP service transformation by 2023/24 are likely to include:

1. **Integrated community based care** - implementing a core offer that ensures people who are frail or have multiple conditions receive timely and personalised care delivered by community multidisciplinary neighbourhood teams, integrated with our 35 PCNs.

2. **Reduce pressure on urgent and emergency care** - providing high quality, consistent and timely services by delivering seamless UEC pathways through an integrated
network of community and hospital based care that ensures patients are seen in the least intensive setting for their need.

3. **Improve planned care outcomes and performance** - cutting long waits and expanding the volume of planned surgery whilst ensuring sustainability of services by better aligning capacity with demand. Transforming the outpatient model to reduce face to face appointments by a third.

4. **Deliver better outcomes for major health conditions** - taking systematic action that focuses on prevention, early detection and best practice treatments in: Cancer, Adult Mental Health, CVD, Respiratory Disease, Heart Disease and Stroke Care, Diabetes, LD and Autism, CYP (in CYP Mental Health) and Maternity services.

5. **Deliver financial savings and achieve financial sustainability** – setting out our system plan for implementing the LTP commitments over the next four years, whilst addressing our underlying recurrent deficit and working towards our system and organisational improvement trajectories.
11. Our Main Provider Organisations

NHS Lewisham CCG has in place mechanisms to meet its duties to ensure that key provider organisations comply with their equality duties, working in partnership with main provider organisations to include equality, diversity and human rights clauses within its contracts.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Lewisham &amp; Greenwich NHS Trust</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>South London and Maudsley NHS Foundation Trust</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
</tbody>
</table>

Lewisham CCG’s quality and performance teams regularly review provider’s patient experience and staff engagement data from our main provider. Lewisham CCG manages the Clinical Quality Review Group (CQRG) for Lewisham & Greenwich NHS Trust (LGT) by clinical directors, senior officers and the South East London Commissioning Alliance Integrated Contracts Delivery Team (ICDT).

The CCG holds providers to account for equality and diversity as part of its processes to assure the quality of services that it commissions.

We hold regular Clinical Quality Review Meetings with our main NHS providers at South London and Maudsley NHS Foundation Trust and at Lewisham and Greenwich NHS Trust. At these meetings we review equality and diversity issues related to the quality of specific services and make suggestions for improvement. We also review the providers’ Equality and Diversity Strategies as they relate to patients and to employees to ensure equitable services and opportunities as far as is possible.

The Clinical Quality Review Meetings also monitor safeguarding information to ensure that the employees at provider services are suitably trained and supported to protect vulnerable adults and children according to their specific needs.

This work is ongoing business as usual.

The CCG is represented at CQRGs of other acute providers by clinical directors and senior officers of respective host commissioning CCGs. Reports including trends and benchmarking data are presented for discussion at the CCG’s CQRG meetings with acute and mental health providers, ensuring any issues are discussed and addressed quickly and providers are held to account to improve patient experience. Where improvements are being made this is recognised.
11.1 Lewisham & Greenwich NHS Trust

Lewisham CCG is the lead commissioner for monitoring quality of this organisation and ensures that it meets its legal duties in relation to equality, diversity and human rights by including clauses within its contract. This also requires the Trust to monitor workforce and service activity in relation to the Public Sector Equality Duty (PSED).

Lewisham & Greenwich NHS Trust has been implementing the Equality Delivery System that is linked to the Trust’s Equality Objectives for 2015-2017. Progress is reported to the Trust’s Equality Steering Group. Equality and diversity progress in Lewisham & Greenwich NHS Trust can be found on their website. The Trust published both WRES and WDES (Workforce Disability Equality Standard) reports for 2018-19.

The Care Quality Commission carried out a routine inspection between 25 - 26 September 2018.

The CQC noted that:

Our rating of the trust stayed the same. We rated it as requires improvement because:

- We rated safe, effective, responsive and well-led as requires improvement and caring as good. Maternity services at both QEH and UHL were rated as good along with urgent and emergency services at UHL. In rating the trust, we took into account the current ratings of the services not inspected this time.
- We rated well-led for the trust overall as requires improvement.

website http://www.lewishamandgreenwich.nhs.uk/equality

11.2 South London and Maudsley NHS Foundation Trust

South London and Maudsley NHS Foundation Trust (SLaM) provides mental health services in Lewisham.

The Trust delivers general and specialist mental health and substance misuse services to Lewisham’s population. They provide services for adults, as well as specialist services for young people. These include daycare, inpatient care and community services.

The quality of services provided by SLaM are monitored at “four borough” CQRG attended by Lewisham CCG clinical directors and senior officers.

SLaM has been using the Equality Delivery System as a framework to identify where they need to focus their attention to improve on equality since 2013. SLaM has published the 2018-19 EDS2 assessment on its website.

SLaM has also published both WRES and WDES (Workforce Disability Equality Standard) reports for 2018-19.

In 2018 SLaM worked in partnership with patients, carers, staff and other stakeholders to develop an integrated equalities action plan 2018-21.

The latest Annual Equality Reports for South London and Maudsley NHS Foundation Trust can be accessed by following this link http://www.slam.nhs.uk/about-us/equality
The Care Quality Commission carried out a routine inspection between 1 April – 22 May 2019.

CQC inspected many SLaM sites. CQC rated two services inspected as outstanding, three requiring improvement and nine services as good.

The Trust was rated as being a well-led trust. The CQC noted that:

The trust, since the last inspection had continued to develop and deliver an equalities strategy. There had been a focus on BME staff experience led by the BME staff network. The trust had plans in place to improve the workforce race equality standards through offering leadership development for BME staff; having BME staff on recruitment panels for all band 7 posts and above; introducing a checklist to enable managers to reflect on whether alternative approaches could take place prior to a disciplinary process. Other networks were less well developed but were being supported to grow. This included an LGBTQ network and one for staff with lived experience.

The CQC rated the Trust as Good overall.

11.3 Friends and Family Test

Patients have an opportunity to routinely give their feedback after receiving care or treatment through the Friends and Family Test (FFT). This test aims to assess the quality of patient experience from responses to the simple question “Would you recommend this service to your friends and family?” A snapshot of results for Lewisham CCG Providers are as follows:

<table>
<thead>
<tr>
<th>NHS Provider</th>
<th>Month/Year</th>
<th>Percentage that would recommend service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lewisham &amp; Greenwich NHS Trust (In Patient)</td>
<td>October 2019</td>
<td>91% (of 1,318 responses)</td>
</tr>
<tr>
<td>Lewisham &amp; Greenwich NHS Trust (Community)</td>
<td>October 2019</td>
<td>97% (of 200 responses)</td>
</tr>
<tr>
<td>South London and Maudsley NHS Foundation Trust</td>
<td>October 2019</td>
<td>88% (of 1,062 responses)</td>
</tr>
</tbody>
</table>


In addition to the core clinical and outcomes data, CQRGs review the results of the Friends and Family Test and other sources of patient feedback.

Lewisham CCG also commissions a significant number of acute hospital services from Guys & St Thomas’s NHS Foundation Trust (GstT) and King’s College Hospital NHS Foundation Trust (KCH) for our local population, as well as a range of other hospital services from other London NHS providers.
Lambeth CCG is the Lead Commissioner for GStT and responsible for ensuring equality reporting and progress. Southwark CCG is the Lead Commissioner for KCH. When necessary, Lewisham CCG has requested equality reporting from both CCGs if it has not been possible to find information from the Trusts themselves.


Equality progress can be found for KCH here [https://www.kch.nhs.uk/about/corporate/equality-and-diversity](https://www.kch.nhs.uk/about/corporate/equality-and-diversity)

12. Safeguarding in Commissioning [update to be confirmed]

As a commissioning organisation Lewisham CCG is required to ensure that all health providers from whom it commissions services (both public and the independent sector) have comprehensive, single and multi-agency policies and procedures in place to safeguard and protect adults and children at risk from abuse and the risk of abuse itself.

The CQRGs (Clinical Quality Review Groups) for each organisation present a range of metrics to the CCG on a monthly basis, for example:

- Number of safeguarding referrals made,
- Percentage of staff compliance in training in safeguarding,
- Percentage of compliance in DBS (Disclosure and Barring Service) checks

The CCG attends the Safeguarding Boards of South London and Maudsley NHS Foundation Trust (SLaM) and Lewisham & Greenwich NHS Trust (LGT) to enable the CCG to challenge performance at both meetings.

In addition, the CCG holds a quarterly Health Safeguarding Sub Group, which is a conference style forum where information and learning can be shared. Private providers e.g. Nursing Homes and private hospitals also are invited to this.

The CCG employs Designated Nurses and a Doctor and they will give safeguarding supervision to the Named Doctors and Nurses in the provider organisations across Lewisham. The CCG also employs a Nursing Home Compliance Nurse who supports nursing homes and has developed a quality dashboard for self-completion.

Annual reports are produced for Adults and Children’s Safeguarding and we also contribute to the Annual reports of the LSAB (Lewisham Safeguarding Adult Board) and LSCB (Lewisham Safeguarding Children Board).

13. Complaints

Lewisham CCG manages the PALS and Complaints services which aim to improve:

- Liaison with our patients
- Understanding of the types of concerns affecting Lewisham residents
- Feedback for CCG staff
- Handling complaints as close to the patient/source as possible, for the best outcomes
• The accuracy of reporting issues or concerns so that the CCG can be warned earlier of gaps or failings in services.
• Wider engagement with our community

Complaints numbers for 1 April 2018 – 31 March 2019
• Total interactions: 237
• Formal complaints requiring a CCG response: 29
• Equality and Diversity monitoring forms received back: 3 (This represents 9.3% of the total sent to formal complainants)

The complaints are a combination of complaints about CCG commissioning / complaints about Provider services.

The CCG is working with Complaints Departments in Provider Trusts to find out the response rates regarding the return of Equality Monitoring Forms and how to improve the response rates for the CCG.

Learning from the CCG’s investigations into complaints has resulted in changes and learning, for example:
• In response to complaints about Continuing Healthcare letters, an electronic pathway and patient records system was implemented to ensure timely responses and up-to-date contact information;
• In response to complaints about the Interpreting Service, the Standard Operating Procedure was reviewed by the CCG to ensure that Interpreters are able to attend all of their appointments;
• In response to a complaint about the processing of a Mental Health Act assessment, the CCG worked in conjunction with NELCSU to review the Collaborative Claims team set up and training requirements to ensure measures were put in place to prevent the incident happening again;
• In response to a complaint regarding the Interpreting Service, the provider reiterated to its interpreters the importance of notifying them should they be running late due to unforeseen circumstances.

14. Workforce Race Equality Standard

The Workforce Race Equality Standard (WRES) is a benchmarking tool introduced by NHS England to assess the progress of race equality within NHS organisations annually, following an initial evidence baseline gathered in 2015. The WRES is based on research on the scale and persistence of disadvantage and the evidence of the close links between discrimination against staff and patient care.

The Standard highlights any differences between the experience and treatment of White staff and BME staff in the NHS with a view to closing those gaps through an action plan. The WRES definition of White and BME staff is as follows:
“White” staff includes White British, Irish and Any Other White. The “Black and Minority Ethnic” staff category includes all other staff except “unknown” and “not stated”. “Any Other White” contains minority groups including white European.

14.1 Workforce Race Equality Standard in Lewisham CCG

For the first time this year, CCGs were required to submit data for national analysis and publication on their websites in the same way as NHS trusts.

The WRES report sets out the CCG’s performance against the nine mandatory NHS Workforce Race Equality Standard (WRES) metrics.

Lewisham CCG has acted to address the issues raised in previous WRES reports, introducing recruitment and selection (within an equality and diversity framework) training, strengthened the recruitment and selection policy and procedures and introduced a training budget, policy and procedure that monitors equality access to non-mandatory training.

This year’s WRES shows that while some progress has been made in 2018-19:

- BME staff numbers increased by 10% (4 posts) in Bands 8a-VSM and 2% in Bands 1-7.
- The likelihood of White candidates being appointed was less likely than BME candidates in 2018-19
- White staff were slightly more likely than BME staff to access non-mandatory training.
- BME representation in the workforce (48%) is representative when compared with the BME population of Lewisham (46.5%).

There is still more work to be done where there are variances in the following areas:

- BME staff were more likely than White staff to enter a formal disciplinary
- Staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
- Staff experiencing harassment, bullying or abuse from staff in last 12 months
- The percentage of White and BME staff who think that the CCG provides equal opportunities.
- More BME staff (18%) have personally experienced discrimination at work from Manager, Team Leader or other colleagues compared to White staff (0%).
- BME representation of Governing Body members in the workforce (36%) is not representative when compared with the BME population of Lewisham (46.5%).

An action plan has been developed continuing with the actions that have resulted in improvements that address the variances between White and BME staff experience.

As Lewisham CCG comes together with the other five South East London CCGs in April 2020 our aim will be to work with the other CCGs to implement the NHSE Model Employer Strategy that asks NHS organisations to set targets for BME representation across the leadership team and broader workforce.

The full 2018-19 WRES report can be found on Lewisham CCG’s website https://www.lewishamccg.nhs.uk/about-us/how-we-work/Equality%20and%20diversity%20docs/1a%20WRES%202018-19%20LEWISHAM%20CCG%20260919.pdf
BME Staff in Band 8-9 & VSM compared to overall Workforce – 30 Nov 2019

Analysis:
In 2017-18, BME staff were 47.29% of the workforce this was 0.79% more representative of Lewisham’s population belonging to BAME communities.

In 2018-19, BME staff are 48.6% of the workforce which is a 2% increase from the previous year and 2% above Lewisham’s population belonging to BAME communities.

In bands 8-9 there is a 7 percent increase of BME staff up 38% from to 45%.

Since April 2018 there have been more appointments of BME staff within bands 8-9, which led the 7% increase at this level.

Governing Body Composition (ethnicity) 30 Nov 2019
In 2019, BME membership on the Governing Body has increased from 16% in 2017 to 36%. However, it remains under-representative compared with the workforce and the population.
14.2 Workforce Race Equality Standard in Lewisham CCG’s Providers

Since 2015-2016, all CCGs need to demonstrate that they are giving “due regard” to using the WRES indicators, and assurance that their Providers are implementing the WRES.

An analysis of performance across the CCG’s Providers in 2019 has been reviewed by the CCG Equality and Diversity Steering Group.

In 2019/20, through the contractual arrangement, the CCG’s will receive reports at the Clinical Quality Reference Groups from local Providers, who are expected to:

- Carry out a comparison of previous years’ data including steps underway to address key shortcomings in data, or significant gaps between the treatment and experience of white and BME staff.
- Publish WRES data for August 2019 on Trust web site and share with Board and staff

Please refer to Section 11 Our Main Provider Organisations for information on WRES reporting.

Case Study: Lewisham WRES Seminar November 2019

In November 2019, Lewisham CCG held a Lewisham Workforce Race Equality seminar inviting significant employers from local health and social care organisations. The event gave an opportunity to start a conversation about what the challenges are and to learn from each other.

- The event was well attended by around sixty participants that were from Lewisham CCG, Lewisham Council, Lewisham and Greenwich NHS Trust, other SEL CCGs, SEL STP Trusts and BME Staff networks of local NHS Trusts.
- The event was opened by Barbara Gray, Mayoress of Lewisham who gave the audience a picture of the diversity history of Lewisham and the opportunities available to Lewisham partners to listen to local people, to come together to share knowledge to
deliver services and support that communities need.

- Dr Habib Naqvi MBE, Deputy Director - NHS Workforce Race Equality Standard described the national picture regarding workforce race equality with respect to BAME representation and experience in NHS Trusts. Dr Naqvi also presented the latest WRES results from local SELSTP Trusts.

- This was followed by Professor Mala Rao, Medical Advisor to NHS England who gave a presentation on race inequality in clinical roles in the NHS, something the standard WRES does not cater for well. Therefore, Professor Rao is developing a WRES tool for clinical roles.

- Both presentations provided great insight into the issues for the participants before they discussed their thoughts on the national picture and how it related to their understanding of the topic and how things are in Lewisham.

- After the break Dr Sebastian Kalwiji gave the results of a workforce race equality survey in Primary Care in Lewisham that he conducted during the summer. The Primary Care WRES survey was the first of its kind and gave a unique perspective from this NHS staff cohort.

- This was followed by a presentation on the Lewisham CCG WRES experience between 2015-2019 described by Valerie Richards, Equality, Diversity and Inclusion Manager focusing on the successes and challenges over the period.

- Participants then talked about what progress had been made in their organisations, the successes, the challenges and how we can work together better as partners to reduce workforce inequalities.

- The last activity participants were asked to do was to make a pledge to: ensure employees from Black, Asian and minority ethnic (BAME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace.

- Dr Faruk Majid, Lewisham CCG Governing Body then closed the event thanking everyone who took part followed by his thoughts on the equality in Lewisham, the challenges facing the organisation and the wider society.

- The event was recorded by a graphic scribe and there was Twitter activity about the event see link below

https://twitter.com/NHSLewishamCCG

15. Lewisham CCG Workforce Information

The Public Sector Equality Duty requires that information on the make-up of the workforce must be published where public authorities have 150 or more employees. The data does not have to be published by organisations with less than 150 employees to protect staff identity
under the Data Protection Act. Lewisham CCG has a total of 70 employees and also purchases additional commissioning support services from NEL Commissioning Support Unit.

The workforce is a critical factor in the effective delivery of Lewisham CCG business. A quarterly workforce monitoring report includes workforce information relating to numbers of staff in post, turnover and sickness absence and an equalities profile relating to six of the nine protected characteristics and highlights key differences and/or issues to the senior management team (please refer to charts below)

15.1 Lewisham CCG Workforce Equalities Profile

Although Lewisham CCG has no legal duty to publish our workforce data, as the CCG employs less than 150 staff, the CCG has chosen to do so as part of our good practice. The following tables are a snapshot profile (as at 30th November 2019) of the organisation (by percentage), relating to six of the nine protected characteristics as defined by the Equality Act 2010.

The data below for Race/Ethnicity shows that the CCG has a representation of BME employees in its workforce of 48.6% which is two percent above the percentage of BME people - 46.5% - of Lewisham’s population (according to the 2011 National Census). This is an improvement, however the CCG continues to work towards reflecting the communities that it serves at all levels of the workforce.

**Ethnicity**

The remainder of the data gives details of a further five protected characteristics:
Gender:

- Female: 73.53%
- Male: 26.47%

Disability:

- No: 91.18%
- Prefer Not To Answer: 2.94%
- Yes: 5.88%

Age:

- 26-30: 5.00%
- 31-35: 10.00%
- 36-40: 15.00%
- 41-45: 20.00%
- 46-50: 25.00%
- 51-55: 20.00%
- 56-60: 15.00%
- 61-65: 10.00%
- 66-70: 5.00%
**Sexual Orientation**

- Bisexual: 1.47%
- Gay or Lesbian: 2.94%
- Heterosexual or Straight: 86.76%
- Not stated (person asked but declined to provide a response): 8.82%

**Religion**

- Christianity: 54%
- Hinduism: 15%
- I do not wish to disclose my religion/belief: 18%
- Islam: 6%
- Other: 1%
15.2 Equality and Diversity Training for Lewisham CCG Staff and Governing Body

In terms of training and development, we have agreed a training package with the NELCSU to provide and monitor mandatory and statutory training including Equality and Diversity training. Further training may be commissioned following a training needs analysis.

During 2019, both CCG Staff and Governing Body members have attended a range of training sessions, workshops and inductions as detailed below:

<table>
<thead>
<tr>
<th>Type of Training</th>
<th>Who Attended</th>
<th>Delivered by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality and Diversity briefing for new staff as part of induction Throughout 2019.</td>
<td>Commissioners, Patient and Public Participation staff</td>
<td>Equality, Diversity &amp; Inclusion Manager NEL Commissioning Support Unit (NELCSU)</td>
</tr>
<tr>
<td>Equality Delivery System briefings and workshop May-October 2019</td>
<td>Lewisham Public Reference Group</td>
<td>Equality, Diversity &amp; Inclusion Manager NELCSU</td>
</tr>
<tr>
<td>Equality Analysis Training workshops covering the theory and reviewing exemplar EAs. June 2019</td>
<td>CCG Staff that signed up to attend.</td>
<td>Equality, Diversity &amp; Inclusion Manager NELCSU</td>
</tr>
<tr>
<td>Strategy and Development Workshop Equalities Progress in 2019 December 2019</td>
<td>Governing Body members</td>
<td>Equality, Diversity &amp; Inclusion Manager NELCSU Deputy Director (Strategy &amp; Organisational Development)</td>
</tr>
<tr>
<td>Unconscious bias in recruitment From November 2019</td>
<td>All CCG staff</td>
<td>On-line</td>
</tr>
</tbody>
</table>
### Useful Information

<table>
<thead>
<tr>
<th>Name of Document</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Strategic Needs Assessment</td>
<td><a href="http://www.lewishamjsna.org.uk/reports">http://www.lewishamjsna.org.uk/reports</a></td>
</tr>
<tr>
<td>Lewisham Health Profile 2019</td>
<td>Lewisham Health Profile Nov 2019.pdf</td>
</tr>
</tbody>
</table>
From the Governing Body:
Dr Faruk Majid, CCG Chair
Mr Martin Wilkinson, Lewisham CCG Managing Director
Ms Anne Hooper, Lay Member
Dr Charles Gostling, Senior Clinical Director

From the CCG:
Mr Charles Malcolm-Smith, Deputy Director (Strategy & OD)

1 member of the public attended

Question 1
Will the Public Reference Group (PRG) continue when the new South East London CCG is established? Experience has shown that it brings benefits to both participants in the group and the CCG.

CCG Response
We are committed to developing public engagement and to maintaining existing mechanisms that have been successful such as the PRG. The PRG has been focused on health and as we bring together health and social care then transparency and involvement will be important to ensure we get feedback from local people for shaping and changing services.
AUDIT COMMITTEE

Minutes of the meeting held 23 July 2019
Room 304, Laurence House, Catford

PRESENT

Shelagh Kirkland (SK) Chair, Lay Member for Audit, LCCG
Anne Hooper (AH) Lay Member, LCCG
Dr Jacky McLeod (JM) Senior Clinical Director, LCCG
Peter Ramrayka (PR) Lay Member, LCCG

IN ATTENDANCE

Melanie Alflatt (MA) Head of Fraud, TIAA
Nick Atkinson (NA) Risk Assurance Partner, Internal Audit, RSM UK
Katie Hitchen (KH) Corporate Service Officer (minutes), LCCG
David Maloney (DM) Director of Finance, Lewisham, Bexley & Greenwich CCGs
Taryn Retief (TR) External Audit Manager, KPMG
Martin Wilkinson (MW) Managing Director, CCG

APOLOGIES

Richard Hewes (RH) External Audit Director, KPMG
Prof. Simon MacKenzie (SM) Secondary Care Doctor, LCCG

AC19/49 Welcome and introductions

SK welcomed all to the meeting.

AC19/50 Declarations of Interest

There were no other new interests declared by members which would knowingly affect the business of the meeting.

AC19/51 Minutes of the last meeting

The minutes of the meeting held on 21 May 2019 were approved as an accurate record.

AC19/52 Matters arising

There were no matters arising.

04.1 Action Log

The action log was updated.

04.2 Any matters not covered on the action log
There were no further matters discussed.

**AC19/53  Internal Audit - RSM**

NA presented the Internal Audit progress report. He confirmed that it was a positive report. There were 2 actions, 1 medium which had been closed and 1 low relating to members declaring conflict of interest which was in progress. A response from the CCG had been received and included in the report and MW confirmed that if there were still problems receiving declarations from members, this would be passed to the clinical directors to escalate. RSM were happy with this response and were happy to close this action.

RSM reported that their review on Local Authority Integration and the Better Care Fund (BCF) has resulted in them issuing a Reasonable Assurance opinion, although there were some areas highlighted for improvements. After some discussion, it was agreed that the BCF should be more explicitly covered at the Health and Wellbeing Board in the future.

RSM presented an updated Controls Catalogue, which also included the 2018/19 Service Auditor Reports that captured key exception reports from outsourced service providers. It was advised that, since preparing the summary, an adequate response had been received from the CSU which would be circulated to the Audit Committee after the meeting. It was noted that the number of Capita exceptions had reduced from last year; however, there were still a high number remaining. The CCG had no contractual relationship with Capita; however, the committee had previously received a letter from NHSE stating that the performance issues with Capita were being addressed.

**Action:** NA to share CSU response to exceptions

**AC19/54  External Audit - KPMG**

TR presented the KPMG Annual Audit Letter, which they finalised once all the accounts had been submitted which summarised the external audit findings for 2018/19. It was confirmed that the Annual Audit Letter would need to be published on the CCG website. There were no changes from the draft version previously seen.

PR queried the statement from KPMG’s VfM conclusion on financial resilience where they review the financial forecasts produced by the CCG that suggested that the demographic assumption was slightly conservative. TR confirmed that there were no issues, risk or concerns with this statement, and similar assumptions had been found across all 6 CCGs.

TR advised that KPMG would next be working on the MHIS (Mental Health Investment Standard) assurance work in August and would confirm dates with DM & MW soon. This work would be testing that the investment put into Mental Health services was at the level it should be.

**AC 19/55  TIAA Report**

MA presented the 2019/20 progress report, congratulating the CCG on the good work which had produced an overall green rating assessment. It was noted that there were a few amber rated standards which would be address throughout the year.
It was reported that there had not been as many training sessions for 2018/19 as previously with 42 CCG staff members attending. It was agreed that MA and CMS would look at the workforce training report to identify the number of staff remaining to complete training, and a further training session would be arranged.

**Action:** CMS & MA to look at workforce for Counter Fraud training

MA advised that the team were currently undertaking a formal investigation regarding continuing health care which DM had approved. Details could not be disclosed whilst the investigation was taking place but further information would be provided once the investigation concluded.

It was reported that Alan Cotton would be joining MA & Inge Damiaens as a security management specialist and it was agreed to link security management with the counter fraud mandatory training for this year.

**AC 19/56 To receive and note rolling logs**

There was one new waiver included in the log for Evalucom.

**The Committee NOTED the updated rolling log**

**AC19/57 Any other business**

There was no other business discussed at this point of the meeting.

**AC19/58 Date of next meeting**

Tuesday 22 October 2019, 9.30am, Room 305, 3rd floor Laurence House.
Integrated Governance Committee
Minutes of Meeting held on Thursday 26th September 2019

Present
Debbie Brown             Clinical Director
Dr Charles Gostling (CG) Senior Clinical Director
Shelagh Kirkland (SKi)   Lay Member
Dr Faruk Majid (FM)      LCCG Chair
Dr Jacky McLeod (JM)     Senior Clinical Director
Peter Ramrayka (PR)      Lay Member
Dr Angelika Razzaque (AR) Clinical Director
Dr Ravi Sharma (RS)      Clinical Director

Attending
Corinne Moocarme (CM)   Joint Commissioning Lead
Mike Hellier (MHe)       Head of System Intelligence
Graham Hewett (GH)       Associate Director of Quality
Mathew Shaw (MS)         Healthwatch Representative

Apologies
Martin Wilkinson (MW)    Managing Director (Chair)
Dr Esther Appleby (EA)   Clinical Director
Dee Carlin (DC)          Head of Joint Commissioning
Diana Braithwaite (DB)   Director of Commissioning & Primary Care
Alison Browne (AB)       Nursing and Quality Director
David Maloney (DM)       Director of Finance
Prof. Simon Mackenzie (SM) Secondary Care Doctor
Dr Sebastian Kalwij (SK) Clinical Director

IGC 19/61 Welcome and Introductions
Chair welcomed all to the meeting.

IGC 19/62 Apologies for Absence
Apologies were taken and noted.

IGC 19/63 Declaration of Interests (DoI)
There were no new interests declared.

IGC 19/64 Minutes of Previous Meeting
It was agreed that the minutes could be considered an accurate record.

IGC 19/65 Review of Actions & Matters Arising
The action log was reviewed and updates agreed. It was noted that as IGC meetings have moved to a bi-monthly cycle, there are long waits for reports. It was agreed that Community Services would be presented, as a brief update, at the November meeting.
The Committee was informed that the Children and Young People mental health transformation standard is currently calculated by year to date numbers, which are used to forecast the full 19/20, based on previous years patterns. Currently for Q1, from the information provided by Providers, the standard is at 25.1% and the local collection is at 27.9%, both of which are lower than the 34% standard. The Committee heard that currently the forecast for South East London is at 33%.

The Committee queried whether there were adequate mitigations in place, to support these figures to reach the standard. MHe stated that further capacity has been identified, with utilisation of the Trailblazer scheme.

**Action: Capacity of the Trailblazer scheme to be assessed and reported back to IGC**

The Committee questioned whether services such as Kooth and Compass are being adequately assessed and whether the CCG can be assured by the data produced. It was agreed that this would need to be discussed in a contractual conversation, focusing on effectiveness as well as access.

**Action: DBr and AR to ask the CYP Mental Health Board**

The Committee was informed that there is a disproportionate race inequality and balance when it comes to these services, which needs to be reflected in the Commissioning Intentions.

**Action: AR to discuss with Caroline Hirst and team.**

In relation to Personal Health Budgets and Continuing Healthcare the Committee was informed that a SEL Project Manager has now been recruited, to identify further cohorts of patients to increase Personal Health Budgets to the Quarter 4 requirement of three times the current level.

The Committee was informed that a new Interim CHC Manager has also been appointed, who will be responsible for ensuring that plans to make PHB the default for CHC packages of care at home is “re-launched”. It was added that a bespoke training plan for new CHC team members is being developed, which is very time consuming but will ultimately make the process of inducting new staff easier. The Committee was also informed that there are currently gaps in the CHC team which are being recruited to.

CM informed the Committee that, at present, there is a problem in 28 day targets being met due to there being “trigger criteria” for a full CHC checklist to be completed, when it is unnecessary. The Committee was informed that conversations are underway to tackle this and that a difference should be noticed by reporting in the next quarter.

The Committee was informed that the CCG is not meeting the Urgent 1 week standard for CYP Eating Disorders Service, as there was a breach in Q3 of 18-19 which will take 6 additional months before it is not counted in the reporting data. The Committee queried the low uptake numbers, with the report stating that only 4 people referred to the service urgently, for Lewisham. It was agreed that validation and explanation of this data would be required and that comparative data to other SEL CCGs would be provided.

**Action: CYP Eating Disorder Service – confirmation of numbers and comparative SEL data to be reported to the next meeting.**
The Committee members heard that in relation to Out Of Area Placements (OAPs), there is a scheduled contract meeting regarding the numbers reported. It is thought that there are significant delays in transfer of patients due to accommodation issues, likely due to the patient being unable to go back to the previous location or having no fixed abode at the time of admission. These patients are medically fit for discharge but more needs to be done to support this process. It is unclear at this time whether these reported figures will increase due to the number of issues faced or whether the mitigations are having any impact at this time. Further information will come to the Committee in due course.

The Committee raised questions in relation to the Primary Care Dashboard, requesting that work be done to understand the Lewisham actions, the level of comparative data and the inclusion of different types of clinicians, such as Pharmacists and Nurses. The Committee also queried the workforce development funding streams, the long term sustainability of existing workforce and requested a review of registered list compared to WTE.

**Action: Actions to be communicated to Director of Primary Care and action transferred to PCOG and ultimately reported at PCCC.**

**IGC19/67 Quality Exceptions Report**

The Committee was reminded of a previous concern regarding a Care Home provider, raised at the July meeting. By way of update, the Committee was informed that a meeting with the provider has been arranged and that process are in place if there is no further improvement. The scheduled meeting will be when placements of new patients is discussed and decided upon, as the provider has yet to reach the thresholds which would trigger not placing patients there. A fuller update will be provided to the Committee following this meeting.

**Action: CM / HH to provide an update for the Committee following the provider meeting**

The Committee received the Infection Prevention and Control Report, which provided a good news story with Lewisham CCG being above the trajectory, except for 1 case of MRSA which was deemed as unavoidable at review. It was agreed that it would be important to keep on top of this work, as it will now be reporting at an SEL level.

The Committee welcomed Mathew Shaw (MS), Healthwatch Representative, to the meeting. MS presented the Healthwatch Report, highlighting key areas:

- Healthwatch have found there to be a real lack of clarity, understanding and awareness regarding BAME CYP living with cancer. Due to this there is a significant lack of uptake in relation to screening and people feeling very alienated should they receive a diagnosis. The Committee questioned how to effectively target communications at young people but identified the perceived gap. It was queried whether more could be done in relation to social prescribing and agreed it would be very useful for Healthwatch to attend a PEEF meeting as well as a PCN meeting.

**Action: The Committee tasked Healthwatch to “tease out” which specific groups were most impacted by this and to discuss with key leads at the CCG how to link these findings into current actions being undertaken.**

**Action: Healthwatch Team to be invited to attend PEEF and PCN meetings.**

- Healthwatch are reporting consistently that access to GPs is still a concern for residents in Lewisham, with the perception being that there is no continuity of care. It
was added, however, that there have been positive improvements with the 60+ group happy to utilise pharmacy services more regularly.

- Healthwatch are reporting there is still a lack of awareness relating to GPEA, with patients unaware of how the service works and how their records are used.
- Healthwatch are reporting extensive concerns relating to Mental Health services and the long waits for treatment. Healthwatch queried whether there are actions and services available ‘in the meantime’, to aid people who are on the waiting list.
  
  **Action: Mental Health leads to receive the Healthwatch report and reply.**

- Healthwatch are reporting that people with Learning disabilities do not feel adequately supported or understood by a range of front line staff.

The Committee discussed the Healthwatch report in relation to The Harbour – a mental health crisis café. It was commented that whilst the report shows this as being a used, useful and welcome service, the Mental Health reporting has considered this style of service as failing. It was agreed that further conversations were needed to work on the design, access and integration of these services, considering the positivity felt in the Community.

The Committee was informed that Healthwatch are currently undertaking more work within the local hospitals, with a focus on communication. It was queried whether more could be done to help residents understand the links between acute and primary care and the dynamics of this work.

  **Action: Healthwatch question to be posed to the Primary Care Team.**

The Committee was informed that in relation to estates, especially in relation to UHL, Healthwatch had received mainly negative comments, with most people stating they don’t feel there enough facilities available. It was requested that more information regarding this section of the report be provided to the CCG.

  **Action: Healthwatch to provide a deep dive on this issue.**

**IGC19/68 For Information Items**

The Committee noted the 18-19 Annual Complaints Report, the PMMOG Chairs Report and the IGSG Chairs Report.

**IGC 19/69 Any Other Business**

The Committee noted the small changes made to the CCGs Business Continuity Plan to alter the plan to fit with Laurence House.

**The next meeting of the IGC will be held on 28TH November 2019.**
South East London
Integrated Governance & Performance Committee

Minutes

1 November 2019

Present

Ray Warburton (RW) Independent Lay Member & Meeting Chair
Christina Windle (CW) Director of Commissioning Operations, SELCA
Sarah Cottingham (SC) Director ICDT, SELCA
Jacqueline McLeod (JM) Clinical Lead, Lewisham CCG
Richard Gibbs (RG) Lay Member, Southwark CCG
Usman Niazi (UN) Chief Financial Officer, SEL Commissioning Alliance (SELCA)
Yvonneke Roe (YR) Clinical Lead, Southwark CCG
Amana Humayun (AH) Lay Member, Greenwich CCG
Neil Kennett-Brown (NKB) Managing Director, Greenwich CCG
Angela Bhan (ABh) Managing Director, Bromley CCG
Adrian McLachlan (AM) Chair, Lambeth CCG
Kieran Swann (KSw) SEL Assurance Team, SELCA
Martin Wilkinson (MW) Managing Director, Lewisham CCG
Ross Graves (RGr) Managing Director, Southwark CCG
Simon MacKenzie (SM) Secondary Care Doctor, Lewisham CCG
Andrew Eyres (AE) Accountable Officer, Lambeth CCG
Andrew Bland (AB) Accountable Officer, SEL Commissioning Alliance (SELCA)
Emir Faisal (EF) Lay Member, Lambeth CCG
Sabah Salman (SS) Clinical Lead, Greenwich CCG
Harriet Agyepong (HA) Associate Director Performance, ICDT
Annabel Appleby (AA) Director of Acute Based Care, ICDT

Apologies

Krishna Subbarayan (KS) Chair, Greenwich CCG
Keith Wood (KW) Lay Member, Bexley CCG
Christine Caton (CC) Chief Financial Officer, Lambeth CCG
Harvey Guntrip (HG) Lay Member, Bromley CCG
Andrew Parson (AP) Chair, Bromley CCG
Siddharth Deshmukh (SD) Chair, Bexley CCG
1. **Introductions, apologies and declarations of interest**

   RW welcomed members to the meeting. Apologies were noted as above. No interests conflicting with the business of the meeting or changes to existing interests were declared. AE recorded his role as a joint appointment with Lambeth Council and confirmed this had been updated on the Lambeth CCG register.

2. **Minutes of the last meeting – 27 September 2019**

   The minutes were approved as an accurate record. RW updated the status of actions included on the log. The action on response to the outstanding workforce questions was proposed to be closed given a number of these questions posed did not relate to areas within the committee’s scope. This was agreed by members and colleagues agreed to pick up outstanding urgent queries through their home organisations. UN confirmed submission of the LPT response and confirmed colleagues will brief CCGs on the details and implications of this at GB part II meetings.

   **The committee reviewed the action log and noted all actions due for September 2019 had been completed.**

3. **SEL CCG Assurance Report – October 2019**

   **SEL Performance Assurance Report – October 2019**

   SC reported that trusts’ emergency department performance remained challenged at all sites, with each provider currently performing below trajectory year-to-date. She said that KCH remained the most challenged, with GSTT and LGT closer to trajectory.

   LGT and GSTT were reported as performing comparatively well against improvement trajectories for 52-week-waiters with KCH further away.

   On the cancer 62 days standards, SC said that LGT had generated some recent improvements in respect of prostate pathways. GSTT had also registered an improvement in overall performance, led largely by improved internal pathways.

   SC reported back from the national pre-winter stocktake for south east London, which has been run as system-focussed calls and has included colleagues from social care, mental health and acute providers. The focus of the stocktakes has been recovery of key constitutional standards. SC reported that the regulator expectation was that all four targets would be recovered by the end of the financial year. SC also reported that a further key area of focus had been the quality and safety of services over winter, with the stocktake looking at some detail at the arrangements in place to review the quality and safety of care.
SC described the actions in place to mitigate pressures in ED. In terms of expectations, GSTT has committed to deliver 90% performance by year end with KCH and LGT looking at achieving targets closer to 80% by the end of the year.

On 52 weeks, there has been regional oversight and KCH has commitment to eliminate 52-week waits from the end of March 2020. SC highlighted a process of national assurance via day long site visits to trusts on 52 week waits. On cancer, KCH and LGT were aiming for 85% by March 2020 and GSTT at this level for internal patients but not overall by year end. For diagnostics all trusts aim to recover performance to the national standard by year end. SC described the actions to deliver these ambitions remained high-risk.

SC described the planning process for 2020/21 emphasising the approach would be bottom-up and look at realistic trajectories and incremental improvement that could be sustained by trusts and the broader system in year.

AH asked about SC’s sense of how the actions asked of CCGs to support demand management were going. SC described the work that was completed collaboratively between the CCGs and ICDT to produce information packs that are then communicated to GPs for action. SC commented that referral pressures are less than have been recorded in previous years, although she noted there is variation on this by pathway and by practice/trust.

RG highlighted a deterioration in RTT 18 weeks performance at KCH. He asked for an update on the status of the LAS contract renegotiation. He also asked about whether there was an issue with 111 response times. SC responded on the first point to say the priority was in reducing 52 week-waiters at KCH. She described the residual issues at KCH and GSTT and said that the plan to recover the 18-week position over the medium term to gradually begin reducing waits. UN confirmed that the CCG had made an agreement with LAS which includes an additional charge of £2.5m for the CCG as part of this. ABh suggested a common issue on 111 performance across London which was linked to retention issues for staff and a greater call volume than planned to the service.

YR commented on some of the challenges with ERS and suggested that anaesthetic delays can often cause delays in cancer pathways. SC described some of the work completed locally to make improvements on ERS. On anaesthetics she suggested there are a range of complexities and pathway issues that can cause delays to happen. She said there is a timing expectation set for each stage of the pathway and this was regularly audited.

SS asked about the educational work with secondary care about alternative care pathways. SC confirmed this was an important part of the team’s work to support the utilisation of alternative care pathways.

RW asked about the degree of control the CCG has over specialised commissioning for transforming care patients in south east London. NKB said he was responsible as SRO for all patients in SEL but did not have responsibility for the specialised commissioners undertaking the brokerage and care planning for these patients. He highlighted workforce issues within the specialised commissioning team, but noted these have been addressed in part and that four patients were expected to receive a discharge date soon.
RW asked about how the data for several performance standards that fell below the SPC range would be considered in setting new year trajectories. SC said that the team plan to take a bottom-up approach to identifying reasonable actions and setting achievable trajectories.

**Deep dive: diagnostics access**

RW invited ICDT colleagues to present the diagnostics deep dive. He praised the papers for their clarity and brevity.

HA described the context and key issues relating to diagnostic performance across south east London. Endoscopy access was highlighted as a key issue. HA described some of the issues with and approaches to performance improvement, including a mismatch of demand and capacity and actions to establish insourced capacity at providers. She reported KCH and GSTT had recently had national bids for CT and MRI scanners to replace older equipment. KCH had similar bid for several CT and MRI scanners and breast screening equipment.

AA described some of the development work and action to support better collaboration between trusts in SEL. She talked through the demand and capacity work completed and the lessons for this, highlighting opportunities to increase utilisation of existing capacity and using equipment more intensively. She highlighted an increase in demand. She also described the work of the Task and Finish group has completed to look at options around training clinicians to undertake some of this endoscopy activity in order to increase capacity. She described wider work on imaging and said that the team would look further at MRI scanners across trusts.

JM asked about variations in clinician-to-clinician thresholds for referral to endoscopy within secondary care and questioned whether these protocols / standards were in place at secondary care and what happens to oversee them. YR asked about the appropriateness of all endoscopy activity. AA said that the group were planning an appropriateness audit for endoscopy and suggested that there was a recognition in secondary care that this pathway and activity may be higher than necessary.

AM asked about virtual endoscopes via imaging and asked whether this activity was counted as part of the data for endoscopy – **Action HA / SC** to review and update. AM also asked about the availability of non-obstetric ultrasounds and asked whether we should be exploring out-of-hospital diagnostics being based in the community. SC and HA gave their view that these services operate efficiently when they are concentrated onto the trust sites.

SM proposed that the audit of appropriateness may not lead to change in practice given that a negative result may not represent an inappropriate diagnostic episode. He commented on the effects of straight-to-test diagnostics as part of pathways. SM asked about the clinical and service fellow roles and questioned whether this offered a longer-term sustainable solution to endoscopy capacity gaps. AA explained the benefits for those opting for these roles and suggested that further work would be under to structure these roles and assess the potential impact.

With reference to slides 7 and 8, the committee discussed the possible medium-term solution to bridging the demand and capacity gaps identified. They discussed the need for a
collaborative and networked approach to utilising workforce and sharing activity across providers.

The committee discussed possibilities for AI to undertake some post-diagnostic reporting.

RG read out questions from Dr Nancy Kuchemann of Southwark CCG. RW read out questions – on health inequalities – from Paul Cutler of Bexley CCG. **Action SC/HA agreed to provide written answers to these questions, where possible.**

**Committee assurance on the reported position**

The committee then discussed and agreed the following levels of assurance in respect of acute performance and performance against transforming care targets:

- Notwithstanding the plans in place to recover performance ahead of year end, the committee is not fully assured on the feasibility in achieving the performance standards or recovery trajectories by year-end for all acute performance standards. The committee agreed a caveat that trajectories may be revised as part of the pre-winter review work.
- The committee is assured that the agreed recovery actions are appropriate and comprehensive.
- The committee is assured that SEL CCGs are delivering the recovery actions / contributions asked of them.
- The committee noted the trusts’ commitment to deliver their action plans but registered a position of not being assured given their recent track-record and future ability to successfully achieve the planned impact from these actions.
- The committee is assured that processes and controls are in place to mitigate the risks to the quality and safety of patient care due to the current performance position and delivery of agreed recovery actions.

It was agreed that A&E and 111, LAS and urgent care would be completed as a single deep dive in December 2019. It was agreed that the January 2020 deep dive would look at quality and safety, and the February 2020 deep dive would look at the future scope of the committee – **Action KS to schedule.**

### 4. SEL CCGs Finance Update – M6 19/20

UN said that the action agreed last month to add comparator page would be included for the M7 report.

UN reported YTD and FOT continue to report on plan for all CCGs, and a £5m contingency has been committed in this position. The drivers for the use of this contingency are outside of the CCGs’ control and include prescribing cost inflation relating to nationally-priced category M drug costs and non-stock drug items; primary care allocation adjustments; and a £6m...
overspend on non-local providers (mainly LAS, Moorfields and University Hospital Croydon), linked to growth in patient flows and new infrastructure being available at these sites.

In terms of position against last year at the same point there was £6m variance to plan; with a net risk position at £26m last year and £11m this year. QIPP delivery is forecasting FYE at 94% vs 87% last year.

UN pointed to slides 6-11 which expands on QIPP reporting and provides members with the detailed QIPP position across SEL. He noted each programme was reviewed monthly and opportunities for learning was also picked-up.

UN agreed to provide further detail on the net risk position and remaining CCG contingencies by CCG into next month’s report – Action UN.

AH asked about continuing healthcare spend and how much was incorporated into the CCG’s risk position. UN confirmed this was £5.6m with CCGs set a target to reduce this risk in the remaining part of the year.

AM asked about the potential for prescribing cost pressures that arise beyond the control of the CCG. UN said that the CCG is not planning for receipt of further external income to mitigate this pressure.

UN reported back on mitigating actions which were agreed via the SEL Executive. He gave the example of recruitment controls and other areas of variable spend. UN also confirmed that boroughs will go through a review of all spend to identify further benefits in-year. It was agreed that an update on these actions would be provided as part of the next report – Action UN.

AB commented that the previous years’ endeavours to reduce costs leave limited opportunity for further savings and asked that GB members take this imperative into account, as they consider business cases and other proposals for spend in the remainder of the year.

The committee noted and approved the M6 finance report.
<table>
<thead>
<tr>
<th></th>
<th><strong>South East London IG&amp;P Board Assurance Framework – October 2019</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>5.</td>
<td>SC reported on the changes made by the team since the last month to reflect the increase in delivery risk. She highlighted the PTL risk as being reduced given the improved performance at GSTT and LGT in these areas.</td>
</tr>
<tr>
<td></td>
<td>NKB confirmed the risk score for TC of 9 and noted this may be reviewed following NHS England discussions.</td>
</tr>
<tr>
<td></td>
<td>ICDT will review the initial and residual score for 52 week waits to check these have been accurately updated. – <strong>Action KS / ICDT</strong>.</td>
</tr>
<tr>
<td></td>
<td>The committee proposed a review of the impact score for the risks relating to control totals for next month. It was proposed this may be reduced from 5 to 4 - <strong>Action UN</strong>.</td>
</tr>
<tr>
<td></td>
<td><strong>The committee approved the BAF for October 2019 and accepted the proposed risk scores for each risk.</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th><strong>8. Any other business</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No items raised.</td>
</tr>
</tbody>
</table>

|   | **9. Date of next meeting:** Friday 6 December 2019 |
Minutes of the meeting of the Strategy & Development Committee held on Thursday 3rd October 2019
Committee Room 1, Civic Suite, Catford

Members
Dr Charles Gostling (CG) Senior Clinical Director, Chair
Dr Esther Appleby (EA) Clinical Director
Debbie Brown (DBr) Clinical Director
Dee Carlin (DC) Head of Joint Commissioning
Dr Sebastian Kalwij (SK) Clinical Director
Dr Faruk Majid (FM) CCG Chair
Charles Malcolm-Smith (CMS) Deputy Director OD and Strategy (notes)
Martin Wilkinson (MW) Managing Director
Tom Brown (TB) Executive Director, Community Services, LBL
Shelagh Kirkland (SKi) Lay Member
David Maloney (DM) Director of Finance

In Attendance
Livia Royle (LR) Lewisham Public Health
Valerie Richards (VR) Equality, Diversity & Inclusion Manager
NELCSU for item 19/32

Apologies
Dr Magna Aidoo (MA) Lewisham Healthwatch Representative
Prof Simon MacKenzie (SMa) Secondary Care Doctor
Catherine Mbema (CM) Acting Director of Public Health
Dr Simon Parton (SP) LMC Representative
Dr Ravi Sharma (RS) Clinical Director
Dr Jacqueline McLeod (JM) Senior Clinical Director
Peter Ramrayka (PR) Lay Member
Andrew Bland (ABI) Accountable Officer
Anne Hooper (AH) Lay Member
Alison Browne (AB) Registered Nurse Member
Dr Angelika Razzaque (AR) Clinical Director
Sarah Wainer (SW) Programme Lead, Whole System Model of Care

SD19/27 Introduction and welcome

The Chair welcomed all to the meeting.

The meeting was not quorate as there was only one lay member present, and neither the registered nurse or secondary care doctor. No decisions were required to be made at the meeting.

SD19/28 Declarations of Interest
There were no new Declarations of Interest.

SD19/29  Summary notes of the workshop on 22nd August 2019

The Group agreed the minutes as an accurate reflection of the meeting. The action relating to membership voting arrangements was completed. There were no further matters arising.

SD 19/30  Brexit Update

MW provided a verbal update on Brexit preparation in the CCG. This includes preparing on an emergency planning and business continuity plan basis. Preparedness is covering workforce, supplies, contracts, fuel shortages and transport problems.

The CCG is working with the council as well as co-ordinating with SEL STP EPRR and Brexit leads, and also an internal Brexit work group. Our risk template submitted the SEL team is all green but subject to review.

There were concerns raised at a recent diabetes meeting about insulin supply and about the information that has been sent out. It was advised that communication is being led by NHSE. TB also updated that the London Resilience Forum has reviewed and is satisfied by the availability of medicines, separate arrangements are being made to ensure supply.

On staffing, MW reported there were small numbers in the CCG. Information had been provided on settled status scheme. From a social care perspective TB advised that it was no expected to be a particular problem for providers. The social care workforce tend to be non-EU nationals. The council is also running a verification process.

Other aspects of planning that the council has been monitoring are to address civil unrest arising from heightened tensions, stocks of fuel for emergency use, and risk to community infrastructure. District nursing and home carers have been identified as priority areas.

Further discussion included need for clarity in communication as some media stories on medicines and vaccination availability that is not related to Brexit are being connected to Brexit.

The medicines management group would review communication about availability not connected to Brexit.

SD 19/31  System Reform & Borough Based Development

MW reported that the application for the SEL CCG merger had been submitted on 30th September, and that the Lewisham membership had voted to support the
proposal. In Lambeth the membership had local concerns that were being addressed.

The application will be considered by NHSE at regional level on 19th October, and a decision is expected by a national panel by mid November.

Draft structures have been circulated to staff with a formal consultation to commence on 18th November.

**Action: MW to share staff communication with Governing Body**

In discussion points raised included the need to recognise differences between and flexibility in arrangements between boroughs. The possibility of a judicial review was raised and risk considered low, there had been indication of any such action at the JOSC.

DM advised that the consultation for the finance teams in south east London had finished and interviews were taking place to implement new structures so that they could be completed by the end of October to transition to a new structure.

MW summarised a slide pack on the future governance structure and role of the Borough Based Board (BBB). The pack had also been considered by Lewisham Health & Care Partners (LHCP). He highlighted the following:

- The BBB will be the commissioning ‘engine room’ to take forward community based care
- There are likely to be two parts to meetings, one as the LHCP with providers and commissioners, the other as the BBB with commissioners only
- The CCG can delegate to BBB through the Borough Based director, though for LBL the Mayor and Cabinet cannot delegate to officers in the same way and for budgetary decisions delegations are very low
- There will be separate terms of reference for BBB and LHCP

There will be different levels of clinical input and leadership, some of which could come from providers to ensure clinical leadership at both an operational and strategic level and continuity of involvement in pathway changes and team working across the system. Budget had been put aside to support clinical involvement.

Arrangements for meetings would be made to link with the business cycle for SEL governing body and Mayor and Cabinet.

The BBB membership and LHCP membership would need to reflect that for the council it would be an officer level group, and the multi-professional nature of providers, and LGT community and acute services.

Potential sub-groups could be management/SMT (for risk management and information governance), professional leadership groups, primary care operational
Areas expected to be covered at BBB include focus on community based care and relevant strategic topics, performance and delivery. Processes and flows of information and data would reflect commissioning point of view. Priority areas of work would be diabetes, respiratory, frailty, mental health.

The meeting divided into two groups for discussion. The feedback from this group work included the need to establish different relationships and ways of working with partners under the new arrangements, and the important contribution that system and organisational development will have.

Next steps will be to develop terms of reference, establish ways of working, co-ordinate timing with Mayor and Cabinet meetings, and further reporting back to the Governing Body on progress and functions.

**SD 19/32 Workforce Race Equality Standard**

VR provided an update on the WRES submission that had been made for the CCG. The report gave a mixed picture in that the CCG is broadly reflective of the community it serves, recruitment and selection has reduced variances between white and BAME applicants, and there was variance in access to training.

Areas of concern would be:

Indicator 5: percentage of Lewisham CCG BME staff stating that they have experienced harassment, bullying or abuse from patients, relatives or the public. The proposed actions agreed are to work with teams that work with the public and lone workers to identify any issues.

Indicator 7: percentage of BME staff believing that the CCG provides equal opportunities for career progression

Indicator 8: BME staff responding stated that they have experienced discrimination at work.

NHSE is expecting implantation of the Model Employer Strategy to support WRES improvement.

The SEL EIA includes recommendations for staffing beyond 1st April.

SK updated on the planned WRES event on 7th November. It would be looking at involving partners in improving workforce race equality in Lewisham. It would share learning and make pledges of commitment for future action. There will be presentations of STP WRES results but with a Lewisham flavour.
SD 19/33    Any Other Business

There were no further items of business.

The next meeting of the Strategy and Development Committee will be 5th December 2019.