AGENDA

A meeting of the Governing Body in public

Date: 10 March 2016
Time: 9:30 – 12:00
Venue: St Laurence Centre, 37 Bromley Road, London SE6 2TS
Chair: Ray Warburton

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

Voting Members

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

Non-Voting Members

Ms Aileen Buckton  Executive Director, Community Services, Lewisham Council
Mr Nigel Bowness  Interim Chair Healthwatch Lewisham
Dr Simon Parton  Chair of Local Medical Council
Dr Danny Ruta  Public Health Director, Lewisham 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 independent members (Lay Members, Secondary Care Doctor or Registered Nurse).

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

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<td>Welcome and introductions</td>
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<td>Chair</td>
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<td>Apologies for absence</td>
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<td>Declarations of Interest</td>
<td>Enc 1</td>
<td>Chair</td>
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<td><em>Members should discuss any potential conflicts of interest with the Chair prior to the meeting</em></td>
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<td>4.</td>
<td>To agree minutes of previous meeting</td>
<td>Enc 2</td>
<td>Chair</td>
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<td>To review the action log</td>
<td>Enc 2.1</td>
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<td>5.</td>
<td>Matters arising</td>
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<td>6. 9.40</td>
<td>Chair’s Report</td>
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<td><em>To receive and note for information</em></td>
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<td>Chair’s Action; to note approval of:</td>
<td>Enc 3.1</td>
<td>Martin Wilkinson</td>
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<td></td>
<td>• Equalities Annual Report</td>
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<td>• Collaborative Framework – copies available on request</td>
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<td>7.</td>
<td>Chief Officer’s Report</td>
<td>Enc 4</td>
<td>Martin Wilkinson</td>
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<td><em>To receive and note for information</em></td>
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<td>8.</td>
<td>Audit Committee Chair’s Report</td>
<td>Enc 5</td>
<td>Ray Warburton</td>
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<td><em>To receive and note for information from the meeting held on 2 February 2016</em></td>
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<td>Lewisham CCG’s Local Auditor Panel and its Terms of Reference</td>
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<td>Ray Warburton</td>
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<td>9.</td>
<td>Finance and Investment Committee’s Chair’s Report</td>
<td>Enc 6</td>
<td>Prof Ami David</td>
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<td><em>To receive and note for information from the meeting held on 19 January 2016</em></td>
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<td>To approve the Finance and Investment Committee’s Terms of Reference</td>
<td>Enc 6.1</td>
<td>Tony Read</td>
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<td>10.</td>
<td>Primary Care Joint Committee Chair’s Report</td>
<td>Enc 7</td>
<td>Rosemarie Ramsay</td>
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<td><em>To receive and note for information from the meeting</em></td>
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### INTEGRATED GOVERNANCE

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<tr>
<td>11</td>
<td>10.15</td>
<td><strong>Board Assurance Framework 2015/16</strong> To receive and agree risks approve the process for 2016/17</td>
<td>Enc 8</td>
<td>Martin Wilkinson</td>
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<td>12</td>
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<td><strong>Delivery Committee</strong> – Chair’s report from the meetings held on January and February 2016</td>
<td>Enc 9</td>
<td>Martin Wilkinson</td>
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<td>13</td>
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<td><strong>Integrated Performance Report</strong> Including Quality, Finance, QIPP and Performance To receive and endorse the reports</td>
<td>Enc 10 Sep Enc</td>
<td>Dr Faruk Majid/ Tony Read</td>
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<td>14</td>
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<td><strong>Governance Review</strong> To receive and approve recommendations</td>
<td>Enc 11</td>
<td>Martin Wilkinson</td>
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<td>15</td>
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<td><strong>Annual Report and Accounts 2015/16</strong> To approve the process and authorise delegated responsibility to the Audit Committee</td>
<td>Enc 12</td>
<td>Tony Read</td>
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<td>16</td>
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<td><strong>Policies for approval:</strong></td>
<td>Enc 13</td>
<td>Martin Wilkinson</td>
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<td>• Safeguarding through Commissioning Policy</td>
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<td>• SE London Treatment Access Policy – to approve delegation to the Delivery Committee</td>
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<td>17</td>
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<td><strong>Questions in relation to agenda items from members of the public</strong></td>
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<td>Chair</td>
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### STRATEGY AND PLANNING

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<td>18</td>
<td>11.30</td>
<td><strong>Strategy and Development</strong> – Chair’s report from meeting held on February 2016</td>
<td>Enc 15</td>
<td>Dr David Abraham</td>
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<td>19</td>
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<td><strong>Potential Audit and Risk Management Issues</strong> To identify any issues which the Governing Body consider would benefit further scrutiny by the Audit Committee</td>
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<td>Chair</td>
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<td>20</td>
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<td><strong>Any Other Business</strong></td>
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<td>21</td>
<td>11:55</td>
<td><strong>Questions from members of the public</strong></td>
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### FOR INFORMATION ONLY
22. **Approved Committee minutes for information only**

- **Delivery Committee** (December 2015 and January 2016)
- **Strategy and Development** (December 2015)
- **Primary Care Joint Committee** (December 2015)
- **Clinical Strategy Committee** (10 August 2015)

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23. **12:00**

**Date of next meeting: 12 May 2016 – St Laurence Centre, 37 Bromley Road, London SE6 2TS**

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, subcommittees 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.
GLOSSARY OF TERMS

AAS Admission Avoidance Service
ACRA Advisory Committee on Resource Allocation
ADASS Association of Directors of Adult Social Services
AEC Ambulatory Emergency Care
A&E Accident and Emergency
AfC Agenda for Change
AHP Allied Health Professional
AHSC Academic Health Science Centre
AHSN Academic Health Science Network
APMS Alternative Provider Medical Services
AQP Any Qualified Provider
ASTRO-PU Age, Sex, Temporary Resident Originated Prescribing Unit
AWP Allocation Working Paper

BDA British Dental Association
BMA British Medical Association
BME Black and Minority Ethnic
BNF British National Formulary
BPPC Better Payment Practice Code

CAMHS Child and Adolescent Mental Health Services
CAS Central Alert System
C&B Choose & Book
CBC Community Based Care

CBT Cognitive Behavioural Therapy
CCG Clinical Commissioning Group
CCNT Children’s Community Nursing Team
CEMACH Confidential Enquiry into Maternal and Child Health
CIO Chief Information Officer
CIP Cost Improvement Programme
CLG Clinical Leadership Group
CNST Clinical Negligence Scheme for Trusts
COPD Chronic Obstructive Pulmonary Disease
CQRG Clinical Quality Review Group
CRL Capital Resource Limit
CPA Care Programme Approach
CPD Continuing Professional Development
CPN Community Psychiatric Nurse
CPR Child Protection Register
CQC Care Quality Commission
CQUIN Commissioning for Quality and Innovation
CRB Criminal Records Bureau
CSU Commissioning Support Unit
CSP Commissioning Strategy Plan
CSR Comprehensive Spending Review
CSS Commissioning Support Service
CVD Cardiac Vascular Disease+
CYP PB Children and Young people Partnership Board

DAAT Drug & Alcohol Action Team
DES Direct Enhanced Service
DGH District General Hospital
DH or DoH Department of Health
DTC Delayed transfer of care

EDS (NHS) Equality Delivery System
EI Early Intervention
EIA Equality Impact Assessment
EIP Early Intervention in Psychosis
EMIS Practice Information System
ENT Ear, Nose and Throat
EPP Expert Patient Programme
EPR Electronic Patient Record
EPRR Emergency Planning Response Register
EPS Electronic Prescription Service
ESR Electronic Staff Record
EWTD European Working-Time Directive

FCE Finished Consultant Episode
FHS Family Health Services
FIMS Financial Information Management System
FLAG For Learning and Action Group
FNP Family Nurse Partnership
LTC Long-Term Conditions

MCATS Musculoskeletal Community Assessment and Treatment Service
MADEL Medical and Dental Education Levy Resignation Scheme
MDT Multi Disciplinary Team
MECS Minor Eye Condition Scheme
MFF Market Forces Factor
MHRA Medicines and Healthcare Products Regulatory Agency
MMR Measles, Mumps, Rubella (vaccination)
MPET Multi-Professional Education and Training
MPIG Minimum Practice Income Guarantee
MRI Magnetic Resonance Imaging
MRSA Methicillin-Resistant Staphylococcus Aureus
MSK Musculoskeletal

NCAS National Clinical Assessment Service Programme
NCEPOD National Confidential Enquiry into Patient Outcome and Death
NCVO National Council for Voluntary
NTDA National Trust Development Authority
NHS National Health Service
NHSE NHS England
NHSE SBS NHS Shared Business Services
NHSLA NHS Litigation Authority

OD Organisational Development
OGC Office of Government Commerce
OHSE Our Healthier SE London
OJEU Official Journal of the European Union
ONS Office for National Statistics
OOH Out of Hours
OP Outpatient Assessment
OSC (local authority) Overview and Scrutiny Committee
PACS Picture Archiving and Communications System
PAED Paediatric
PALS Patient Advice and Liaison Service
PASA Purchasing and Supplies Agency
PBMA Programme Budgeting and Marginal Analysis
PbR Payment by Results
PDP Personal Development Plan
PEG Public Engagement Group
PHE Public Health England
PHO Public Health Observatory
PI Performance Indicator
PMS Personal Medical Services
PNA Pharmaceutical Needs Assessment
POD Point of Access
PPA Prescription Pricing Authority
PPAG Patient and Public Advisory Group
PPE Patient and Public Engagement
PPG Patient Participation Group
PPI Patient and Public Involvement

PPV Patient and Public Voice
PRCC Principles and Rules for Cooperation and Competition
PROM Patient-Reported Outcome Measure

QA Quality Assurance
QALY Quality-Adjusted Life Year
QIPP Quality Innovation Productivity and Prevention
QMAS Quality Management and Analysis System
QOF Quality and Outcomes Framework

RIO System Provider Serviced
RO Responsible Officer
RRL Revenue Resource Limited
RTT Referral to Treatment

SAU Surgical Assessment Unit
SBS (NHS) Shared Business Services
SCG Specialised Commissioning Group
SELDOC South East London Doctors on Call
SFI Standing Financial Instructions
SIRO Senior Information Responsible Officer
SLA Service Level Agreement
SLaM South London and Maudsley Mental Health Foundation Trust
SMR Standardised Mortality Ratio
SNOMED Systematised
Nomenclature of Medicine

SO Standing Order
SOPHID Survey of Prevalent HIV Infections that are Diagnosed
SRO Senior Responsible Officer
SSBU Shared Service Business Unit
STP Sustainability and Transformational Plan
SUS Secondary User Services

TIA Trans Ischaemic Attack- Stroke Indicator
TDA – Trust Development Authority
TSA – Trust Special Administrator
TUPE Transfer of Undertakings (Protection of Employment) Regulations 1981
UCC Urgent Care Centre
UDA Units of Dental Activity

VCS Voluntary and Community Sector
VFM Value for Money
VPR Virtual Patient Record
VSM Very Senior Managers
VTE Venous Thromboembolism

WHO World Health Organization
WIC Walk in Centre
WTD Working-Time Directive
WTR Working Time Regulations
### Section 3: Interests of Board Members

| Name | Role | Interests | Connection with a voluntary or other organisation
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<td><strong>Academic</strong></td>
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<td><strong>Director of Public Health, London</strong></td>
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<td><strong>Director of Adult Social Care Lead Commissioner for Joint</strong></td>
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<td><strong>Director of husband's company</strong></td>
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<td><strong>Partner of Jenner Practice</strong></td>
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<td><strong>Salaried GP, The Vale Medical Centre,</strong></td>
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<td><strong>Interim Chair, Healthwatch</strong></td>
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LEW 16/01 Welcome and Announcements

Mr Warburton welcomed all and informed the meeting that he would, in the absence of Dr Rowland, chair the Governing Body meeting.

LEW 16/02 Declarations of Interest

Prof. David announced that her company AD Community Nursing Consultancy was now known as Quest for Community Health. Dr Parton informed the meeting that practices in Neighbourhood 3 were registered as a limited company. The register would be updated. There were no other new declarations of interest given at this point of the meeting.

LEW 16/03 Previous Minutes

There were 11 members of the public present for the meeting.
The minutes of the previous meeting were taken as a true record.

Mr Wilkinson reported that a governance review was currently underway which would include looking at the timings and venues for Governing Body meetings. A report would come back to the meeting in March 2016.

**ACTION:** Martin Wilkinson

**LEW 16/04  Action Log and Matters Arising**

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

132.2 With regard to information on the involvement of housing organisations in Neighbourhood Care Networks (NCNs), Ms Buckton was unsure what the action referred to. Ms Ramsay clarified that housing issues had been raised at engagement events and Dr Parton added that this action was to do with the communication between the NCNs and housing organisations. Ms Buckton would ensure the framework was circulated to members before the next meeting.

**ACTION:** Aileen Buckton

55 Mr Wilkinson would be reviewing the information on the time commitment for independent members of the Joint Committee for Primary Care Co-commissioning. A report would come back to a Part II GB meeting.

**ACTION:** Martin Wilkinson

It was explained that the actions shown as amber are those which officers have proposed from their point of view were actioned and therefore closed. These could be challenged by Governing Body members.

128 Regarding the GP representative on the Maternity Services Steering Group Mr Wilkinson confirmed that Dr Razzaque was the CCG link for the Early Years work. This could be discussed further at Clinical Directors meeting if needed.

**04.1 Lewisham CCG Annual General Meeting minutes**

The minutes of the Lewisham CCG Annual General Meeting held on 30 September 2015 plus the Questions and Answers raised at the meeting were brought for approval. These would be published on the CCG website.

**The Governing Body APPROVED the minutes of the 30 September 2015 Annual General Meeting.**

**LEW 16/05  Chair’s Report**

Mr Warburton highlighted issues from Dr Rowland’s Chair’s report. Dr Rowland, in his report, said that Lewisham CCG had developed positively, and across southeast London and pan-London CCGs were working effectively together. Mr Warburton said that devolution and the junior doctor’s strike would be covered more fully in the Chief Officer’s report. The Chair’s report highlighted the areas where the CCG had done well in the past year was highlighted:

- Lewisham Integrated Medicines Optimisation Service (LIMOS)
- Leg ulcer healing
- Quality in district nursing
- Referral Support Service
- Flu vaccination
- Dementia diagnosis rate
- Improving Access to Psychological Treatments (IAPT)
- Primary Care
- A&E Waiting times and Friends and Family experience

**The Governing Body NOTED the report**
Mr Wilkinson gave the report and highlighted the following:

OHSEL - Work continued on the Our Healthier South East London Programme (OHSEL). Over 2,000 people had been involved in 2015 in order to develop the strategy to its current state. A public consultation was likely to be held later in 2016 on some of the proposed models of care in six clinical areas. There would be more in future reports.

Devolution – Lewisham CCG and Lewisham Council had signed a cross London Agreement with the aim to support transformation of services and improve health and wellbeing for Londoners with the possible devolution of central powers and flexibilities to London. There were a number of pilots to test arrangements within London to see what central powers and flexibilities might be most helpful. Lewisham had expressed an interest in a pilot around integration through its Adult Integration Programme. A Statement of Intent has been written which includes the three enablers where devolution by working with national bodies to agree may help; estates, workforce models and incentives. An integration plan was being worked on (as per the separate agenda item) with the case for devolution to be developed from this and produced between April - June 2016. In response to a question Mr Wilkinson said that the CCG can withdraw from the pilot if necessary. There was a need to look at the support funding from central government to progress plans for Lewisham and its residents. It was confirmed that it was devolution to London with Lewisham’s pilot helping to test and shape how arrangements across London might move forward. No devolved powers would come to London until the case had been developed and national negotiations had occurred.

Junior Doctors Strike – plans had been put in place in advance of the Junior Doctors strike and no particular problems or issues had been raised in Lewisham, though demand continues for A&E services.

South London and Maudsley (SLaM) Foundation Trust CQC report – the CQC had given a ‘good overall with some areas of improvement’ rating. Dr Martin Baggaley, SLaM Clinical Director would attend the February Delivery Committee to discuss further, this would in turn be reported to the Governing Body through the Delivery Committee’s Chairs report.

Annual Statutory Obligations on Public Engagement report 2014/15 – NHS England’s (NHSE) assessment of the CCG’s delivery of its statutory obligations was consistent with an assurance level for patient and public participation activity of overall good with multiple elements of outstanding. Mr Wilkinson praised the engagement team and PEG (Public Engagement Group) in fulfilling the statutory duties and more.

The Governing Body NOTED the report

Prof David, as Chair of the Finance and Investment Committee (FIC), presented the report from the meeting held on 17 November 2015. She reported that that there were three specific areas discussed at the meeting for the Governing Body to consider and approve:

1. That the Committee should strengthen its role in terms of scrutiny over the CCG’s major procurements.
2. The current delegated financial limits are stated as the lifetime of the project proposed. It was agreed that it was more practical to express delegated limits in terms of £ per annum. The recommended delegated limit would be a maximum £500k per annum (revenue).
3. The Committee would routinely conduct its business in confidence and would report to Part II Governing Body. Where matters are public it would report also to Part I Governing Body.
Approval at the meeting was given to an Outline Business Case for procurement of an end to end MSK and pain referral assessment and treatment service, excluding self-referral.

The Committee endorsed, with caveats, the recommendation to extend the RSS (Referral Support Service) pilot for an additional period of up to 18 months.

Mr Warburton added that the FIC’s Terms of Reference would need to be revised to cover the areas 1-3 detailed and brought to Governing Body for approval.

**ACTION: Tony Read**

Mr Read continued that currently the delegated limits are £1.5m lifecycle costs, if the Governing Body agreed the new limit of £500k per annum limit this would be reflected in the revised terms of reference.

Dr Parton said that the Referral Support Service (RSS) should streamline proposals for referrals with an aim to reduce acute sector spend. Dr McLeod added that patient feedback provided alerts to areas not working well which would lead to discussions with providers on changes needed to be made.

**The Governing Body APPROVED in PRINCIPLE recommendations 1 and 3, subject to a revision of the Terms of Reference and APPROVED in FULL recommendation 2 to change the Committee's delegated limit to £500k (revenue) for any project proposed.**

**LEW 16/08 Primary Care Joint Committee (PCJC) Chair’s Report**

Ms Ramsay gave the report as Chair of the PCJC. The report was from the meeting held on 10 December 2015 which was hosted by Lewisham. She highlighted the following:

- **Primary Care Finance** – figures to 31 October 2015 indicated an under-delivery QIPP and that work was underway to resolve the situation.
- **Quality and Performance** – overall the majority of Lewisham GP practices, when benchmarked against the national performance for satisfaction, remained high but that there were areas which required consideration including the increase of where confidence and trust in primary care professionals in GP practices was lower than the national average. A joint report from NHSE and the CCG would be developed for review at the January 2016 Primary Care Programme Board and the PCJC in February 2016.
- **Primary Care Premises Infrastructure** – NHSE had announced a £1bn, four year investment programme in primary care infrastructure in England. The scheme would be named the Primary Care Transformation Fund.
- **Personal Medical Services (PMS) Review** – a three month extension to the PMS review was given by NHSE. There would be further engagement with the membership and members of the public.
- **Primary Care Programme Board (PCPB)** – each CCG has specific borough-based business which it would take to the PCPB, which held its inaugural meeting on 25 November 2015. There was endorsement for the equalities objectives for Primary Care to support the CCG’s intention to reduce the gap between Black and Minority Ethnic (BME) patients and White British experience in feeling supported coping with long term conditions.

Further details from the meeting on 10 December can be found on the Lewisham CCG website on the about us page.

Dr Parton stated that though the funding for premises infrastructure was welcomed he was disappointed about the timelines that practices had been given (two weeks) for preparing a presentation towards this funding.

Dr Abraham, recognising that he as a GP had a conflict of interest, asked that at the PCJC has Lewisham a voice that’s heard. He also highlighted that due to growth in the number of Lewisham residents there was a lag effect between treatment and funding for GPs. He acknowledged the paradox of the high level of satisfaction at GP practices and the lower level of trust of primary care professionals.
New systems had improved access and Dr Abraham queried how the work of the joint committee can contribute to an answer to how to improve patient outcome and experience.

Ms Ramsay added that most business and debates took place at the PCPB whose membership includes public health and NHSE. The PCJC raises the profile of what has been agreed.

Mr Wilkinson responded that Lewisham had been vocal at the PCJC, in particular in relation to the PMS reviews where some issues were common across SE London CCGs. He added that full delegation of Primary Care co-commissioning at Level 3 was an option for Lewisham CCG yet to make.

Regarding the PMS Review, Mr Read said that the CCG cannot individually give financial verification of information as it does not have access to the finances of GP practices, these are held by NHSE.

Ms Ramsay added that during a telecom with PCJC Chair’s the pertinent questions raised by Lewisham were recognised, but that was a need to ensure that members of the public understand the process of the PCJC.

In response to Dr Abraham on whether there was a common sense of process with NHSE on the access and outcomes for patient encounters and the benefit for money invested, Ms Ramsay explained that this was discussed at the December meeting where it was agreed that a range of areas including equality and communications needed to be taken forward.

The Governing Body NOTED the report

LEW 16/09  Board Assurance Framework (BAF) 2015/16

Mr Wilkinson gave the report and highlighted the following:

- Following the review of the risk register at the Risk Management Group’s meeting in December work was underway to revise the risk Q6 \textit{provider services do not deliver against contracted performance and/or quality standards} so that risks to achieving constitutional commitments are listed separately. The work would be completed in time to be reviewed by the Delivery Committee at the end of January 2016.
- Internal Audit had awarded a ‘Significant Assurance with minor development opportunities’ from their review of the CCG’s risk management processes.
- Work has continued to implement the new Datix Risk Management system, which would improve the tracking of risks and the format, including the font size, of the BAF.

Mr Bowness asked for an update on risks N2, PE1 and PE2 that had actions dates for January 2016. Mr Wilkinson responded that:

- N2 \textit{- the Adult Integrated Care Programme is not effective} - in January the critical pathway would be looked at, there was a presentation regarding the Adult Integrated Care Programme Board later on the agenda.
- PE1 \textit{- Public participation is dominated by single of limited issues and not the wider change} there were working sessions with OHSEL to develop a ‘you said we heard’ report with a deliberative event.
- PE2 \textit{- Public engagement is not perceived to be meaningful} – there was to be a meeting in January for feedback on OHSEL workshops including planned care, maternity services and emergency care.

In response to the point from Mr Bowness that messages should be factored in regarding the risk in relation to devolution and how it would be managed, Mr Wilkinson said that the neighbourhood teams and devolution programme would reflect on communication processes.

Mr Warburton concluded that the risk workshop scheduled for 4 February would help form the Governing Body’s understanding of its tolerance of risk.
The Governing Body NOTED the report and APPROVED the Board Assurance Framework

LEW 16/10 Delivery Committee Chair’s Report

Mr Wilkinson gave the Chair’s report from the Delivery Committee meetings of 26 November and 17 December 2015. He highlighted the following:

- Recovery on the 62 day cancer wait from GP referral to treatment – there was concern that this standard was not being achieved; work was underway with the Lewisham and Greenwich NHS Trust (LGT) on a recovery plan. Additional staff resources had been found by LGT with some financial support from the CCG to improve patient tracking. Revised South East London governance has been put in place to manage delivery across providers as many patients require expertise across the cancer network of providers.
- Quality assurance and escalation processes – the levers available to support the work to manage delivery of contracted commitments by providers.
- System resilience – Winter plans had been discussed. There had been challenging times though the performance was better than last year. Work was ongoing with councils on discharge issues.
- South East London CCG Collaborative framework – the existing agreement was discussed. The Committee supported Chair’s action for the agreement following delegated agreement at the July Governing Body. The final version would be signed by Chair’s action and reported to the March Governing Body meeting.

**ACTION: Martin Wilkinson**

- Quality – the CQC report for the London Ambulance Service had been published with an overall rating of ‘Inadequate’ and the Trust was placed in special measures. The CCG, among others, was holding them to account.
- Emergency Preparedness, Resilience and Response (EPRR) – the Committee received positive assurance that the CCG was aware and prepared for its EPRR responsibilities and the assurance score of ‘substantial’ against the NHSE Core Standards.

Dr Parton pointed out that referring more people for cancer diagnosis/treatment would have an effect on treatment times, which was an area that the cancer networks would need to pick up. Regarding treatment pathways which crossed providers, Dr Parton asked if has timings had been looked at? Mr Wilkinson responded that they had looked at transfer times within pathways, which was around 38-42 days, though there was some concern around diagnostics. Further work was required at SE London level to look at how providers work together.

In response to a question from Dr Abraham, Mr Read confirmed that LGT had an existing patient tracker system. The internal processes leading into the tracker had raised issues which were being addressed.

The Governing Body NOTED the report

LEW 16/11 Integrated Performance Report

Mr Read gave the report which presented information by exception and focussed on the challenging issues.

He highlighted the following:

- The exception report for Cancer Waits relating to 62 days from GP Referral to Treatment. The original trajectory from October was not achieved; there would be a new trajectory with an action plan from January.
- RTT – This was being achieved within 18 weeks but there were concerns about some specialities; trauma and orthopaedic, ENT and gynaecology. LGT had put a mitigation plan in place for additional capacity which includes the cleansing of data. This would be a risk in
February as performance was now close to 92%. Kings College had not met the standard all year.

- A&E 4 hour standard – the performance at Lewisham Hospital site was above the standard but was below at QEH, which meant that overall LGT had not met the standard, though performance was better this year than last.
- Finance – at Month 8, the CCG was forecasting to deliver its planned surplus at year-end and is meeting all targets within the budget area. The Better Practice Payments Code (BPPC) was achieving over 95%. The CCG has a negative balance sheet as it holds no fixed assets, it holds a low cash position, and has low debtors and high creditors, which was normal for CCGs due to the nature of their business.

Dr Parton asked whether the 4 hour target for A&E was measuring clinical care and could the CCG start to develop locally a position that the right patients were being seen in the appropriate area. Mr Read said that admitting patients was not always the appropriate pathway. Short term admissions had increased, and the reason for this needs to be understood and addressed.

Dr Abraham added that a dialogue had been started with LGT to understand some of these issues. In relation to RTT was the contract in place sufficient? Mr Read responded that additional capacity had been bought within contract in particular in orthopaedics. There was confidence that this was the right action to deliver the standard.

Mr Bowness queried the Improving Access to Psychological Therapies (IAPT) standard. Mr Read explained that a review of patients who have been in the service for a long time and have exhausted all treatment options had been held. A business case was being developed for Psychological Therapies for those patients who did not meet the criteria for IAPT services.

The Governing Body NOTED the Integrated Performance Report

LEW 16/12 Briefing on 2016/17 Comprehensive Spending Review

Mr Read reported that the detail on the Comprehensive Spending Review was now available. His presentation would be an early view, with more detail to come at a later date. The slides circulated at the meeting would be published on the CCG website. He highlighted the following:

- NHSE Comprehensive Spending Review Settlement - The England budget from 2016/17 to 2020/21 was increased by £8.4bn. This was to be loaded at the front end in 2016/17 and back end in 2020/21. Of this amount £1.83bn was for sustainability and transformation.
- NHSE had issued a mandate which had nine national priorities including constitutional targets
- Two separate but connected plans needed to be submitted; a five year sustainability and transformational plan (STP) for 2016/17 to 2020/21 which would drive forward the Five Year Forward View, and an organisational based one year operational plan for 2016/17
- The CCG allocations, which had recently been received, gave new formulas for calculating the CCG allocation targets, the change being on sparsity of population and ambulance journey times. Updated information on inequalities had been used. Lewisham starts 2016/17 at 5% above target though the policy would be to bring the CCG to target over 5 years.
- The specialised services and primary care support services allocations would be set at CCG level.
- A minimum of £10m of efficiency savings would be need to be delivered to meet a balanced plan by the CCG in 2016/17.

Dr Parton raised how demand would be managed with the planned cuts at local authority level. Mr Read responded that the new primary care target for Lewisham was less that the NHSE target. The CCGs that are over target would receive below average inflation rises and vice-versa, this would be the same for specialist services and primary care support services allocations. From 2017/18 there would be a single aggregated allocation.
In response to Ms Buckton asking if the STP would require substantial change? Mr Wilkinson stated that work would continue with SE London but that the direction of travel for the strategy would need a refresh. Current models and ways of working would not change. Ms Buckton further asked if there was work being undertaken on future funding for integration work and, in particular, on the real growth on costs of staff. Mr Read agreed that more work needed to be undertaken locally.

Ms Buckton confirmed that the national cuts on public health budgets were on top of in-year spending reductions

Ms Ramsay suggested that STP/ medium term planning was a good topic for a Governing Body workshop.

**ACTION:** Martin Wilkinson/Susanna Masters

**The Governing Body NOTED the report**

**LEW 16/13 Questions in relation to agenda items from members of the public**

Q. Where is demand factored into the target allocation?

A. Mr Read said that there are milestone estimates for population changes which are based on the Office for National Statistics and GP list size.

Q. Is the budget set in stone? For example; if there was inflation or a recession which affects the country as a whole, could the budget change?

A. Mr Read said that it was the first time that CCG’s had received 3 year confirmed allocations. The first 3 years are considered as fixed and the final 2 years of the 5 year planning period are indicative. In addition to CCG allocations there is £2bn budgeted at a national level to support NHS sustainability and transformation. It is not yet known how that may benefit Lewisham citizens.

**LEW 16/14 Strategy and Development – Chair’s Report**

Dr Abraham gave the report from the meeting held on 10 December 2015. The main areas covered included reports on CCG outcomes indicators and indicative procurement plans for 2016-17, the strategic development of the Healthy London Partnership, the CCG’s IM&T Strategy, and the CCG’s Estates Strategy. He presented the Transforming Urgent and Primary Care Services paper and highlighted:

- There was a national requirement for the CCG to review Urgent and Emergency Care.
- Regionally the OHSEL was in place
- The importance of Integrated Urgent Care (formally 111) requirements
- Locally the Primary Care Development Strategy was crucial to Neighbourhood Care Networks (NCNs) which aims to reduce the demand on urgent care.
- The importance of listening to patients and public
- The case for change includes looking at what is appropriate attendance at A&E, and how to achieve value for money and the best outcomes for our residents.
- The proposal is for an Integrated Primary and Urgent Care Service on the hospital site which would replace existing access via A&E for all walk-in attendance. There would be walk-in appointments to primary care, with more delivered in the Neighbourhood hubs.
- All of the above to be underpinned by good communications and IT
- NCNs would offer shared delivery of primary and urgent care services across the four neighbourhoods.
- The changes would start in 2017/18 with preparatory work already underway.
- They would affect all community and providers services
Referring to the diagram of the service, Dr Abraham confirmed that the format of the hubs is out for discussion. It was agreed to bring back the public engagement plan which would include clarity on the diagram when completed.

**ACTION: Dr David Abraham**

**The Committee NOTED the report**

**LEW 16/15 Annual Equalities Report**

Mr Wilkinson presented the Annual Equalities Report which sets out how the CCG has commissioned services during 2015 whilst fulfilling the aims of the Equality Act 2010 and reducing health inequalities as required by the Health and Social Act 2012. The report had been to the Strategy and Development Committee in draft form. The requirement was to publish on the CCG’s website by 31 January.

The Equality Delivery System (EDS) has four goals:

1. Better health outcomes
2. Improved patient access and experience
3. A representative and supported workforce
4. Inclusive leadership

Case studies assessments were used for goals 1&2, which had been graded as ‘excelling’ by an external panel, in line with the EDS tool. Lessons to be learned would apply to the broader intentions.

Prof David raised the issue of support to members of the African and Caribbean community with long term conditions. An action from the survey included how to hear the views from seldom heard communities. Mr Wilkinson added that more outreach services were needed in order to get their voices heard. Ms Ramsay continued that JPEG were reviewing ways of integrated working in discussion with key partners.

Ms Buckton pointed out that the report does not reflect all the work which the CCG has supported on areas such as; Learning Disabilities, hate crime work and domestic violence. A way of cross referencing supported work needs to be found. Mr Wilkinson said that these examples should to be included by 31 January 2016.

**ACTION: Ms Aileen Buckton to supply list**

Mr Warburton said while the CCG had made good progress on equality, he was uncertain that we were ‘excelling’ with regard to health outcomes and patient access and experience across all the protected characteristics. He cited the issues with responsiveness to complaints and lengthy RTTs for some patients. He added that to a degree our EDS performance was contingent on the performance of our providers. Mr Warburton asked if the nine protected characteristics were used in the case studies and whether written comments he had already provided had been taken on board. Mr Wilkinson responded that a process had been followed had been discussed further in the Strategy and Development Committee. He acknowledged that there were lessons to be learned.

Material on which the grades were based be made available before Chair’s action taken to approve the Annual Equality Report 2015-16 before publication on 31 January 2016.

Mr Warburton welcomed this suggestion, and emphasised that the CCG is on a journey and is setting a good standard, and should be commended.

**The Lewisham CCG's Annual Equality Report to be APPROVED by Chair's action before 31 January 2016**

**LEW 16/17 Lewisham Adult Integrated Care Programme**

Mr Wilkinson presented the report. He stated that this was a substantial shift in the way of working; he highlighted that:
It was a way of working differently using a whole system model of care with a shared view between the CCG, Lewisham Council, emerging GP Federations, LGT and South London and Maudsley Foundation Trust (SLaM) to deliver the vision for Neighbourhood Care Networks (NCNs).

An implementation plan for 2016/17 was being worked on.

A report would come back to the Governing Body with specific outcomes, measures and goals for 2016/17.  

ACTION: Martin Wilkinson

There was intensive engagement during 2015 with the public informing us on what they want, which included; co-ordinated care, teams to be developed locally, improved services, more diverse ways of communicating and a focus on prevention.

Four NCNs are being developed in Lewisham to bring together the different organisations which would have a continued focus on improving quality and maintaining safety.

There would be a need to develop infrastructure such as estate.

The Adult Integrated Care Programme Board (AICPB) provides the leadership with representation from all the key organisations.

The programme is supported by Better Care Fund investment with schemes and scheme managers in place.

There would be a comprehensive Directory of Service and website which can be used by users, carers and service providers providing a kept up to date resource.

There would be a single point of access building on Phase I which brought Social Care and Advice Team and district nurses together.

Further work is underway to improve the referral processes between the NCNs and mental health with a workshop being held on 25 January.

Co-location of the NCTs was being rolled out in Neighbourhood 1, this should be operational by April 2016. An options appraisal for the other three neighbourhoods is being developed.

A review of the Neighbourhood Team Co-ordinator role has been undertaken with the current job description being updated to reflect the focus of the role and improve the NCTs effectiveness.

The main purpose of the NCTs was to support independence for individuals and co-ordinated care. Enhanced care and support (ECS) was a set of coordinated interventions for up to six weeks to support crisis or deterioration.

To enable the requirements of the Lewisham Adult Integrated Care Programme estates, workforce and IM&T areas are being worked on.

Preventive work with children’s and maternity services need to be brought into the work.

A further report would come back to the Governing Body in March. The AICP would feature in corporate objectives and the Operating Plan.

ACTION: Martin Wilkinson

Ms Buckton said that there was a legal duty to integrate; she would like to see a timeline added to the presentations made. Mr Warburton added that finances should also be included.

Mr Wilkinson said that the teams are operational now but were looking at better co-locations, working with staff, and looking at the different ways of working.

In response to a comment by Dr McLeod regarding voluntary organisations as contributors, Mr Wilkinson stated that GP Federation representation is included on the AICP Board and voluntary organisations contribute via the HWBB. He acknowledged that there was a need to link to existing structures including ‘stronger communities’. Ms Buckton added that voluntary organisations are working in partnership with the council on community resilience.

Prof David suggested looking at staff from LGT coming into the community team. Ms Ramsay added that there should be timely communications with updates going to stakeholder meetings. She added that we need to look at how to engage the public, and that JPEG would look at the role of the AICP.

ACTION: Rosemarie Ramsay
Mr Wilkinson confirmed that communication and engagement was being increased around the programme.

The Governing Body RECEIVED the update

LEW 16/18  **Potential Audit and Risk Management Issues**

Mr Warburton said that the changes to the BAF and the risk workshop would be discussed at the Audit Committee on 2 February 2016.

LEW 16/19  **Any Other Business**

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

LEW 16/20  **Questions from Members of the Public**

Q. Can a diagram be produced of how the AICP works, and the drivers into it.
A. Mr Wilkinson said that the AICP was on a journey to develop the NCNs, he would think of a way of describing it diagrammatically.

Q. One member of the public mentioned they had a dementia test following a flu jab at his GPs, and asked if this is that common practice throughout the borough? The individual highlighted the Pensioner Forum event on dementia to be held on 27 January at the Civic Suite at 10:30am. It would be good to have GP attendance.
A. Dr Kalwij said that the dementia test was a good idea but not common at practices following the flu jab. Dementia testing was regularly carried out at GP surgeries.

There were no questions raised at this stage of the meeting.

LEW 16/21  **Reports Taken for Information**

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

- Delivery Committee (August and September 2015)
- Strategy and Development Committee (August 2015)
- Health and Wellbeing Board (July 2015)

LEW 16/22  **Date of Next Meeting**

The next meeting of the Governing Body would be held on Thursday 10 March 2016, St. Laurence Centre, 37 Bromley Road, London SE6 2TS
<table>
<thead>
<tr>
<th>Minute Ref</th>
<th>Action</th>
<th>Owner</th>
<th>Agreed at meeting</th>
<th>Due Date</th>
<th>Status</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>Engagement plan for the Neighbourhood Care Networks and clarity on the Integrated Primary and Urgent Care service diagram to come back.</td>
<td>Dr David Abraham</td>
<td>January 2016</td>
<td>When completed</td>
<td>Open</td>
<td>A Service Specification is being developed. A full Engagement and Communication pack will be circulated for information when finalised.</td>
</tr>
<tr>
<td>15</td>
<td>List of collaborative work between CCG and Local Authority for the Annual Equalities Report to be supplied</td>
<td>Aileen Buckton to Valerie Richards</td>
<td>January 2016</td>
<td>Deadline of 31 January has passed.</td>
<td>Open</td>
<td>This was not feasible in the given time for 2015/16 Annual Report. A process is being set up to facilitate greater sharing of collaborative work for future reporting.</td>
</tr>
<tr>
<td>17.1</td>
<td>JPEG to look at the way in which the Adult Integrated Care Programme is engaging the public</td>
<td>Rosemarie Ramsay</td>
<td>January 2016</td>
<td>To be confirmed</td>
<td>Open</td>
<td>The current way JPEG is working with partners and the different Programme Boards is being reviewed to improve the effectiveness of sharing the experience and learning across Lewisham.</td>
</tr>
<tr>
<td>130.1</td>
<td>OHSEL - JPEG to look at the involvement of the council and voluntary organisations in co-ordination in the capture of local</td>
<td>Rosemarie Ramsay/Charles Malcolm-Smith</td>
<td>Nov 2015</td>
<td>Date of next meeting to be confirmed</td>
<td>Open</td>
<td>To go to next JPEG meeting.</td>
</tr>
<tr>
<td>132.2/16.04</td>
<td>In relation to communication between NCNs and housing associations the framework would be sent</td>
<td>Aileen Buckton</td>
<td>Nov 2015 and Jan 2016</td>
<td>TBC</td>
<td>Open</td>
<td>Outstanding action</td>
</tr>
<tr>
<td>17</td>
<td>Lewisham Adult Integrated Care Programme – a report to come back with specific outcomes, measures of success and goals for 2016/17</td>
<td>Martin Wilkinson</td>
<td>January 2016</td>
<td>To be confirmed</td>
<td>Open</td>
<td>The programme priorities for 16/17 are currently being developed and these will be reported to the Governing Body once finalised.</td>
</tr>
<tr>
<td>03</td>
<td>The Governance Review to come to the March meeting</td>
<td>Martin Wilkinson/Susanna Masters</td>
<td>January 2016</td>
<td>March 2016</td>
<td>Action to be closed</td>
<td>Report is on the March agenda for the Governing Body</td>
</tr>
<tr>
<td>07</td>
<td>Finance and Investment Committee Terms of Reference to come to March meeting</td>
<td>Tony Read</td>
<td>January 2016</td>
<td>March 2016</td>
<td>Action to be closed</td>
<td>FIC Terms of Reference are on the March agenda for the Governing Body</td>
</tr>
<tr>
<td>10</td>
<td>SE London CCG Collaborative Framework to be supported by Chair’s action and reported back to the meeting.</td>
<td>Martin Wilkinson</td>
<td>January 2016</td>
<td>March 2016</td>
<td>Action to be closed</td>
<td>This is referred to on the Chief Officer’s report in March 2016</td>
</tr>
<tr>
<td>128.2</td>
<td>A report on maternal deaths to be taken to FLaG and reported back to Part II Governing Body</td>
<td>Dr Faruk Majid/Alison Browne</td>
<td>Nov 2015</td>
<td>February 2016 FLaG meeting Part II Governing Body meeting</td>
<td>Action transferred to Part II Governing Body</td>
<td>The report is not yet published; to be considered by FLaG. This action is moved to Part II Governing Body</td>
</tr>
<tr>
<td>132.1</td>
<td>An action on how to tackle health inequalities would be taken back to the Adult Joint Strategic Commissioning Group.</td>
<td>Martin Wilkinson/Susanna Masters</td>
<td>Nov 2015</td>
<td>March 2016</td>
<td>Action to be closed</td>
<td>Reported through the Corporate Objectives item which is on the March agenda.</td>
</tr>
<tr>
<td>134</td>
<td>A report on the impact of the</td>
<td>Aileen Buckton</td>
<td>Nov 2015</td>
<td>February 2016</td>
<td>Action to be</td>
<td>The Adult Joint</td>
</tr>
<tr>
<td>55</td>
<td>Further information on the time commitment for members of the Joint Committee for Primary Care Co-commissioning would be given when known.</td>
<td>Martin Wilkinson</td>
<td>July 2015 &amp; Jan 2016</td>
<td>June Remuneration Committee and</td>
<td>Action transferred to Part II Governing Body</td>
<td>Commissioning Group discussed this item on 13 January</td>
</tr>
</tbody>
</table>

**CLOSED ACTIONS AT JANUARY 2016 MEETING**

| 32 | Quality arrangements within contracts to be made explicit through the Delivery Committee Chair’s report. | Martin Wilkinson | March 2015 | November Delivery Committee | Closed | A report was taken to the Delivery Committee which summarised the contractual arrangements as part of NHS Standard Contract, to escalate quality issues and concerns. Please see Delivery Chair’s report in November 2015 |

| 80 | Issues around risk appetite and tolerance would be discussed at the Risk Management Group with a report to the Governing Body | Martin Wilkinson/ Graham Hewett | July 2015 | February 2016 workshop | Closed | The February 2016 Workshop on Risk Appetite has been held. |

| 121.1 | An update report on the Adult Integrated Care Programme to come back to the meeting. | Martin Wilkinson | Nov 2015 | January 2016 | Closed | To be reported through the regular update in the Chief Officer’s report. |

<p>| 127 | The review period and termination clause for the S75 agreement for Children’s Community Services | Tony Read | Nov 2015 | January 2016 | Closed | To be reported through the Chief Officer’s report in January and |</p>
<table>
<thead>
<tr>
<th>Issue</th>
<th>Description</th>
<th>Responsible</th>
<th>Date</th>
<th>Date</th>
<th>Status</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>128</td>
<td>To clarify whether there was a GP on the Maternity Services Steering Committee</td>
<td>Justine Roberts</td>
<td>Nov 2015</td>
<td>December 2015</td>
<td>Closed</td>
<td>There is a GP representative from Greenwich on the Maternity Commissioning Steering Group which supports trust wide working. There are plans to secure a Lewisham GP</td>
</tr>
<tr>
<td>120</td>
<td>A link to be sent to Ms Buckton regarding the PCJC on the CCG website.</td>
<td>Lesley Aitken</td>
<td>Nov 2015</td>
<td>December 2015</td>
<td>Closed</td>
<td>Link sent on 1 December to Ms Buckton</td>
</tr>
<tr>
<td>121</td>
<td>How to reflect the risks more clearly on the BAF would be reviewed</td>
<td>Martin Wilkinson/Graham Hewett</td>
<td>Nov 2015</td>
<td>December 2015</td>
<td>Closed</td>
<td>The Risk Register was reviewed at the Delivery Committee and Risk Management Group</td>
</tr>
<tr>
<td>128.1</td>
<td>The information on infant mortality in Lewisham to be available on request to Governing Body members.</td>
<td>Dr Danny Ruta</td>
<td>Nov 2015</td>
<td></td>
<td>Closed</td>
<td>This information can be access through the JSNA website <a href="http://www.lewishamjsna.org.uk">www.lewishamjsna.org.uk</a> under the public health Information portal on the site where graphs and data for a whole host of indicators of mortality and morbidity is published.</td>
</tr>
<tr>
<td>103</td>
<td>A report on complaints regarding nursing services to be taken to FLAG and reported to Delivery Committee</td>
<td>Alison Browne</td>
<td>Sept 2015</td>
<td>December Governing Body</td>
<td>Closed</td>
<td>FLAG received the Lewisham and Greenwich Trust Complaints report in November.</td>
</tr>
</tbody>
</table>
It is sometimes difficult to realise how much is happening around health and social care in Lewisham, across London and nationally given the volume and the space to reflect on progress across the sector. My natural desire is for positive change to happen much faster. This especially applies to primary and community care in its broadest sense. At the moment it is getting the worst of all worlds with high workload, reducing budgets, not meeting patient expectations and consequent feedback, impacting on morale. This applies to many frontline staff. Pharmacists have been in the news this week.

On the positive this gives us great opportunities to link up between frontline staff, such as GPs with Pharmacists and provide better integrated services, clearer pathways and access to our population to deliver better outcomes from care. We can also use the pressure on mental health and secondary care services to achieve the same but it will need courage and we won't always get things right first time. We need to take the positives where possible.

NHSE certainly understand the problems in primary care and more money is being directed towards it to deliver system wide benefits. It is difficult to know how much will be available locally to use to help tackle existing problems and take forward developments.

Our clear objectives are to develop primary and community based care and integrate care across Lewisham linking with neighbouring systems as makes sense but this must link in with provision of services in secondary care as international experience, such as in the Netherlands, shows that it is essential we get the balance right.

At the moment it is a difficult time for both commissioners and providers. The last quarter of the financial year is always a challenging time for the CCG, as it is required to submit a balanced financial plan which delivers local priorities, meets national standards and requirements whilst in parallel secure contracts with our key acute, mental health, community and primary care providers. But this year it seems even more difficult than usual with the late notification of national guidance, a much tighter financial position across the Lewisham health and care system and continuation of growing demand for healthcare. Within the Governing Body agenda papers you will see how we plan to address these challenges during 2016/17.

For me these difficulties emphasise the importance of us seeing this as an opportunity to change from a reactive health service to a more preventive one, orientated more to what patients realistically can expect and want from a service and lessen unrealistic, media driven expectations. This approach will take courage and has risks.

The GP federations are starting to work well as providers and, working with the conflict of interest issues, we are hopeful of getting effective contracts in place between them and our CCG for the new financial year. The new underpinning one Federation company, P5 (Provider 5) is coming on steadily and should be operational soon.
Lewisham is developing steadily and effectively in our own way working closely with all our stakeholders and most especially with our council and population. We must ensure the next few years set firm foundation for the health and social care outcomes we all expect to see for our population, working closely with them.

Dr Marc Rowland
3 March 2016
CHAIR'S ACTION

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

Title: Annual Equalities Report January 2016

Recommendation proposed:

The draft Annual Equalities report was presented to the Governing Body at its meeting on 14th January. Further background to the proposed Equality Delivery System (EDS) gradings was requested before approval by Chair’s action.

A meeting was held on 26th January to review the EDS process and gradings, and agreed revised gradings for EDS goals 1 and 2 that were incorporated into the report with other changes proposed by the Governing Body. Background material on the EDS grading had been distributed beforehand to all Governing Body members. Participants at the meeting were the CCG Chair, Chief Officer, both Lay Members, Corporate Director, Deputy Director (Strategy & OD), South East CSU equalities lead.

Rationale for Chair's action:

Publication of the annual equalities report by 31st January is a statutory requirement.

Further action required:

Approving Lay Member: Ray Warburton (Audit & Governance Lead)

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

Signature: [Signature]
Date: 2/3/16

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

Signature: [Signature]
Date: 2/3/16

Date of Governing Body meeting:

CCG Chair: Dr Marc Rowland   Chief Officer: Martin Wilkinson
CHAIR'S ACTION

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

Title: Collaborative Framework between South East London CCGs

Recommendation proposed: To support Chair's action for approval of the Collaborative Framework across the six CCG's in South East London.

The South East London CCG's Collaborative Framework was considered and approved in principle by the six CCGs in December 2015/January 2016, which included agreement that each CCG delegated authority for the final sign off to their Chair and/or Chief Officer. Lewisham CCG considered the South East London Collaborative Framework at the December Delivery Committee meeting where it was agreed that Chair's action would be taken by the Chief Officer as Chair of the Delivery Committee. Some minor improvements were suggested by Lewisham CCG (as detailed below) which have been incorporated in the final version which was signed off by the Chief Officer and other SEL Chief Officers on 26 February 2016.

<table>
<thead>
<tr>
<th>Request</th>
<th>Action</th>
</tr>
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<tbody>
<tr>
<td>Principle of health inequalities referenced</td>
<td>Now referenced in the Executive Summary purpose</td>
</tr>
<tr>
<td>Re-title section 5 to reflect scope and reference to Sustainability and Transformation planning</td>
<td>Section title changed. Planning guidance referenced.</td>
</tr>
<tr>
<td>Helpful in section 5 to also reference EPRR policy and collaborative work.</td>
<td>EPRR referenced in section 5</td>
</tr>
<tr>
<td>Appendix 3 Table 1 under LGT, please show Lewisham CCG as Lead CCG.</td>
<td>Changes made as requested.</td>
</tr>
<tr>
<td>Appendix 3 Table 3 Lewisham CCG has hosting role for SLAM and co-ordination across Lambeth, Southwark and Croydon.</td>
<td>Changes made as requested.</td>
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The SEL CCGs' Collaborative Framework now formally replaces the previous CCGs' Collaborative Framework which was developed in 2012.

Rationale for Chair's action:

Chief Officer approved the updated Collaborative Agreement on behalf of the Governing Body in line with the delegated agreement at the July 2015 Governing Body meeting. On this basis the Chair is requested to support the action.

CCG Chair: Dr Marc Rowland  Chief Officer: Martin Wilkinson
Approving Lay Member: Ray Warburton (Audit and Governance Lead)

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

Signature: 
Date: 2/3/16

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

Signature: 
Date: 2/3/16

Date of Governing Body meeting: 10 March 2016
1. **Our Healthier South East London Programme (OHSEL) (January/February 2016 update)**

The OHSEL programme has provided an update on progress on each of our proposed new models of care and outlines our priorities for the coming months. The headlines from each clinical area covered in the strategy are summarised below.

<table>
<thead>
<tr>
<th>Clinical area</th>
<th>How we want to improve care</th>
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</table>
| **Planned care** (orthopaedics) | - We want to improve orthopaedic care to address the variation in quality and outcomes for patients in different parts of south east London, reduce operation delays and cancellations, and tackle ever increasing demand for services.  
  - One of our ideas is to develop consolidated elective orthopaedic care centres for inpatient operations.  
  - We are now working with patients, clinicians and partners on a detailed development of this option. |
| **Community-based care**     | - ‘Local Care Networks’ are being developed in all south east London boroughs to improve care outside of hospital for Lewisham these are our Neighbourhood Care Networks.  
  - Work is already underway, which delivers clinical and financial improvements, including initiatives like extended access to GP services and better co-ordination of end of life care. |
| **Urgent and emergency care** | - All care providers are working collaboratively across south east London to achieve the London Quality Standards, which includes increasing consultant cover.  
  - To reduce waiting times we are looking how to stream patients to specialist services more effectively.  
  - Investment in primary and community care should help avoid increase in A&E activity and hospital admissions.  
  - We expect that we will need to retain all existing A&Es in south east London. |
| **Maternity**                | - We want to ensure women have a positive experience of pregnancy through access to safe and personalised care, including mental health support.  
  - Work to date suggests we will continue to need all of our existing maternity units.  
  - Providers of maternity services have looked at whether they are currently meeting the London Quality Standards. One area of improvement we are looking to progress is increasing the presence of obstetric consultants on labour wards to ensure 24/7 cover by October 2016. Providers are working together to review rota systems. |
| **Children and young people** | - We want to get better at supporting families to keep children and young people physically and mentally well. We will achieve this through Local Care Networks providing more joined up support and making hospital a last resort. |
- We are also working to ensure the short stay paediatric assessment unit at each hospital meets the London Quality Standards.

<table>
<thead>
<tr>
<th>Cancer</th>
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<td>- We want to improve patient outcomes and experiences through better prevention and earlier diagnosis.</td>
</tr>
<tr>
<td>- We are working to develop education packages for Local Care Networks to support early detection and fast access to diagnostics.</td>
</tr>
<tr>
<td>- We are working on plans to introduce a 24/7 advice line to help patients and carers access support and information.</td>
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</table>

**What is the benefit of more change to your local NHS?**

The OHSEL strategy is about building better health and care services for the future by working together to address challenges faced across south east London. We know that the population in the six boroughs is growing. We also know that people are living longer with multiple, complex conditions. Meanwhile medical technology continues to advance as new or improved treatments and medicines become available to patients. NHS funds available to spend on healthcare will not be able to keep pace with this ever increasing demand.

Each of the new models of care in the strategy are about improving patient care by working differently. Our work suggests that by more parts of the healthcare system working together at scale, we can make the best use of resources, share expertise and skills and focus on preventative care rather than dealing with illness when it arises. Local healthcare providers are also working to get better value for the money they spend, which will help to close the funding gap.

In addition, we think there is even greater scope to combine efforts, share skills and reduce duplication across south east London. There are opportunities to provide better patient care and support the committed staff working across the six boroughs by pooling resources and reducing spend on agency staff. We want to make better use of our estates so they serve local communities more efficiently. We also think healthcare organisations can work together more often when buying care from providers to cut down on the administrative procedures that would usually happen for six separate boroughs.

Change of this scale won’t happen overnight but we want to create a legacy for the future as the improvements in prevention and care should result in benefits which will materialise beyond the next five years.

**Testing ideas to improve orthopaedic services**

Patients who live in south east London and need orthopaedic care then at the moment could be treated at one of nine sites.

Right now, quality and outcomes for patients who need orthopaedic are varies across south east London. Too many procedures are cancelled and there are unnecessary delays in the patient journey. We also know that a growing and ageing population means the demand for these services is rising.

The OHSEL programme is looking at the feasibility of a consolidated orthopaedic service in south east London to increase capacity and address these issues. This idea was recently tested with

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Chair: Dr Marc Rowland    Chief Officer: Martin Wilkinson
representatives from the voluntary and community sector, and patient voices at the first meeting of our Planned Care Reference Group. This group was formed specifically to increase the involvement of people that could be most impacted by any potential changes to services through our strategy, for example: carers, older people and people with a disability.

Discussions were lively and covered people’s experience of care including an 11 month wait for surgery, delayed discharge and poor communication. Initial reactions to the idea of a consolidated orthopaedic service were positive, though people felt there needed to be clear evidence that developing this type of service would result in better outcomes and quality of care.

To continue our discussions on how to improve orthopaedic care the programme is holding the next Planned Care Reference Group meeting on 16 March. Based on participant feedback from the January meeting, there will be more evidence on the case for change and exploring the proposed model of a consolidated elective orthopaedic service. To help with this we will welcome the director of the South West London Elective Orthopaedic Centre to share experience of how their model works.

You can follow the meeting live on Twitter between 9.30am and 12.30pm using the hash tag #OHSEL.

You can also read the final report from the January meeting and tell us what you think of the ideas.

More support for staff in ‘care navigator’ roles

Care navigators (or Coordinators) can play a crucial role in helping people to get the right support to manage a wide range of health and care needs. This can include providing information about health, social services and voluntary sector organisations, support with managing long term conditions, help with managing money and guidance on self-care – all of which can enhance a person’s health and wellbeing, help them to live independently and even help avoid unplanned hospital admission. Currently, some members of staff in health and social care organisations across south London sometimes operate as care navigators but may have a different job title, such as, patient liaison officer, care co-ordinator, health champions and case navigators.

55 health and social care professionals and patient representatives from across south London attended a care navigator workshop this month. Discussions focused on the variety of tasks that could be performed by care navigators to help people to find the right support from local services and co-ordinated care, and also explored what non-clinical staff would need to provide this support.

There was unanimous agreement that the non-clinical support and guidance offered by care navigators is crucial to preventative care. Participants felt that better training in communications and negotiation skills was key to helping care navigators take early action to keep people well and independent. The workshop also heard about the challenges care navigators face in guiding patients to the right support and the need for better IT systems to increase their understanding of the vast and changeable array of services available. You can look back at some of the key themes discussed on Twitter by searching for #OHSEL.
Feedback from participants is being collected on different care navigator job descriptions and aim to develop a set of competencies to inform a package of training and support. For more information about this work contact ourhealthiersel@nhs.net

Mental health

We often hear that the mental and physical health needs of people using local healthcare services are not considered together. The OHSEL is addressing this by having mental health embedded in each of the areas of health and care our strategy is aiming to improve. Working alongside local residents and the organisations providing mental health service across south east London, we are identifying a number of ways to give people a better experience of mental health services. Some of the key interventions we want to work towards in each clinical model are summarised below.

- **Urgent and emergency care** – experts streaming at the front door of urgent and emergency care services to identify people with mental health needs early and get them the right specialist support. We also want to work towards referring young people under 18 to paediatric mental health nurses within one hour from triage.
- **Cancer** – improving access to psychological and emotional support for patients and carers. We also want to increase training for staff using expertise from Macmillan to ensure the mental health needs of people affected by cancer are recognised.
- **Children and young people** – a more joined up approach to community based care is being developed for those children and young people with more complex needs. Each borough has also developed a Mental Health and Wellbeing Transformation Plan specifically for children and young people.
- **Community based care** – helping people to free counselling by expanding the Improving Access to Psychological Therapies (IAPT) programme to all areas in south east London, more training for GPs to help them better manage patients with mental health needs, early intervention support for people at high risk of psychosis.
- **Maternity** – physical and mental health promoted before conception through Local Care Networks, continuity of midwife-led care will help maintain emotional wellbeing of women and support early identification of people experiencing mental health issues. We are also considering how to improve training for midwives in perinatal mental health and female genital mutilation.
- **Planned care** – opportunities recognised to provide more comprehensive psychological support to patients waiting for, receiving, recovering from a planned operation, for example using mental wellbeing questionnaires with orthopaedic patients. We are recruiting mental health representatives to join our planned care working group.

Change in action - New 24 hour mental health helpline launches in Lambeth, Lewisham and Southwark

People experiencing mental distress in Lambeth, Lewisham, Southwark and Croydon can now get advice and support via a [new 24 hour helpline](#).

The line is for patients, carers and anyone who needs advice, help and assistance while in crisis or facing difficulties dealing with mental illness.
South London and Maudsley NHS Foundation Trust launched the support line in December as a single point of contact for advice on mental health and medication, accessing services, crisis reviews and liaison with care teams.

The helpline is jointly funded by the four borough’s clinical commissioning groups (CCGs) and is staffed by a team of six nurses covering 24 hours a day. Nurses explore with callers the reasons for their call and identify what help they need at the time, and in the future.

There are currently a range of different helpline numbers across the boroughs but the new dedicated line will provide more coordinated and easier access to support from trained professionals when people are in need.

The freephone support line number is 0800 731 2864.

Patient voices - Doing more to listen to the views of local people

To strengthen our relationship with the six Healthwatch organisations in south east London the programme ran the first of two workshops to exchange priorities and ideas. While Healthwatch have been involved in OHSEL plans from the outset, they recently asked for a deeper understanding of the new models of care and our ideas about how to improve local services, so that they can look at what work they are doing that links in.

The first workshop focused on community based care and there was a strong commitment for more joined up working. The programme will also be using its regular ‘You Said, We Did’ reports to demonstrate how the findings and recommendations from Healthwatch conversations with local people is being taken into account as the strategy develops.

SEL CCG Committee in Common – held in public and residents invited to attend

9am – 12pm
Thursday 17 March 2016
The Chapter Room, Southwark Cathedral, London Bridge, SE1 9DA

This is the first meeting of the Committee in Common. It brings members of each CCG’s governing body together for decision making on issues that affect every borough. At this inaugural meeting, the committee will discuss Our Healthier South East London. The CCG members are Dr Marc Rowland, Martin Wilkinson and Rosemarie Ramsay with deputies to cover if they are unable to attend.

Please send any questions in advance to souccg.selstrategy@nhs.net

Papers will be published one week prior to the meeting at ourhealthiersel.nhs.uk

2. Adult Integrated Care Programme

Throughout 15/16, the Adult Integrated Care Programme Board has been focusing on the development of Neighbourhood Care Networks and multi-disciplinary working between GPs and
the Neighbourhood Community Teams; the redesign of admission avoidance and hospital discharge services and processes; the coordination of information, advice and community resources to support prevention and early intervention; and the roll out of Connect Care, Lewisham’s information sharing system across health and care. This work has been aligned with the wider transformation and improvement work taking place within primary care, such as the establishment of neighbourhood federations.

This work has highlighted the need to ensure that across the system we are utilising our buildings and estates to maximum effect, and that we have the technology in place to support mobile working and to enable shared health and care information to be easily accessed by users, patients and practitioners. We also need to make sure that staff across the system are able and supported to deliver multi-disciplinary and integrated ways of working.

Building on the work that has taken place over the past year and recognising the pace and scale required to achieve a sustainable and transformed health and care system, the Adult Integrated Programme Board has been reviewing its plans for 16/17 and setting its priorities for action. The Board also recognises that it needs to improve its communication on what the programme is trying to achieve and what needs to be done to secure improvements in performance and outcomes across the system. These priorities are being aligned with other key strategic and operating plans including the Better Care Fund Plan for 16/17.

3. GP Federations – update

The development of the four emerging neighbourhood GP provider federations in Lewisham continues with all federations on schedule to be formalised (including CQC registration) by 1st April 2016.

4. Adult Safeguarding – Deep Dive with NHSE

NHSE undertook a deep dive of safeguarding assurance across all 32 CCGs in London with Lewisham CCG being subject to its deep dive on November 5th 2015.

The final report was circulated this week and Lewisham has scored ‘assured as good’ with areas of good practice identified across governance, systems and process, workforce and capacity within the CCG for both adults and children. The only area where there is limited assurance is around adult safeguarding within primary care. This is because of an outstanding business case for a named nurse for adults safeguarding within primary care, who will also lead on the Identification and Referral to Improve Safety (IRIS) project. This business case is currently being reviewed internally.

5. Industrial Action by Junior Doctors

Following failure to achieve a resolution between the BMA and the Government regarding junior doctors terms and conditions, the BMA is planning further industrial action in March and April. These will take the form of 3 x 48 hour strikes with junior doctors providing emergency care only.

The first is scheduled to take place from 8am on 9th March until 8am on the 11th March. The remaining two are scheduled for the 6th-8th April and 26th-28th April respectively.

Chair: Dr Marc Rowland
Chief Officer: Martin Wilkinson

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If the action goes ahead it is likely to have a significant impact on acute provider organisations with increased pressures on the emergency care pathway, reduction in capacity for routine care (e.g. cancellation of electives, outpatients and non-urgent diagnostics), reduced discharge capability and increased ambulance handover times at A&E. NHS England is working with acute trusts and other partner organisations to ensure robust plans are in place to manage the anticipated impacts of the industrial action.

GP practices are asked for their support with this by reinforcing messages to patients to only use A&E in a serious emergency and giving information about alternatives to A&E, including self-care advice, NHS 111, pharmacies and urgent care centres as appropriate.

The system resilience group is leading the planning framework to ensure all service areas are ready to respond appropriately to any changes in demand. This planning is being linked to planning for Easter and the May Bank Holiday.

Martin Wilkinson
Chief Officer – Lewisham CCG
3 March 2016
Main issues discussed

The Committee received the Internal Auditor’s (KPMG) report on Workforce management arrangements. The auditors provided an overall assessment of ‘partial assurance with improvement required’. Six recommendations were raised, including five medium priority and one low priority recommendation. All of them were agreed by management. Among these recommendations was one for the CCG to have a formal medium- or long-term workplace plan in place. Another was for workforce performance to be RAG rated to identify likely areas of underperformance and areas that will have greatest impact on the CCG.

The Committee continued with its deep dives into the way Corporate Objectives are set out in the Board Assurance Framework. Diana Braithwaite (Commissioning Director) and Alison Browne (Nursing and Quality Director) talked the Committee through how risks are identified, mitigated, managed and monitored. They tabled very useful papers that summarised their respective approaches to the risks and assurance processes for the development of Primary Care and Neighbourhood Networks within Lewisham.

The CCG’s Counter Fraud Specialist, TIAA, reported to the Committee on work done on the Fraud Risk Assessment exercise with respect to commissioning, prescribing, personal health budgets, continuing health care, overseas patient charges, the Better Care Fund, human resources and payroll. Areas requiring action have been identified for management’s consideration. TIAA also reported on the Fraud and Bribery Awareness Training carried out for the CCG in 2015/16. Feedback from those staff attending the training was reported. TIAA also spoke to the Q&A for ‘Standards for Commissioners, which have been issued by NHS Protect to help CCGs guard against fraud, bribery, corruption and security management. Copies of ‘Fraudstop’, TIAA’s regular newsletter to the NHS describing recent instances of crime within the NHS, were made available to the Committee.

Tony Read, CFO, reported on the Annual Report and Accounts timetable and plan for 2015/16. Ways to improve the process, compared with last year, were discussed. By 22 April 2016, the CCG’s full draft annual report and accounts should be reported to NHS England, together with a copy of the Head of Internal Audit Opinion as issued by the CCG’s Internal Auditors. By 27 May 2016, the CCG should submit full audited and signed accounts to NHS England. By 30 September 2016, the CCG should hold a public meeting at which the annual report and accounts are presented.

The Committee discussed and agreed the process for setting up a Local Auditor Panel, in light of the demise of the Audit Commission (which used to appoint
External Auditors to public bodies) and the need for CCGs to re-appoint External Auditors from 2017/18. A separate paper on this matter is coming to the Governing Body on 10 March.

Key achievements

Shelagh Kirkland was welcomed to the Committee as the newly appointed Independent Member. Shelagh, who is CCAB- (Consultative Committee of Accountancy Bodies) qualified brings additional expertise, experience and knowledge to the Committee’s work.

The Committee was pleased to both receive the Workforce report from the CCG’s internal auditors, and hear of management’s positive response.

The Committee was grateful for the presentations made by Diana Braithwaite and Alison Browne and were greatly assured that the processes for risk identification and management are working well as far as the Primary Care and Neighbourhood Networks corporate objectives are concerned.

The Committee was pleased with the work of TIAA, the CCG’s counter-fraud specialists, and looked forward to receiving the Counter Fraud work plan for 2016/17, based on the results of the Fraud Risk Assessment and management’s response to it.

The Committee noted that lessons learnt from 2015/16 would help to ensure that the production of the Annual Report and Accounts would potentially go more smoothly for 2016/17. In particular, the Committee welcomed the greater clarity of the terms of reference of the Editorial Group and its interface with the Audit Committee. As last year, the inclusion of a rounded collection of case studies and success measures, including measure on the Constitutional Standards, should ensure the Annual Report reads well and accurately reflects the year.

The Committee approved the accounting policies for the completion of the 2015/16 Annual Accounts and noted the good work of the CFO and his team on the Month 9 accounts for 2015/16. The accounts were submitted to NHS England and will help to ensure that the process of completing the full accounts will run smoothly.

Key challenges addressed

The timeline for completing the Annual Report and Accounts will be as challenging as ever, but based on the experience of the last two years, CCG management and staff will rise to the challenge.

While the feedback from staff on the Fraud and Bribery Awareness training was positive, there is always more that can be done to help staff remain on top of developing issues and concerns.

Key risks (include assurances received positive and negative)
Key risks with regard to workforce management, primary care development and neighbourhood networks, fraud and bribery awareness and the production of the Annual Report and Accounts are currently being well managed, anticipated or mitigated.

How did the meeting help address inequalities and fairness?

The Committee has a strong interest in issues of equality and fairness, and some key matters were touched on during the meeting. For example, it was stressed that the Annual Report should reflect the diverse nature of Lewisham’s population.

Ray Warburton,
Chair of the Audit Committee
3 March 2016
ENCLOSURE 5.1
Planning for Commencement of the Local Audit Arrangements

MANAGERIAL LEAD: Tony Read  Post  Chief Financial Officer

AUTHOR: Ray Warburton  Post  Lay Deputy Chair

RECOMMENDATIONS:

• Note the requirement to appoint the external auditor for financial year 2017/18 onwards and the next steps
• Agree in principle the Terms of Reference for the Local Auditor Panel, which identifies the members of the CCG’s Audit Committee as members of the Local Auditor Panel.

SUMMARY: Lewisham CCG will need to establish a Local Auditor Panel for the appointment of external auditors from 2017/18. This paper summarises the requirement and process, and presents a draft Terms of Reference for the Governing Body’s comment and in principle agreement.

KEY ISSUES:

The Department of Health announced on 24 September 2015 that health bodies will move to the new audit framework in 2017/18 under the Local Audit and Accountability Act 2014, as originally planned. This will mean that NHS Trusts and CCGs will select and appoint their own auditors and directly manage their contracts for the audits for the financial year starting in April 2017, with the legislation requiring that the auditors are appointed by 31 December 2016.

For NHS Trusts and CCGs, the direct appointment and management of external auditors will increase their local accountability and move them into line with the arrangements already in place for NHS Foundation Trusts. The first stage of the new process is for CCGs and NHS Trusts to set up Auditor Panels, to advise and oversee the auditor appointments. The Healthcare Finance Management Association (HfMA) has produced guidance on the role of the panels and model Terms of Reference.

The legislation requires that the auditor panel must be appointed either by the organisation or by the organisation and one or more other relevant authority. The auditor panel must be either a specially established panel or an existing committee, sub-committee or panel.

Through recent reports by the Audit Chair to the Governing Body, the CCG has already been advised that members of the Audit Committee are best placed to form the Local Auditor Panel for
the CCG. The Terms of Reference which the Governing Body is asked to approve in principal are based on the HfMA guidance, and identifies members of the Audit Committee as the members of the Local Auditor Panel. Please see Enclosure 5.1 Appendix 1. Changes are likely to be required to the CCG’s Constitution as a result.

Other South East London CCGs are taking similar Terms of Reference to their Governing Bodies. The plan is that once Local Auditor Panels have been set up for all six CCGs, they will undertake the procurement of external auditors jointly. More details of the appointment will be shared with Governing Bodies in due course.

In developing a core specification for the external audit service the NHS is intending to use the main statutory duties that are summarised at Appendix C of NAO’s Code of Audit Practice (https://www.nao.org.uk/code-audit-practice/wp-content/uploads/sites/29/2015/03/Final-Code-of-Audit-Practice.pdf)

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<tr>
<th>CORPORATE AND STRATEGIC OBJECTIVES</th>
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<td>Robust governance</td>
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<tr>
<td>Name: Tony Read</td>
</tr>
<tr>
<td>E-Mail: <a href="mailto:tonyread@nhs.net">tonyread@nhs.net</a></td>
</tr>
<tr>
<td>Telephone: 020 3049 3833</td>
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<th>AUTHOR CONTACT:</th>
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<tbody>
<tr>
<td>Name: Ray Warburton</td>
</tr>
<tr>
<td>E-Mail: <a href="mailto:r.warburton@nhs.net">r.warburton@nhs.net</a></td>
</tr>
<tr>
<td>Telephone: 0207 206 3200</td>
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</table>
Constitution

The Governing Body hereby resolves to nominate its Audit Committee to act as its Auditor Panel in line with schedule 4, paragraph 1 of the 2014 Act. The Auditor Panel is a non-executive committee of the Governing Body and has no executive powers, other than those specifically delegated in these terms of reference.

Membership

The Auditor Panel shall comprise the entire membership of the Audit Committee with no additional appointees. This means that four of the five members of the Auditor Panel are independent non-executive members of the Governing Body. (This satisfies the requirement that an Auditor Panel must have at least three members with a majority who are independent and non-executive members of the Governing Body.)

In line with the requirements of the Local Audit (Health Service Bodies Auditor Panel and Independence) Regulations 2015 (regulation 6) each member’s independence must be reviewed against the criteria laid down in the regulations.

Chairperson

The Audit Committee chairperson will be appointed by the Governing Body to chair the Auditor Panel. This will ensure that the chairperson is independent and a non-executive member of the Governing Body.

Removal/ resignation

The Auditor Panel chairperson and members of the Auditor Panel can be removed in line with rules agreed by the Governing Body.

Quorum

To be quorate, three members of the Panel should be present, at least one of which should be a lay member.
Attendance at meetings

The Auditor Panel's chairperson may invite executive directors and others to attend depending on the requirements of each meeting's agenda. These invitees are not members of the Auditor Panel.

Frequency of meetings

The Auditor Panel shall consider the frequency and timing of meetings needed to allow it to discharge its responsibilities but as a general rule will meet on the same day as the Audit Committee.

Auditor Panel business shall be identified clearly and separately on the agenda; and Audit Committee members shall deal with these matters as Auditor Panel members not as Audit Committee members.

The Auditor Panel's chairperson shall formally state at the start of each meeting that the Auditor Panel is meeting in that capacity and not as the Audit Committee.

A notice period of at least 14 days shall be given before the Committee meets. The Agenda and supporting papers will be circulated 7 days prior to the meeting.

Conduct and Conflicts of interest

The Auditor Panel shall conduct its business in accordance with national guidance, relevant codes of practice including the Nolan Principles and the Conflict of Interest policy. Members should make every effort to attend Committee meetings.

Conflicts of interests must be declared and recorded at the start of each meeting of the Auditor Panel.

A register of Auditor Panel members’ interests must be maintained by the Panel’s chairperson and submitted to the Governing Body in accordance with the organisation’s existing conflicts of interest policy.

If a conflict of interest arises, the chairperson may require the affected Auditor Panel member to withdraw at the relevant discussion or voting point.

Authority

The Auditor Panel is authorised by the Governing Body to carry out the functions specified below and can seek any information it requires from any employees/ relevant third parties. All employees are directed to cooperate with any request made by the Auditor Panel.
The Auditor Panel is authorised by the Governing Body to obtain outside legal or other independent professional advice (for example, from procurement specialists) and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary. Any such ‘outside advice’ must be obtained in line with the organisation’s existing rules.

Functions

The Auditor Panel’s functions are to:

- Advise the organisation’s Governing Body on the selection and appointment of the external auditor. This includes:
  - agreeing and overseeing a robust process for selecting the external auditors in line with the organisation’s normal procurement rules;
  - making a recommendation to the Governing Body as to who should be;
  - ensuring that any conflicts of interest are dealt with effectively.
- Advise the organisation’s Governing Body on the maintenance of an independent relationship with the appointed external auditor.
- Advise (if asked) the organisation’s Governing Body on whether or not any proposal from the external auditor to enter into a liability limitation agreement as part of the procurement process is fair and reasonable.
- Advise on (and approve) the contents of the organisation’s policy on the purchase of non-audit services from the appointed external auditor.
- Advise the organisation’s Governing Body on any decision about the removal or resignation of the external auditor.

Reporting

The chairperson of the Auditor Panel must report to the Governing Body on how the Auditor Panel discharges its responsibilities.

The minutes of the panel’s meetings must be formally recorded and submitted to the Governing Body by the panel’s chairperson. The chairperson of the Auditor Panel must draw to the attention of the Governing Body any issues that require disclosure to the full Governing Body, or require executive action.

Remuneration

Payments to Auditor Panel members shall be in line with the organisation’s existing approach to remuneration and allowances.

Review

These Terms of Reference will be reviewed on an annual basis or sooner if required, with recommendations made to the Governing Body for approval. Any resulting changes to the terms of reference will be approved by the Governing Body.
Administrative support

A Director of the CCG shall be responsible for organising effective administrative support to the Auditor Panel. The duties of the person appointed to fulfil this role shall include:

- Agreement of agendas with the chairperson
- Preparation, collation and circulation of papers in good time
- Ensuring that those invited to each meeting attend
- Taking the minutes and helping the chairperson to prepare reports to the Governing Body
- Keeping a record of matters arising and issues to be carried forward
- Arranging meetings for the chairperson
- Maintaining records of members’ appointments and renewal dates etc
- Advising the auditor panel on pertinent issues/areas of interest/ policy developments
- Ensuring that panel members receive the development and training they need
- Providing appropriate support to the chairperson and panel members.
Governing Body meeting on 10th March 2016

Report from Rosemarie Ramsay MBE, CCG Lay Member and Chair of the Primary Care Joint Committee

Date of Meeting reported: 11th February 2016

Author: Diana Braithwaite, Director of Commissioning & Primary Care

Primary Care Joint Committee with NHS England was held in common with other South East London Primary Care Joint Committee’s covering the other South East London CCGs.

1. Primary Care Medical Services Financial Report

Nine months results to 31st December are showing an overspend of £219k (0.6%) of which £414k is attributable to under-delivered QIPP offset by an underspend on seniority cost and a non-recurrent benefit from 2014/15 accruals. The underspend on seniority cost is due to contractual changes emanating from a phased reduction in seniority payments over six years which has been reinvested in core services effective from October 2015. The forecast year end outturn variance based on month 9 is an overspend of £249k (0.8%) which comprises £551k QIPP savings under-achievement, an overspend on QOF (£128k) offset by an underspend on seniority cost (£110k) and a non-recurrent prior year accruals (£364k). Lewisham’s weighted population has increased by 0.2% year on year from April 2014 to April 2015. There has been a growth of 1.7% (5,229 weighted population) year to 1st October 2015 (quarter 3). The committee noted the report.

2. Lewisham Primary Care Programme Board

The Primary Care Joint Committee ratified the amendments to the Primary Care Programme Board Terms of Reference. The changes were to enable improved assurance, scrutiny and governance with regard to the management of Conflicts of Interest (CoI).

3. Contract Variation

The Joint Committee approved the application from Dr Shashi Arora (currently a single handed GP with a PMS contract) to take on an additional Partner.

4. Commissioning Intentions for Primary Care PMS Contracts

(a) Primary Care Joint Committee Approval

The CCG commissioning intentions for primary care were agreed by NHS England and the CCG, as Level Two Joint Commissioners of primary care. The Joint Committee confirmed the process and associated governance that had been followed to derive commissioning intentions under the PMS Contract review, including adherence to the CCGs Conflict of Interest Policy. The Committee went on to approve the commissioning intentions subject to completion of specifications, Key Performance Indicators (KPIs) and associated prices; and formal consultation with the local medical committee.

(b) National Requirements

The CCGs commissioning intentions for primary care demonstrated compliance with the national requirements for the review and providing equality of opportunity for all Lewisham practices whether, GMS, PMS or APMS.
5. **Further information**

   Full meeting papers for the Primary Care Joint Committee held on the 11\textsuperscript{th} February 2016 are available at: [http://www.lewishamccg.nhs.uk/about-us/how-we-work/PublishingImages/Pages/Primary-Care-Joint-Committee/SEL%20PCJC%20Meeting%2020160211.pdf](http://www.lewishamccg.nhs.uk/about-us/how-we-work/PublishingImages/Pages/Primary-Care-Joint-Committee/SEL%20PCJC%20Meeting%2020160211.pdf)

6. **Date of next meeting**

   The Primary Care Joint Committee in public will be on 28\textsuperscript{th} April 2016.

3 March 2016
A meeting of the Governing Body  
10th March 2016

Enclosure 8
Board Assurance Framework

<table>
<thead>
<tr>
<th>LEAD: Martin Wilkinson</th>
<th>Post: Chief Officer</th>
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</thead>
<tbody>
<tr>
<td>MANAGERIAL LEAD: Susanna Masters</td>
<td>Post: Corporate Director</td>
</tr>
<tr>
<td>AUTHOR: Graham Hewett</td>
<td>Post: Associate Director for Quality and Designated Adult Safeguarding Manager</td>
</tr>
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</table>

RECOMMENDATIONS

The Governing Body is asked to:

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

Appendices:
Appendix A. Board Assurance Framework

Risk Management Report

The Risk Management Group reviewed the CCG Risk Register at its meeting at the end of February 2016 and the current CCG Risk Register has been reviewed at recent meetings of
Delivery Committee, Strategy and Development Committee and FLAG.

There are currently eleven risks on the CCG Risk Register that meet the criteria for inclusion on the BAF (Residual Risk Score of 12 or over).

There is one risk (Risk Q6a) with a Residual Risk Score of Very High (4x4) related to the NHS Constitution Commitments on waiting times for patients with cancers or suspected cancers. This is the first time that this risk has appeared separately on the BAF. It has previously been reported to Delivery Committee and the Integrated Governance Report (Enclosure10) includes the exception report for cancer waiting times.

All other risks on the BAF have a Residual Risk Score of 12, just meeting the threshold for inclusion. There has been no movement in the Residual Risk Scores for these risks.

1. The Heat Map below shows the distribution of all the 39 risks on the CCG Risk Register. GB will note that there is a cluster of risks at Major x Unlikely (ten risks) and Moderate x Possible (six risks). These risks do not feature on the BAF and are reviewed elsewhere.

### Heat Map

<table>
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<tr>
<th>Likelihood</th>
<th>Almost certain</th>
<th>Likely</th>
<th>Possible</th>
<th>Unlikely</th>
<th>Rare</th>
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<td></td>
<td></td>
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</tr>
<tr>
<td>4</td>
<td></td>
<td>1</td>
<td>1</td>
<td>2</td>
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<tr>
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<tr>
<td>2</td>
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<td>1</td>
<td>10</td>
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<tr>
<td>1</td>
<td></td>
<td>2</td>
<td>5</td>
<td></td>
<td></td>
<td>Catastrophic</td>
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</tbody>
</table>

### Risk Matrix

- Negligible: 1
- Minor: 2
- Moderate: 4
- Major: 5
- Catastrophic: 5
2. **Datix Risk Management system**

Work has continued to implement the new Datix Risk Management system and it is anticipated that this will be completed in March. The CCG is working to a timetable established by Datix UK Ltd. The new risk management system will be more flexible than present arrangements, allowing the CCG to print its risk registers and the Board Assurance Framework in a variety of formats that are easier and clearer to read.


Risk Management Group has agreed a process for developing the CCG Risk Register for 2016/17. RMG agreed that a workshop will be held in March to review the risks to the 2016/17 Corporate Objectives. Corporate Objectives Owners will prepare draft risks for the workshop so that they can be themed and reviewed, triangulated with OHSEL and the Adult Integrated Care Programme’s risks and the discussions held at the Governing Body workshop on 4th February 2016 about the risk management process – key risks, risk assurance, risk tolerance and risk appetite.

Amended versions of the risks will be agreed at the RMG in April and recommendations to the Governing Body on Risk Appetite for each of the risks will be made.

Governing Body will receive the new BAF at its meeting on 12th May

The Governing Body is asked to approve the Board Assurance Framework (BAF) as evidence that:

a. the CCG is aware of the significant risks presenting to the Corporate Objectives
b. that the CCG has adequate controls to mitigate the risks to the Corporate Objectives
c. where existing controls have not reduced the residual risk score to the target there are credible action plans
The Board Assurance Framework is attached at Appendix A

CORPORATE AND STRATEGIC OBJECTIVES
Governance and Equalities – ensure that robust governance arrangements are in place

CONSULTATION HISTORY:

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

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

PUBLIC SECTOR EQUALITY DUTY
How does this report take into account the duty to:
- Eliminate discrimination, harassment and victimisation and any other conduct that is prohibited under the Equality Act 2010
- Advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it
- Foster good relations between people who share a relevant protected characteristic and those who do not share it

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

RESPONSIBLE MANAGERIAL LEAD CONTACT:
Name: Susanna Masters
E-Mail: 32TUsusanna.masters@nhs.net

AUTHOR CONTACT:
32TName: Graham Hewett
32TE-Mail: Ugraham.hewett@nhs.netU
NHS Lewisham Risk Register

Date Printed  02/03/2016

Version Control

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<td>Changes to Q6</td>
<td>GH</td>
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<td>3.4</td>
<td>22.01.2016</td>
<td>SM and DB updates</td>
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<td>3.5</td>
<td>27.01.16</td>
<td>Updated following RMG 26.01.16 Updates to PC2, PC3, N2, N3, N4 and N1 (italics) NH and PC Risks extracted for Audit Committee Q6 updated (in italics)</td>
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**Risk Matrix**

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

Risks are evaluated using the matrix x y, shown as I x L (Impact x Likelihood), and scored as 1 - 3 (green) Low Risk, 4 - 6 (yellow) Moderate Risk, 9 - 12 (amber) High Risk, 15 - 25 (red) Very High Risk.

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

**Column Headings**
- Controls - What the CCG has put in place to lessen the impact of the risk should it occur and reduce the likelihood of it occurring
- Response - what the CCG has decided to do about the risk: mitigate, accept, transfer or close.
- Assurance Source - where the CCG finds evidence that its controls are effective
- Assurance Given - The evidence that controls are effective or not
- Assurance Type - whether the evidence was generated and collated by management (Internal Assurance shown as IA+ for positive assurance and IA- in red text for negative assurance) or by an independent body (External Assurance shown as EA+ for positive assurance and EA- in red text for negative assurance).
- Assurance Level - the strength of the evidence; None, Limited, Adequate, Significant
- Assurance Gaps – where the CCG has no evidence of whether or not its controls are effective
- Action Required – work that is required to close assurance gaps
- Action Target Date – the date that the actions are due to be completed
- Residual Score (I*L) – the risk score after the controls have been applied

**Format**

Negative assurances, where evidence shows that the controls are not fully effective, are shown in red text.
## Task Completion

### 1. Task Description

**Risk Description**

- Develop the Common Specification
- Review the Neighbourhood Team Coordinator role
- Completion of the workforce planning exercise
- Secure and develop appropriate resource
- Agree commissioners narrative for Neighbourhood Care Network as they refine the work
- Complete NCT business cases for the work
- Neighbourhood care networks.
- Agree commissioners narrative for Enhanced Neighbourhood Care Network for each borough
- Neighbourhood care networks.
- Review the Neighbourhood Team Coordinator role
- LANAs will present an update on the Enhance Neighbourhood Care Network workstream at the May 2016 Adult Integrated Care Board Meeting
- Neighbourhood care networks.
- Ensure co-commissioning discussion with Urology & Oncology.
- Secure appropriate resource to manage.

### 2. Task Assurance

- Assurance Source
  - Governance
  - Management

- Assurance Grade
  - Adequate

- Response Controls Assurance Source
  - Adequate

### 3. Task Mitigation

| Hazard | Risk Mitigation | Department | Level | Date | Action
|--------|----------------|------------|-------|------|--------|
| Loss of reputation / credibility | Mitigating misunderstandings and disagreements about the Neighbourhood Team Coordinator role | Governance | Adequate | September 2015 | Presentation of impact and risk register at Neighbourhood Team Coordinator role.

### 4. Task Completion

- Enhanced Care and Support Workstream aims, purpose and objectives agreed. July – Sep 2015
- Neighbourhood Community Teams monthly operational leads delivery group established to drive multidisciplinary working.
- Neighbourhood Community Teams Work stream bi-monthly steering group refreshed and new membership.
- Monthly Cancer Pathway Clinical Review Group and the Commissioning Narrative.

### 5. Task Monitoring

- Neighbourhood Community Team Coordinator role has been agreed.
- Neighbourhood Community Teams Work stream bi-monthly steering group refreshed and new membership.

### 6. Task Reporting

- Neighbourhood Community Team Coordinator role has been agreed.
- Neighbourhood Community Teams Work stream bi-monthly steering group refreshed and new membership.

### 7. Task Implementation

- Neighbourhood Community Team Coordinator role has been agreed.
- Neighbourhood Community Teams Work stream bi-monthly steering group refreshed and new membership.

### 8. Task Evaluation

- Neighbourhood Community Team Coordinator role has been agreed.
- Neighbourhood Community Teams Work stream bi-monthly steering group refreshed and new membership.

### 9. Task Compliance

- Neighbourhood Community Team Coordinator role has been agreed.
- Neighbourhood Community Teams Work stream bi-monthly steering group refreshed and new membership.
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<td>The CCG has not implemented any organisational capacity to identify and deliver the envisaged.</td>
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**Risk Description**

- **Patient Engagement**: Patient engagement is not provisioned to be meaningful and effective.
- **Service Delivery**: The CCG is unable to deliver the quality of provider services.
- **Financial Management**: The CCG does not have the organisational capacity to identify deliver the financial targets.
- **GPO Quality**: The CCG is unable to deliver the quality of provider services.
- **Governance**: The CCG has not implemented any organisational capacity to identify and deliver the envisaged.

**Impact**

- Partial Assurance

**Control**

- Quality Assurance Framework

**Efficiency Management Strategy**

- ghg

**Performance Management Strategy**

- ghg

**Key Performance Indicators**

- ghg

**Assurance Source**

- ghg

**Assurance Grade**

- ghg

**Contract & Assurance Gap**

- ghg

**Need for Engagement**

- ghg

**Need for Action**

- ghg
Governing Body meeting on 10th March 2016

Report from the Chair of the Delivery Committee
Date of Meeting reported: 26th January and 25th February 2016
Author: Martin Wilkinson, Chair of Delivery Committee

1. Main Issues discussed

1.1 Cancer – The Committee received an exception report on the recovery against the 62 day cancer wait from GP referral to treatment. The committee was please that there had been significant progress over the last few months with 84.60% of patients in December treated within the 62 days of referral, which is above previously agreed trajectory. This level of performance is projected to continue in January with a dip in performance February as the backlog of patients waiting is reduced. The 85% standard is expected to be achieved in March 2016 and sustained thereafter. This improvement follows some systematic work within Lewisham and Greenwich Trust and across the South east London provider network. There had also been improvements to patient tracking locally and sharing of relevant pro-active tracking information across providers where patient pathways rely on diagnostics or treatment interventions from more than one provider.

1.2 The January Committee welcomed Dr Martin Baggaley, Medical Director from South London and Maudsley NHS Foundation Trust to appraise the Committee on their recent CQC inspection, which had rated them overall as good with some areas requiring improvement. An action plan had been developed to address improvement areas such as acute wards for working age adults and older people, and staff recruitment and retention. Dr Baggaley also reported that an internal review had been commissioned into the timeliness of responding to complaints received by the Trust.

1.3 Operating Plan – the Committee received updates on the development of the Operating Plan for 2016/17. This included an update on plans for Quality, Innovation, Productivity and Prevention (QIPP) and an assessment of their maturity. This showed that further work was required on some plans and the pipeline, which would be discussed further with Clinical Directors and through reviewing potential opportunities from the recently updated RightCare benchmarking tool. The Committee discussed the likely year end positions on Constitutional standards and advised on the CCG’s ambition for 2016/17, as well as identified priority quality improvement areas. A briefing on progress with contract negotiations with providers was also provided. The February
meeting included feedback from a stocktake held with NHSE on our draft operating plan submitted on the 8th February. A further submission was planned for 2nd March 2016.

Further details regarding the Operating plan 2016/17 can be found at appendix A

1.4 NHS Constitutional Standards – The CCG is on track against most standards or against agreed recovery plans and performance improvement trajectories where standards were not met last year, with the following exceptions:

- **A&E**: Lewisham and Greenwich Trust overall performance is below trajectory for December 2015, although delivered 91.6% which was a marked improvement on December 2014.
- **Cancer Waits**: The 62 day from GP referral to treatment target was not met in December 2015 at 84.6% and amber rated following systematic work.
- **RTT**: The 18 week standard was marginally under standard at 91.9% in December, although year to date performance is above the 92% standards. There remain significant issues in specialty pathways at LGT (Trauma and orthopaedics, gynaecology and ENT).

1.5 Quality – An action plan had been presented by LGT to the Contract Quality Review Group which showed how improvement in the timelines of responses to complaints would be secured. Some improvement had already been made to the process and a further update, with the agreed improvement trajectory, would be shared with the Committee.

2. Key achievements

2.1 The CCG is on track to deliver its planned year-end financial targets and deliver all statutory financial duties in 2015/16.

2.2 There has been significant improvement against the A&E 4 hour standard at Lewisham and Greenwich Trust compared to last year.

3. Key challenges addressed

3.1 Focus of providers on sustaining improvements to the Cancer 62 day waits standard and A&E 4 hour waits and associated risks as part of Operating Plan discussions.

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

4.1 A&E: Lewisham and Greenwich Trust will not recover sustainable performance to standard as planned in 2015/16.

4.2 Despite significant improvement, there remains delivery challenges around the 62 day wait cancer standard and risks to the Referral to Treatment standard.

5. How did the meeting promote quality and safety?
5.1 Through the review of quality reports from FLaG and linking quality to financial and other performance metrics.

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

6.1 Delivery of the NHS Constitutional standards reduces the risk of unequal access to services

Martin Wilkinson
1 March 2016
Planning 2016-17

Key Plans and Assumptions

Enclosure 9A
Key Summary Issues

- A&E 4 hour performance for LGT will improve another 2% to 93% following a 3% improvement in 2015-16 over 2014-15. A review of the current state of play and diagnostics (One Version of the Truth) has been conducted and proposals will be reviewed by System Resilience Group and Executive in March. This work will identify the best balance between increasing capacity - between hospital, community and hospital at home. – and improved clinical practice to improve how patients move through the hospital.

- The CCG plans to improve Cancer waiting times 62 days to standard in Q4 15-16, so plans its achievement in 16-17.

- Improved Access to Psychological Therapies standards, including waiting times, will be met, although it will take us until Q4 2016/17 to achieve the Recovery Rate standard of 50%, as Lewisham GPs are keen that the service continues to see Lewisham people who may benefit from the service, but who may not be able to meet the recovery level.
Key Summary Issues

• Activity assumptions are based on 3.2% per cent growth – 1.2% for population growth and 2% for non demographic growth apart from:
  - Cancer Wait 2ww referrals which continue to rise at 12%
  - Endoscopy activity which will rise at around 5% based on London based analysis by CCG.

• Transformation or QIPP plans are aimed to reduce Emergency Admissions and Outpatients

• The CCG has built in the LGT proposed outpatient and elective work to:
  - Deal with any remaining long waiting patients for 18 weeks Referral to Treatment standards e.g. Trauma and Orthopaedics.
  - To conform with the NICE guidance on cancer due for the coming year.
Governing Body meeting

10th March 2016

ENCLOSURE 11
Rapid Governance Review – Phase 1

<table>
<thead>
<tr>
<th>ROLE</th>
<th>NAME</th>
<th>POST</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLINICAL LEAD</td>
<td>Dr Marc Rowland</td>
<td>CCG Chair</td>
</tr>
<tr>
<td>MANAGERIAL LEAD</td>
<td>Martin Wilkinson</td>
<td>Chief Officer</td>
</tr>
<tr>
<td>AUTHOR</td>
<td>Susanna Masters</td>
<td>Corporate Director</td>
</tr>
</tbody>
</table>

RECOMMENDATIONS:

The Governing Body are asked to agree:

- the 18 recommendations of the Rapid Governance Review, Phase 1, which are shown at Appendix A
- the proposed immediate action and next steps required to implement the Governance Review’s recommendations as set out in section 3 below
- the change of timing of the Governing Body’s meeting Public Forum session and subsequent time change for the Governing Body meeting as set out in section 4.2 below

Summary

Phase 1 of the Governance Review was a rapid review of the decision making processes across the CCG’s Committee structure undertaken during December 2015 and January 2016.

The Review puts forward a number of recommendations on how the CCG could improve its structures and processes to make them simpler and clearer, to resolve issues and streamline the decision making processes, whilst continuing to provide sufficient assurance to the Governing Body.

In parallel to the Governance Review, a specific review has taken place of the Governing Body’s meeting Public Forum session, which was introduced in September 2014 to increase public participation in the CCG’s decision making processes.
1. Context

This Governance Review is Phase 1 of a 3 phased programme to review Lewisham CCG’s decision making arrangements. The proposed phases are:

- Phase 1 – Rapid review of the decision making processes across the CCG’s Committee structure and decision making processes
- Phase 2 – A wider review of both the CCG’s Committee structure and relevant commissioning partnership committees, including reviewing accountability to the Membership and the sub committees and working group meetings that have been set up to deliver ‘Business As Usual’
- Phase 3 – Consider the future Governance arrangements that would most enable the CCG to carry out its commissioning function effectively in 2020.

The aim of Phase 1 was to review whether NHS Lewisham CCG committee structures and decision making processes could be made simpler, clearer and more responsive to resolve issues, whilst continuing to provide sufficient assurance.

The review was led by an independent governance officer who undertook a desk based review to analyse the current decision making processes as set out in Lewisham CCG’s governance documentation including the Constitution, Committee Terms of Reference and other appropriate materials. Also he carried out structured interviews with a sample of CCG Governing Body members, Directors and their deputies during December 2015 and January 2016.

The proposed recommendations have been discussed with the Chairs of each of the key Committees to seek their views and to incorporate their comments.

2. Proposed Recommendations

The draft recommendations of Phase 1 of the Governance Review have been summarised into three categories (see Appendix A):

- Recommendations that are aimed to support the CCG’s decision making being simpler, quicker and more transparent by making the committee structure flatter with fewer layers of committees and groups – recommendations 1-5
- Recommendations that are intended to facilitate the Governing Body having a greater involvement in developing and overseeing the strategic direction of the CCG - recommendations 6 - 11
- Recommendations from the ‘desk top’ review to align Committees’ Terms of Reference with the CCG’s Constitution. These are mainly technical changes – recommendation 12-18.
Further suggestions for improvements in the organisation’s development are shown at Appendix A page 6. These suggestions will be considered further as part of the wider developmental work with Governing Body members and staff on ways of working, relationships and values.

The impact of the above recommendations on changes to CCG’s Governance structure is shown at Appendix B

The Governing Body are asked to agree the 18 recommendations of the Rapid Governance Review, Phase 1 which are shown at Appendix A.

3. **Next Steps**

3.1 **Immediate Action**

Immediate action is required to address three key areas of concern that have been raised during the Review:

- how will the Integrated Governance Committee incorporate the current responsibilities of FLAG effectively, to ensure that the Learning and Development remit of the FLAG and its responsibility for all aspects of quality – safety, effectiveness and experience – are addressed? It is proposed that the Delivery Committee is tasked to consider the way in which the Integrated Governance Committee will operate - structure of agenda, sub group structures, reporting mechanisms - to undertake its role effectively and efficiently.

- how best to achieve the current ‘business function’ of the Strategy and Development Committee? It is proposed that the different options are reviewed by the Chair of the Strategy and Development Committee, working with the Corporate Director.

- how best to provide the Governing Body oversight of its Public Sector Equality Duty and its interface with the Public Engagement and Communication workshop? It is proposed that the Lay members and the Chief Officer consider this further, supported by the Corporate Director.

It is recommended that the above ‘Immediate Action’ is addressed during March and April, with an update report provided to the Governing Body at its May meeting.

3.2 **Governance Implementation Plan**

A Governance Implementation Plan will be drawn up to support the agreed changes in the Committee structures to ‘go live’ from 1st April 2016. This will include consideration of revisions to Committees’ Terms of Reference and, if required, revisions to the CCG’s
Constitution. Built into the Governance Review Implementation Plan will be a formal review of these governance changes in April 2017, informed by the Governing Body’s Self Assessment in 2016.

3.3 Governance Review – Phase 2

The scope and specification of Phase 2 of the Governance Review will be discussed during March and April with the aim to:
- streamline ‘business as usual’ and reduce capacity required in attending meetings
- membership engagement in clinical commissioning

The Governing Body are asked to agree the proposed immediate action and next steps required to implement the recommendations of the Governance Review as set out in section 3 above.

4. Governing Body’s meeting Public Forum session

4.1 Background

The Governing Body’s meeting Public Forum session was introduced in September 2014 to increase public participation in the CCG’s decision making processes. Following the low attendance at recent Public Forum sessions prior to the Governing Body meetings held in public, it was agreed that the timings of these sessions and how they are conducted would be reviewed in comparison to neighbouring CCGs at Bromley and Greenwich.

Currently the Public Forum session is held at 9:00, 30 minutes prior to the Governing Body meeting and is held as a separate meeting from the in. Questions are raised at the meeting by members of the public which relate to the meeting’s agenda items. Those questions that can be answered at the meeting are and those which require more detailed information are responded to in writing within the Q&A paper, which is published on the website prior to the next Governing Body meeting.

4.2 Recommendations

The conclusion of this review to encourage higher attendance is to recommend that:
- The Public Forum session is moved to 9:30 – 10:00 with full attendance from the Governing Body
- Questions relating to the agenda would be invited in writing before the meeting but with an allowance for taking oral questions on the day.
- The Governing Body meeting is held 10:00 – 12:30 inclusive of 10 minutes at the end of Part I Governing Body meeting for questions relating to the business heard.
- If required Part II Governing Body in confidence will be held 12:30 – 13:00

The Governing Body are asked to agree the change of timing of the Governing Body’s
meeting Public Forum session and subsequent time change for the Governing Body meeting as set out above

APPENDIX A - Rapid Governance Review’s Recommendations
APPENDIX B – Current and Propose CCG’s Governance Structure

CORPORATE AND STRATEGIC OBJECTIVES
Corporate Core Objective – to ensure robust governance arrangements are in place.

CONSULTATION HISTORY:
- Governing Body workshop on Organisational Development – 3rd December 2015
- Joint Clinical Directors and SMT - 4th February 2016 – discussed the emerging draft recommendations
- Membership Forum - 10th February 2016 - governance review process and draft recommendations were highlighted to Members

PUBLIC ENGAGEMENT
It is intended that the repositioning the Public Engagement and Communication workshop accountable to the Governing Body will strengthen public engagement and further demonstrate the CCGs commitment to its duty to involve the public in its decision making processes.

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

It is intended that by refreshing the current format and membership of the Strategy and Development Committee and reconstituting it as a Strategy and Development workshop based Committee that discusses strategic matters including health inequalities.

PUBLIC SECTOR EQUALITY DUTY
How does this report take into account the duty to:
- Eliminate discrimination, harassment and victimisation and any other conduct that is prohibited under the Equality Act 2010
- Advance equality of opportunity between people who share a relevant protected
characteristic and people who do not share it

- Foster good relations between people who share a relevant protected characteristic and those who do not share it

Further consideration is required on how the CCG ensure that the Public Sector Equality Duty remains a key focus of the Governing Body, using Governance arrangements, supporting the work being coordinated by the Equalities and Diversity Steering Group

RESPONSIBLE MANAGERIAL LEAD CONTACT:
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Telephone: 020 7206 3371

AUTHOR CONTACT:
Name: Susanna Masters
E-Mail: susanna.masters@nhs.net
Telephone: 020 3049 3216
ATTACHMENT A

Lewisham CCG Rapid Governance Review: Phase 1

Proposed Recommendations

Governing Body – 10th March 20216
Proposed Recommendations for Actions from Interviews

<table>
<thead>
<tr>
<th>Summary of Recommendations</th>
<th>Commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td>It is recommended that the CCG’s Governance structure is refreshed to make it a flatter structure with fewer layers of committees and groups to make decision making more simple, quicker and transparent by:</td>
<td></td>
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</tbody>
</table>

**Integrated Governance Committee**

1. Merging the work of the FLAG into the Delivery Committee to become the Integrated Governance Committee.

   Responsibility for quality in primary care will remain with the Primary Care Programme Board with an interface with the Integrated Governance Committee.

   **IMMEDIATE ACTION:** to consider how will the Integrated Governance Committee incorporate the current responsibilities of FLAG effectively, to ensure that the Learning and Development remit of the FLAG and its responsibility for all aspects of quality – safety, effectiveness and experience – are addressed.

**Clinical Directors Committee**

2. Strengthening the role of the Clinical Directors Committee as a Clinical Executive Committee while being accountable to the CCG Membership.

   To be considered further in Phase 2 of the Governance Review - the specific roles and actions required to improve Membership engagement and to test and develop thinking for future service redesign and QIPP schemes at an early stage.

**All CCG’s Committees**

3. Amending the Terms of Reference of Committees to ensure that the frequency with which all committees and groups are held is less rigid and more agile, to “meets a minimum of x times a year”, without resulting in rapidly convened important meetings at short notice.

   This recommendation is to reflect that the amount of business to be done at different times throughout the year/commissioning cycle varies.

   Committee Chairs’ Report to cover the whole remit of the Committee including both achievements, exceptions, risks, learning and assurance on the status on relevant Assurance Framework’s Key Areas of Enquiry.

   The underlying principle to be that an issue/proposal is considered by one Committee for discussion/decision and then to the Governing Body for ratification if appropriate (with earlier engagement of the Membership when required).

4. Developing a refreshed check list for Committees Chairs’ reports to the Governing Body.

5. To develop a simple decision tree that signposts which types of decision (including business cases) should be taken to which Committee for approval.
## Proposed Recommendations for Actions from Interviews

<table>
<thead>
<tr>
<th>Summary of Recommendations</th>
<th>Commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>It is recommended that the Governing Body has a greater involvement in developing and overseeing the strategic direction of the CCG by:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Strategy and Development Workshop:</strong></td>
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<tr>
<td>6. Refreshing the current format and membership of the Strategy and Development Committee and to reconstitute it as a Strategy and Development workshop that considers the strategic context and risks, exploring creatively all possible options and developing a collective view on CCG’s strategic direction and priorities.</td>
<td>All Governing Body members and Senior Management Teams to be members of the reconstituted committee, chaired by Dr David Abraham. The frequency of the workshops should be flexible, initially arranged on a bimonthly basis; and kept under review. The Strategy and Development workshops will replace the current Governing Body workshops. <strong>IMMEDIATE ACTION – to consider how best to achieve the current ‘business function’ of the Strategy and Development Committee during March 2016</strong></td>
</tr>
<tr>
<td>7. Ensuring that the work of the Strategy and Development workshop continues to be accountable to the Governing Body so that strategic decisions are taken by the Governing Body in public.</td>
<td></td>
</tr>
<tr>
<td><strong>Public Engagement and Communication Workshop:</strong></td>
<td></td>
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<tr>
<td>8. Repositioning the Public Engagement Group as the Public Engagement and Communication workshop to be accountable to the Governing Body to strengthen public engagement and further demonstrate the CCGs commitment to its duty to involve the public.</td>
<td>It is noted that the current Equalities and Diversity Steering Group is a short-life management group to support the Chief Officer to ensure a specific focus is given within the CCG on the delivery of the Public Sector Equality Duty. <strong>IMMEDIATE ACTION – to consider how best to provide the Governing Body oversight of its Public Sector Equality Duty and its interface with the Public Engagement and Communication workshop</strong></td>
</tr>
<tr>
<td>9. Changing the format of meetings to a developmental workshop basis and the membership to be reviewed to strengthen CCG staff and clinical engagement.</td>
<td></td>
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</tbody>
</table>
### Proposed Recommendations for Actions from Interviews

<table>
<thead>
<tr>
<th>Summary of Recommendations</th>
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<td></td>
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</table>

<table>
<thead>
<tr>
<th>Primary Care Programme Board</th>
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</tr>
</thead>
<tbody>
<tr>
<td>10. Revising the membership to include the Lay Member who has responsibility for Governance (including Conflicts of Interests).</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Committee in Common for Strategic Decision Making</th>
<th>The Committee in Common for Strategic Decision Making has not met</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. Ensuring the Committee in Common for Strategic Decision Making is activated to ensure that there is specific oversight of the programme to reduce health inequalities.</td>
<td></td>
</tr>
</tbody>
</table>

03/03/16
Recommendations for Action from the ‘desk top’ review

Summary of Changes to Current Governance Structure -

It is recommended that the Governing Body agree to the following amendments to the CCG’s Constitution and/or Committees’ Terms of References by:

**Governing Body**

12. Amending the Governing Body’s Terms of Reference to state “The Chair of the CCG is an ex-officio member of all the CCG’s committees and sub groups with full voting rights, except for the Audit Committee”.

**Finance and Investment Committee**

13. Amending the Finance and Investment Committee’s Terms of Reference to reflect the existence of the Committee in Common for Strategic Decision Making and put into context which has primacy in the decision making process.

14. Updating the Finance and Investment Committee’s Terms of Reference as agreed in principle at the CCG’s Governing Body in January 2016.

15. Introducing pre-meetings between the Chair and the lead Officer for the Finance and Investment Committee to facilitate proactive management of the potential Conflicts of Interest.

**Audit Committee**

16. Amending the Audit Committee's Terms of Reference to exclude the Chair of the CCG as an ex-officio member of the Audit committee.

**All CCG’s Committees**

17. Ensuring that the oversight of the NHS England Assurance Framework’s key areas of enquiry is explicitly written into the terms of reference of the relevant CCG Governing Body Committees to maintain the focus in this area.

18. Amending the sentence in all other Committee’s Terms of Reference to read ‘The Chair of the CCG is an ex-officio member of this Committee with full voting rights’, except for the Audit Committee.
## Proposed Recommendations for Action from the Interviews

### Summary of suggested changes - ‘Developmental’

#### Clinical Engagement:

- Improve engagement by Clinical Directors with the Members to engender a sense of shared purpose and priorities
- Raise level of clinical involvement by Membership

#### Training and Development:

- Provide personal impact and effectiveness training and corporate effectiveness training for GB and GB Committee members. The Executive Team need to have the confidence (and support from the GB) to take appropriate decisions
- More training/development opportunities for committee chairs – discussion at Committee needs to be focused on achieving the CCGs strategic objectives
- Need to develop a more collective approach including for risk tolerance
- Create more space for its senior leadership team to think, discuss and be creative, rather than rely on everything being channelled through its committee structure
- Give more time needs to building personal relationships between the senior team
Lewisham CCG – Proposed Governance Structure

NHS Lewisham CCG Governance Structure

Arrows are lines of accountability

CCG Membership

- Membership Forum
- Clinical Directors’ Committee (Clinical Executive Committee)
- Governing Body
- Strategic Committee in Common for Decision Making
- South East London Clinical Strategy Committee
- Health and Well Being Board

Neighbourhood Meetings

- Audit Committee
- Remuneration Committee
- Primary Care Joint Committee
- Finance and Investment Committee
- Integrated Governance Committee
- Strategy and Development Workshop
- Public Engagement and Communication Workshop

Primary Care Programme Board

Key
Black – Accountability
Dotted Line – Close interface
ENCLOSURE 12

NHS Lewisham CCG Annual Report and Accounts to the Audit Committee

<table>
<thead>
<tr>
<th>CLINICAL LEAD:</th>
<th>Dr Marc Rowland</th>
<th>Post Chair</th>
</tr>
</thead>
<tbody>
<tr>
<td>MANAGERIAL LEAD:</td>
<td>Susanna Masters</td>
<td>Post Corporate Director</td>
</tr>
<tr>
<td>.AUTHOR:</td>
<td>Charles Malcolm-Smith</td>
<td>Post Deputy Director (Strategy &amp; OD)</td>
</tr>
</tbody>
</table>

RECOMMENDATIONS:

The Governing Body is asked to:

1. Note the timeline for preparing and approving the 2015/16 Annual Report and Accounts.
2. Delegate authority to approve the 2015/16 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 2015/16 NHS Lewisham CCG unaudited Annual Report and Accounts are due to be submitted to NHS England in draft form on the 22nd April 2016 and as a final audited version by the 27th May 2016.
- The Governing Body is asked to delegate authority to the Audit Committee to approve the 2015/16 Annual Report and Accounts.

Key Issues:

The management team has already started work on preparing the annual report, taking account of the conclusions of the ‘after action review’ that was carried out after the 2014/15 annual report submission. This is being led by an operational steering group that is accountable to the Chief Officer.

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.

2015/16 Annual Report and Accounts Key Dates

Dates set by NHS England
<table>
<thead>
<tr>
<th>When</th>
<th>What</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friday 22nd April</td>
<td>Full draft annual report and accounts including the annual governance statement, as approved by the accountable officer and chief financial officer (and passed to appointed auditors for audit). A full copy of the final head of internal audit opinion statement as issued by the CCG internal auditors.</td>
</tr>
<tr>
<td>Friday 27th 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>Friday 30th September</td>
<td>CCGs should hold a public meeting which the annual report and accounts should be presented.</td>
</tr>
</tbody>
</table>

**Annual report proposed sign-off process**

<table>
<thead>
<tr>
<th>Action</th>
<th>Paper to be submitted by:</th>
<th>Committee meeting/milestone date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audit Committee approve unaudited draft annual report and accounts</td>
<td>Wednesday 13th April</td>
<td>Tuesday 19th April</td>
</tr>
<tr>
<td>Unaudited draft annual report and accounts submitted to NHSE</td>
<td>Friday 22nd April (9.00am)</td>
<td></td>
</tr>
<tr>
<td>Audit Committee approve final annual report and accounts</td>
<td>Wednesday 18th May</td>
<td>Wednesday 25th May</td>
</tr>
<tr>
<td>Final annual report and accounts to be submitted to NHSE</td>
<td>Friday 27th May (noon)</td>
<td></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 reader’s panel will be asked to comment on a late draft of the 2015/16 Annual Report
- The annual report will include a summary of the CCG’s progress in meeting its responsibilities for public engagement during 2015/16
HEALTH INEQUALITY DUTY
How does this report take into account the duty to:

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

PUBLIC SECTOR EQUALITY DUTY
How does this report take into account the duty to:

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

The Annual Report will report the CCG’s progress in meeting these duties during the 2015/16 financial year.

RESPONSIBLE MANAGERIAL LEAD CONTACT:
Name: Susanna Masters
E-Mail: Susanna.masters@nhs.net 020 3049 3237

AUTHOR CONTACT:
Name: Charles Malcolm-Smith
E-Mail: charles.malcolm-smith@nhs.net 020 7206 3246
A meeting of the Governing Body  
10th March 2016

<table>
<thead>
<tr>
<th>Enclosure 13</th>
<th>Safeguarding Through Commissioning Policy</th>
</tr>
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<tbody>
<tr>
<td><strong>LEAD:</strong></td>
<td>Martin Wilkinson</td>
</tr>
<tr>
<td><strong>MANAGERIAL LEAD:</strong></td>
<td>Alison Browne</td>
</tr>
<tr>
<td><strong>AUTHOR:</strong></td>
<td>Graham Hewett</td>
</tr>
</tbody>
</table>

The Governing Body is asked to:

1. Approve the Safeguarding Through Commissioning Policy pending further comments from FLAG.
2. Note that the Policy will be discussed at FLAG on the afternoon of 10th March 2016.
3. Agree that Chair’s Action can be taken to approve the policy if significant changes are recommended by either the Governing Body or FLAG on the 10th March.

Appendices:
Appendix A. Safeguarding Through Commissioning Policy

**Safeguarding Through Commissioning Policy**

The Governing Body will be aware that the CCG’s arrangements for Safeguarding Children, Young People and Adults at Risk were “Assured as Good” by NHS England in its deep dive as part of the assurance process for CCGs in 2015/16.

In relation to the CCG’s safeguarding policy, NHS England said:

*Good Practice  
Excellent Children and Adult Safeguarding in commissioning policy in draft form features FGM / CSE / Prevent. Due to be signed off by January 2016 – Assured as Outstanding post sign off."

Since the deep dive the Safeguarding Through Commissioning Policy has been reviewed and updated to ensure that it is aligned with The Care Act (2015) the new London Multi-Agency Adult Safeguarding Policy and Procedures and other updates to national and local guidance.
Governing Body is asked to approve the policy.

CORPORATE AND STRATEGIC OBJECTIVES
Quality – Commission High Quality Services

CONSULTATION HISTORY:
CCG Safeguarding Team
NHS England
FLAG (10th March 2016 pm)

PUBLIC ENGAGEMENT
Healthwatch will be invited to comment on the Policy at the March 10th FLAG meeting.

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

PUBLIC SECTOR EQUALITY DUTY
How does this report take into account the duty to:
- Eliminate discrimination, harassment and victimisation and any other conduct that is prohibited under the Equality Act 2010
- Advance equality of opportunity between people who share a relevant protected characteristic and people who do not share it
- Foster good relations between people who share a relevant protected characteristic and those who do not share it

The Safeguarding Through Commissioning Policy sets out how the CCG will work with other partners in Lewisham and across London to safeguard and protect vulnerable people.

RESPONSIBLE MANAGERIAL LEAD CONTACT:
Name: Alison Browne
E-Mail: Alison.browne@nhs.net

AUTHOR CONTACT:
Name: Maureen Gabriel, Graham Hewett, Fiona Mitchell,
E-Mail: graham.hewett@nhs.net
NHS Lewisham CCG

Safeguarding Through Commissioning Policy

<table>
<thead>
<tr>
<th>Version:</th>
<th>Version 6 Draft</th>
</tr>
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<tbody>
<tr>
<td>Supersedes:</td>
<td>Version 5 August 7th 2013</td>
</tr>
<tr>
<td>Ratified by:</td>
<td></td>
</tr>
<tr>
<td>Date ratified:</td>
<td></td>
</tr>
<tr>
<td>Name of originator/author:</td>
<td>Alison Browne</td>
</tr>
<tr>
<td>Name of responsible committee/ individual</td>
<td>FLAG (For Action and Learning Group)</td>
</tr>
<tr>
<td>Effective from:</td>
<td>March 2016</td>
</tr>
<tr>
<td>Review date:</td>
<td>March 2019</td>
</tr>
<tr>
<td>Target audience:</td>
<td>CCG employees, members and health and social care providers in Lewisham (and those commissioned for Lewisham residents elsewhere)</td>
</tr>
</tbody>
</table>
# Contents

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7 Adults at Risk | 9  

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Appendix B Terms of Reference: Health Safeguarding Assurance Group | 20
1. Principles and Values

1.1. Safeguarding children, young people and adults at risk is of the highest priority for NHS Lewisham Clinical Commissioning Group (the CCG).

1.2. The CCG has a core objective to commission services that are safe, effective, responsive, caring and well led. Safeguarding children, young people and adults at risk is central to achieving this objective.

1.3. The CCG’s approach to safeguarding is based on six principles of safeguarding:

- **Empowerment**: People being supported and encouraged to make their own decisions and give informed consent.
- **Prevention**: It is better to take action before harm occurs.
- **Proportionality**: The least intrusive response appropriate to the risk presented.
- **Protection**: Support and representation for those in greatest need.
- **Partnership**: Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
- **Accountability**: Accountability and transparency in delivering safeguarding.

1.4. The CCG expects that these six principles will inform the ways in which its own employees, its members and professionals working across the health economy and the borough of Lewisham will work with vulnerable people.

1.5. Promoting equality and addressing health inequalities are at the heart of the CCG’s values. Throughout the development of this document we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from, healthcare services and in securing that services are provided in an integrated way where this might reduce health inequalities.

2. Policy Statements

2.1. The CCG will deliver its duties for safeguarding in line with:

- The London Child Protection Procedures (2007 and as subsequently updated)\(^1\)
- The London Multi-Agency Adult Safeguarding Policy and Procedures (2015 and as subsequently updated)\(^2\)

\(^1\) [http://www.londoncp.co.uk/](http://www.londoncp.co.uk/)

2.2. The London wide safeguarding policies and procedures take precedence over this document, which is the CCG’s local operational policy. The London wide policies and procedures set out the detailed operational procedures that the CCG will follow.

2.3. The CCG will take a health economy wide view of its responsibilities for safeguarding.

2.4. The CCG will support the London Borough of Lewisham (LBL) to deliver its statutory duties for safeguarding via membership of the Lewisham Safeguarding Children Board (LSCB) and the Lewisham Adult Safeguarding Board (LSAB) and their sub committees and working groups, ensuring appropriate senior and clinical representation. The CCG will work in partnership to deliver the Boards' strategies, policies and plans.

2.5. The CCG will use its contracting arrangements to ensure that the services it commissions meet all statutory safeguarding duties and work to the London wide procedures (where services are based in London) or other relevant local multi agency procedures.

2.6. The CCG will work with LBL, NHS England and other commissioners to ensure that providers of health and social care services not commissioned by the CCG meet all statutory safeguarding duties and work to the London wide procedures (where services are based in London) or other relevant local multi agency procedures.

2.7. The CCG will ensure that its employees and members are appropriately trained and skilled to deliver their statutory duties, the London wide procedures and the CCG’s safeguarding policy, strategies and plans.

3. Scope

3.1. This policy applies to all employees and members of the CCG and will be applied to all contracts and service level agreements that the CCG enters into.

4. Duties and Responsibilities

4.1. The Governing Body Lead for Safeguarding – (Senior Clinical Director)

4.1a. The Governing Body Lead (Senior Clinical Director) will be the Governing Body executive for safeguarding and will be accountable to the CCG’s Governing Body for providing assurance that the range of safeguarding statutory duties are discharged and all responsibilities met.

4.1b. The Governing Body Lead will be responsible for seeking assurance that the organisation from which the CCG contracts or commissions provide a safe system that safeguards children and adults at risk.

4.1c. The Governing Body Lead will ensure that the CCG has an appropriate internal governance framework and operating arrangements that can properly implement and support robust systems and processes to monitor all safeguarding requirements, including an early warning system of a failing provider.

4.2. Director of Nursing and Quality

4.2a. The Nurse Director is responsible for the management of the safeguarding team and for providing support to the Governing Body Lead for Safeguarding.
4.2b. The Nurse Director is responsible for ensuring that funding is available to enable the designated and other professionals to fulfil their roles and responsibilities effectively.

4.2c. The Nurse Director is responsible for ensuring that funding is available to contribute to the adult’s and children’s safeguarding boards budgets

4.2d. The Nurse Director is responsible for ensuring that Serious Incident (SI) procedures are followed in relation to health safeguarding.

4.2e. The Nurse Director is responsible for ensuring that the appropriate local authority is informed when a child has been in an in-patient setting for more than three months

4.2f. The Nurse Director is responsible for ensuring that allegations against staff of the CCG are followed up appropriately.

4.2g. The Nurse Director is responsible for the recruitment and management of the designated professionals and ensuring that they have training and supervision in relation to safeguarding children, young people and adults. This is to ensure that:
   
   • CCG employees, members and health care providers in Lewisham have easy access to paediatricians trained in assessing young people who may be experiencing abuse or neglect and that suitable professionals are available for undertaking forensic medical examinations.
   • CCG employees, members and health care providers in Lewisham have access to specialist opinion specifically to assess adults at risk who may be experiencing abuse or neglect.

Designated and other professionals will include:

• Designated Nurse for Safeguarding Children and Looked After Children (LAC)
• Designated Doctor for Safeguarding Children
• Designated Paediatrician for Child Deaths
• Designated Doctor for Looked After Children (LAC)
• Named General Practitioner for Safeguarding Children
• Designated Adult Safeguarding Manager
• Named General Practitioner/named professional in adult safeguarding for Primary Care (in conjunction with NHS England)

4.2h. The designated and named professionals are members of the NHS Lewisham CCG Health Safeguarding Assurance Group. All the designated professionals will be employed in a senior capacity to influence local thinking and practice.

4.2i. The CCG has agreed with LBL Director of Children’s Services, Director of Adults Services and the Chair of the LSCB and LSAB that:

• The CCG will be represented at the LSCB by the Designated Nurse for Safeguarding Children, the Designated Doctor for Safeguarding Children, and the Governing Body Lead for Safeguarding.
• The CCG will be represented at the LSAB by the Designated Adults Safeguarding Manager, and the Governing Body Lead. The Nurse Director will deputise for the Governing Body Lead for Safeguarding.
• Any learning and recommendations from the LSCB and LSAB will be reported to the CCG’s Health Safeguarding Assurance Group.
• The Chief Officer of the CCG will represent the CCG at the Executive LSCB. The Governing Body Lead for Safeguarding will deputise as necessary.

4.2j. Designated safeguarding professionals will receive regular safeguarding/child protection supervision/peer review and undertake reflective practice. This should be provided by an external provider with the relevant expertise.

4.3. Commissioning Director and Head of Joint Commissioning

4.3a. The Commissioning Director and Head of Joint Commissioning (and all other CCG commissioners) are responsible for ensuring that all contracts and or service level agreements placed by the CCG with providers includes a requirement that the provider will comply with:

• The London Child Protection Procedures (2007 and as subsequently updated)
• The London Multi-Agency Adult Safeguarding Policy and Procedures (2015 and as subsequently updated)
• NHS Lewisham CCG Safeguarding Through Commissioning Policy (this document)

Contracts

4.3b. Where appropriate the CCG will use a standard NHS Contract.

The following clauses within the NHS Standard Contract relate specifically to Safeguarding Children:

“Clause 4A.1 of the NHS standard contract requires that the provider complies with the commissioner’s policy for safeguarding and protecting the welfare of children as appended in Schedule 10.

Clause 4A.2 states that following a ‘reasonable written request’ from the commissioner, the provider shall provide evidence within 10 working days that it is addressing any safeguarding concerns that have been raised.

Clause 4A.3 makes provision for the provider to ‘participate in the development of any local multi-agency safeguarding quality indicators’.

The CCG will use the following wording in Schedule 10: ‘The provider is required to demonstrate strong commitment to safeguarding children within all the services they provide and to comply with the commissioner’s policy which is attached.’

Provider Safeguarding Policies

4.3c. Before placing contracts with provider organisations, CCG commissioners will ensure that the provider organisation has comprehensive safeguarding policies in line with the London procedures and statutory guidance and that the provider organisation a named Senior Officer(s) responsible for the implementation and operation of the policies.

The policies should demonstrate how:

• provider staff will be trained to be competent and to be alert to potential indicators of abuse and neglect in children, young people and adults at risk and know how to act on their concerns and fulfil their responsibilities.
• Safer Recruitment and Disclosure, Vetting and Barring Procedures will be implemented
• procedures for responding to allegations against staff will be implemented
• providers will contribute to multi-agency working and participate at the LSCB and LSAB
• the provider will implement information sharing protocols including for MASH, MARRAC, MAPPA
• staff will be provided with safeguarding supervision and support. The level of supervision provided should be in accordance with the degree and nature of contact that staff have with children, young people, adults at risk and families. A confidential service should be provided for staff for emotional support when dealing with cases of child, young people or vulnerable adult abuse
• staff will know how to contact the Safeguarding Lead in their service
• the Serious Incident and Complaints Policies in the organisation reflect national guidance and includes escalation to the designated professionals in and out of hours.
• the provider will ensure full participation in the processes which form part of Serious Case Reviews (SCRs) and multi-agency reviews (MARs). All agencies must contribute when requested by the safeguarding team of the CCG who will lead on the health components of SCRs and MARs.
• the provider will respond to the death of a child and the review process including providing staff with the time and resources to fully engage in the process
• the provider will support and participate in Domestic Homicide Reviews

Service Level Agreements

4.3d. Any local service level agreement or service specification that does not conform to the NHS Standard Contract should include within it the clauses above. It is not acceptable to include just a generic reference to safeguarding, or limit safeguarding requirements to disclosure and barring service checks.

Primary Care

4.3e. The CCG will work jointly with NHS England to ensure that primary care providers have robust systems in place to fulfil their role in safeguarding, promoting the welfare of children and protecting adults at risk.

4.4. CCG employees

4.4a. If an employee of Lewisham CCG has concerns that a child, young person or adult is at risk of harm or abuse they should notify their line manager and/or local safeguarding lead and the local Social Services Department. The person should also consider informing the local Police.

4.4b. In hours the CCG safeguarding team will offer advice and additional support and the Designated Professional will be available for advice and support.

4.4c. Out of hours, staff may contact the Social Services Emergency Duty team, in the case of an emergency staff may also consider contacting the Police.

4.4d. Keeping children, young people and adults at risk safe is everybody’s business. Everyone has a responsibility in our private and professional lives. If you think a child is at risk of harm, you must take action.

If you think the child, young person or adult at risk may be in immediate danger call 999.

Otherwise contact Lewisham Children’s Social Care on 020 8314 6000.

For the Children’s Social Care Duty Team call 020 8314 6660.
5. Safeguarding Assurance

5.1. The CCG will seek assurance that the providers it commissions health care services from are compliant with the relevant policies at a quarterly Health Safeguarding Assurance Group.

5.2. Every health care provider commissioned by the CCG will be required to send a representative to the CCG Health Safeguarding Assurance Group.

5.3. Other providers of health care services in Lewisham will be invited to join the CCG Health Safeguarding Assurance Group as a means of learning from and sharing best practice.

6. Definitions

6.1. Children and Young People

6.1a. All children and young people under 18 years of age, in particular those who are seen as vulnerable; who are referred to health and social services and assessed for risks of potential significant harm or are suffering significant harm, have the rights to protection by health and social services.

- Children 0 - 5 years old are seen as the most vulnerable group in this section; health and social care, along with parenting education is provided to support the development of these children;
- Children 5-16 years are in the developing and most formative years and it is essential that health and social care services continue to monitor development and progress in partnership with education departments.

6.1b. Children and young people with mental health or learning difficulties present additional need and therefore, through appropriate health, education and social care continue to be monitored through their development.

6.2. Abuse and Neglect

6.2a. Abuse and neglect are forms of maltreatment of a child.

6.3. Physical abuse

6.3a. Physical abuse may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning, suffocating, or otherwise causing physical harm to a child. Physical harm may also be caused when a parent or carer fabricates the symptoms of, or deliberately induces, illness in a child.

6.4. Emotional abuse

6.4a. Emotional abuse is the persistent emotional maltreatment of a child such as to cause severe and persistent adverse effects on the child’s emotional development.

6.5. Sexual abuse
6.5a. Sexual abuse involves forcing or enticing a child or young person to take part in sexual activities, not necessarily involving a high level of violence, whether or not the child is aware of what is happening. The activities may involve physical contact, including assault by penetration (for example, rape or oral sex) or non-penetrative acts such as masturbation, kissing, rubbing and touching outside of clothing. They may also include non-contact activities, such as involving children in looking at, or in the production of, sexual images, watching sexual activities, encouraging children to behave in sexually inappropriate ways, or grooming a child in preparation for abuse (including via the internet).

6.6. Neglect

6.6a. Neglect is the persistent failure to meet a child’s basic physical and/or psychological needs, likely to result in the serious impairment of the child’s health or development. Neglect may occur during pregnancy as a result of maternal substance abuse.

6.7. Domestic violence

6.7a. The Home Office defines domestic violence as ‘Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality’. Aged 16 years and above.

6.8. Female genital mutilation

6.8a. Female genital mutilation (FGM) is a collective term for procedures which include the removal of part or all of the external female genitalia for cultural or other non-therapeutic reasons.

6.9. Child Sexual Exploitation

6.9a. Child Sexual Exploitation (CSE) is a form of sexual abuse that involves the manipulation and/or coercion of young people under the age of 18 into sexual activity in exchange for things such as money, gifts, accommodation, affection or status.

6.10. Honour Based Abuse / Forced Marriage

6.10a. Honour based violence" is a crime or incident, which has or may have been committed to protect or defend the honour of the family and/or community'.

7.0. Adults at Risk

7.0a. The Care Act 2014 sets out a clear legal framework for how local authorities and other parts of the system should protect adults at risk of abuse or neglect.

7.0b. Local authorities have new safeguarding duties. They must:

- lead a multi-agency local adult safeguarding system that seeks to prevent abuse and neglect and stop it quickly when it happens
- make enquiries, or request others to make them, when they think an adult with care and support needs may be at risk of abuse or neglect and they need to find out what action may be needed
- establish Safeguarding Adults Boards, including the local authority, NHS and police, which will develop, share and implement a joint safeguarding strategy
• **carry out Safeguarding Adults Reviews** when someone with care and support needs dies as a result of neglect or abuse and there is a concern that the local authority or its partners could have done more to protect them

• **arrange for an independent advocate** to represent and support a person who is the subject of a safeguarding enquiry or review, if required.

Any relevant person or organisation must provide information to Safeguarding Adults Boards as requested.

Adults at Risk could include:

- People with learning difficulties
- People with physical disabilities
- People with sensory impairment
- People with mental health needs
- People with a long term illness
- People who misuse substances or alcohol
- People who are physically or mentally frail and/or
- People with dementia.

7.0c. Carers may be regarded as Adults at Risk in some situations.

7.0d. Abuse is the violation of an individual’s human and civil rights by any other person or persons. Types of abuse defined in the Care Act 2014

**7.1. Physical abuse**

7.1a. This may be defined as ‘the use of force, or any action, or inaction which results in pain or injury or a change in the person’s natural physical state’ or the ‘non-accidental infliction of physical force that results in bodily injury, pain or impairment’. Inadvertent physical abuse arising from poor support or care e.g. bruising arising from poor moving and handling is classified as ‘neglect’. Concerns about the quality of care will not be addressed under safeguarding procedures unless there is a direct impact on an individual adult.

**7.2. Domestic Abuse**

7.2a. In 2013, the Home Office announced changes to the definition of domestic abuse. It is defined as an

Incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse by someone who is or has been an intimate partner or family member regardless of gender or sexuality aged 16 years and over. (Young people up to the age of 18 years are protected by Lewisham Child Protection Procedures).

7.2b. Domestic abuse includes intimate partners and other family members, and much safeguarding work (that meets the criteria set out in the 3 Key Tests) that occurs in a person’s home is concerned with domestic abuse. Domestic abuse approaches and legislation can be considered safeguarding responses in appropriate cases.

**7.3. Sexual abuse**

7.3a. Direct or indirect involvement in sexual activity without valid consent (this can include when an adult has not or cannot consent, or was pressured into consenting).
7.4. **Financial or material abuse**

7.4a. Financial abuse is the main form of abuse recorded by the Office of the Public Guardian both amongst adults and children at risk. Financial abuse can occur in isolation but it is also likely to be connected to some other forms of abuse. Although this is not always the case, everyone should be aware of this possibility.

7.5. **Psychological or emotional abuse**

7.5a. This includes: emotional abuse, threats of harm or abandonment, deprivation of contact with others, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, cyber-bullying, isolation or unreasonable and unjustified withdrawal of services or supportive networks.

7.6. **Neglect and acts of omission**

7.6a. Neglect can take several forms and can be the result of an intentional or unintentional act(s) or omission(s).

   Note: Under the Mental Capacity Act 2005 wilful neglect and ill-treatment of a person lacking capacity is a criminal offence and can result in a fine or imprisonment.

7.6b. The offence can be committed by anyone responsible for that adult’s care and support including paid staff, family carers and those with legal authority to act on that adult’s behalf (i.e. persons with power of attorney or Court-appointed deputies).

7.6c. Ill-treatment covers both deliberate acts of ill-treatment and also those acts which are reckless which results in ill treatment. Wilful neglect requires a serious departure from the required standards of treatment and usually means that a person has deliberately failed to carry out an act that they knew they were under a duty to perform.

7.6d. Under ss20-25 Criminal Justice and Courts Act 2015 it is an offence for a care worker or care provider to ill-treat or wilfully neglect an individual in their care.

7.7. **Discriminatory abuse**

7.7a. The principles of discriminatory abuse are embodied in legislation including the following:

   - Human Rights Act 1998
   - Equality Act 2010

7.7a. Discriminatory abuse exists when values, beliefs or culture result in a misuse of power that denies mainstream opportunities to some groups or individuals. It is the exploitation of a person’s characteristics, which excludes them from opportunities in society, for example, education, health, justice, civic status and protection. It includes discrimination on the basis of age, disability, gender reassignment, marriage, civil partnership, pregnancy, maternity, race, religion or belief, sex or sexual orientation and includes hate crime incidents. Discriminatory abuse includes: forms of harassment and slurs or similar treatment because of race, gender and gender identity, age, disability, sexual orientation or religion. See also: www.gov.uk/discrimination-your-rights/types-of-discrimination. Examples of behaviour: treating a person in a way that is inappropriate to their age and / or cultural background, unequal treatment, verbal abuse, inappropriate use of language, slurs, harassment and deliberate exclusion.

7.8. **Organisational abuse**
7.8a. Repeated instances of poor or inappropriate care or support may be an indication of more serious problems and this is referred to as ‘organisational abuse’.

7.8b. Organisational abuse occurs when an organisation’s systems and processes, and / or management of these, fails to safeguard a number of adults leaving them at risk of, or causing them, harm. Organisational abuse can also occur when the routines, systems and norms of an organisation override the needs of those it is there to support, or fail to provide those individuals with an appropriate quality of care. This can be the product of both ineffective and / or punitive management styles, creating an environment within which abuse can take place, intentional or otherwise.

7.8c. Organisational abuse includes: neglect and poor care practice within an institution or specific care setting such as a hospital or care home, or in relation to care provided in a person’s own home. This may range from one-off incidents to on-going ill-treatment. It can be through neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation.

7.9. Restraint

7.9a. Restraint Unlawful or inappropriate use of restraint or physical interventions and / or deprivation of liberty are physical abuse.

7.9b. Restrictive physical interventions are only justified when they are used in the best interest of the person and / or to protect the safety of others. Where these are necessary the least restrictive approach should always be used. If the person lacks capacity regarding this, any interventions must be in line with the Mental Capacity Act and Deprivation of Liberty Safeguards Code of Practice.

7.9c. There is a distinction between restraint, restriction and deprivation of liberty. This will depend on the particular circumstances of the case, taking into account the type of restriction, degree of intensity, duration, the effect and the manner of the implementation of the measure in question.

7.9d. In extreme circumstances unlawful or inappropriate use of restraint may constitute a criminal offence.

7.9e. Someone is using restraint if they use force, or threaten to use force, to make a person do something they are resisting, or where a person’s freedom of movement is restricted, whether they are resisting or not.

7.9f. Restraint covers a wide range of actions. It includes the use of active or passive means to ensure that the person concerned does something they do not want to do, or does not do something they want to do. For example, the use of key pads to prevent people from going where they want from a closed environment or one to one supervision restricting rights of freedom. Appropriate use of restraint may be justified to prevent harm to a person who lacks capacity as long as it is a proportionate response to the likelihood and seriousness of the harm.

7.9g. Providers of health must have in place internal operational procedures covering the use of physical interventions and restraint, incorporating best practice guidance and the Mental Capacity Act, Mental Capacity Act Code of Practice and the Deprivation of Liberty Safeguards (DoLS). This should include a clear outline of how physical interventions and restraint will be implemented for individuals. For example, how adults and other relevant parties are involved in agreeing the use of physical interventions and restraint as part of the support planning and risk assessment process. This provides a safeguard for adults, relatives and other professionals. Physical interventions which are
used routinely and which do not reflect the above guidelines or are not in line with the Mental Capacity Act will be considered abusive.

7.10. Modern slavery

7.10a. Modern slavery exists in the UK and can be perpetrated against men, women and children, UK nationals, and those from abroad. Modern slavery includes exploitation in the sex industry, forced labour, domestic servitude in the home and forced criminal activity. These types of crime are often called human trafficking. The true extent and nature of modern slavery in Lewisham is not presently known as this crime remains largely invisible to the general public. It can include victims that have been brought from overseas and vulnerable people in the UK, being forced to work illegally against their will in many different sectors, including brothels, cannabis farms, nail bars and agriculture.

7.11. Self-neglect

7.11a. Self-neglect is ‘the inability (intentional or non-intentional) to maintain a socially and culturally accepted standard of self-care with the potential for serious consequences to the health and well-being of people who self-neglect and perhaps even to their community’ (Gibbons 2006).

7.11b. An individual may be considered as self-neglecting and therefore at risk of harm where they are:

- Either unable or unwilling to provide adequate care for themselves
- Unable or unwilling to obtain necessary care to meet their needs, and/or declining essential support without which their health and safety needs cannot be met.

7.12. ‘Honour’- based violence

7.12a. Honour’-based violence may be committed when family members feel that dishonour has been brought to their family. Women are predominantly (but not exclusively) the victims, and the violence is often committed with a degree of collusion from family members and / or the community. Many victims are so isolated and controlled that they are unable to contact the police or other organisations.

7.12b. Safeguarding concerns that may indicate ‘honour’-based violence include domestic abuse, concerns about forced marriage or enforced house arrest and missing person reports. If a concern is raised and there is a suspicion that the adult is the victim of ‘honour’-based violence, a referral to the police should always be considered as they have the necessary expertise to manage the risk.

7.13. Forced marriage

7.13a. Forced marriage is a term used to describe a marriage in which one or both of the parties is married without their consent or against their will. A forced marriage differs from an arranged marriage, in which both parties consent to the assistance of their parents or a third party in identifying a spouse.

7.13b. The multi-agency practice guidelines Handling Cases of Forced Marriage (Home Office, 2009) recommend that cases involving forced marriage are best dealt with by child protection or ‘adult protection’ specialists. In a situation where there is concern that an adult is being forced into a marriage they do not or cannot consent to, there may be an overlap between action taken under the forced marriage provisions and the adult safeguarding process. In this case action will be coordinated with the police and other relevant organisations, such as The Forced Marriage Unit.
7.14. Prevent

7.14.a. Prevent is a key part of the Government’s Counter Terrorist Strategy. Its aim is to stop people becoming terrorists or drawn into terrorism. Early intervention to divert people away from being drawn into terrorist activity is at the heart of Prevent.

7.14.b. For all specified authorities, it is expected that those in leadership positions:

- establish or use existing mechanisms for understanding the risk of radicalisation;
- ensure staff understand the risk and build the capabilities to deal with it;

7.14.c. Prevent work depends on effective partnership. To demonstrate effective compliance with the duty, specified authorities must demonstrate evidence of productive co-operation, in particular with local Prevent co-ordinators, the police and local authorities, and co-ordination through existing multi-agency forums, for example Community Safety Partnerships. These include those that Lewisham CCG commission.

7.14.d. Frontline staff who engage with the public should understand what radicalisation means and why people may be vulnerable to being drawn into terrorism as a consequence of it. They need to be aware of what we mean by the term “extremism” and the relationship between extremism and terrorism (see section B, above).

7.14.e. Staff need to know what measures are available to prevent people from becoming drawn into terrorism and how to challenge the extremist ideology that can be associated with it. They need to understand how to obtain support for people who may be being exploited by radicalising influences.

7.15.f. All specified authorities subject to the duty will need to ensure they provide appropriate training for staff involved in the implementation of this duty. Such training is now widely available.

7.15.g. The Prevent programme must not involve any covert activity against people or communities. But specified authorities may need to share personal information to ensure, for example, that a person at risk of radicalisation is given appropriate support (for example on the Channel programme).

7.15.h. Information sharing must be assessed on a case-by-case basis and is governed by legislation. To ensure the rights of individuals are fully protected, it is important that information sharing agreements are in place at a local level. When considering sharing personal information, the specified authority should take account of the following:

- necessity and proportionality: personal information should only be shared where it is strictly necessary to the intended outcome and proportionate to it. Key to determining the necessity and proportionality of sharing information will be the professional judgement of the risks to an individual or the public;
- consent: wherever possible the consent of the person concerned should be obtained before sharing any information about them;
- power to share: the sharing of data by public sector bodies requires the existence of a power to do so, in addition to satisfying the requirements of the Data Protection Act 1998 and the Human Rights Act 1998;
• Data Protection Act and the Common Law Duty of Confidentiality: in engaging with non-public bodies, the specified authority should ensure that they are aware of their own responsibilities under the Data Protection Act and any confidentiality obligations that exist.

7.15.i. There may be some circumstances where specified authorities, in the course of Prevent related work, identify someone who may already be engaged in illegal terrorist-related activity. People suspected of being involved in such activity must be referred to the police.

7.15.j. Safeguarding adults from radicalisation is no different from safeguarding them from other forms of harm. Indicators for vulnerability to radicalisation include:

7.15.k. Family tensions, isolation, migration, distance from cultural heritage, experiences of racial discrimination, and feelings of failure.

7.15.l. Indicators that someone might be engaged with an extremist group, cause or ideology include:

- Spending time in the company of suspected extremists, changing style of dress or personal appearance to accord with the group.
- Day-to-day behaviour becoming increasingly centred on an extremist ideology, group or cause.
- Loss of interest in other friends and activities not associated with the extremist ideology, group or cause.
- Possession of material or symbols associated with an extremist cause (e.g. the swastika for far-right groups).
- Attempts to recruit others to the ideology, group or cause. Communication with others that suggests identification with an ideology, group or cause.
- Excessive use of the internet access to extremist propaganda.

7.15.m. Channel is the name of the process of identifying and referring a person for early intervention and support. It uses existing collaboration between local authorities, statutory partners, the police and the local community to identify people at risk of being drawn into terrorism. It is also used to assess the nature and extent of that risk and develop the most appropriate support plan for the individuals concerned. For further information see: https://www.gov.uk/government/policies/protecting-the-uk-against-terrorism/supporting-pages/prevent
Appendix A

Legislative Framework and Guidance

Responsibilities for safeguarding are enshrined in legislation. Some duties apply only to children, some apply only to adults, and some apply to both. This section deals with each in turn.

There are fundamental differences between the legislative framework for safeguarding for children, and for adults, which stem from who can make decisions.

Adults have a legal right to make their own decisions, even if they are unwise, as long as they have capacity to make that decision and are free from coercion or undue influence. However decision-making power relating to children lies with those who have parental responsibility for the child. As a child grows in maturity and understanding, the law gives the child a greater say in decisions. Once a child understands fully the choice to be made and its consequences, the child’s view prevails at least as regards consent, though on occasions the courts have been prepared to override a capable child’s refusal of life-saving treatment.

The Mental Capacity Act covers and empowers children aged 16 and 17. Once 18, the young person is an adult. When issues about a child’s upbringing, or their money or property, are considered by a court, statute makes it clear that “the child’s welfare shall be the court’s paramount consideration” Known widely as the “paramountcy principle”, this has a far-reaching effect on children’s social care practice, emphasising to all what a court would need to see in order to approve arrangements.

While many key statutory provisions apply directly to a broad range of public bodies, including the NHS and the Police, some key provisions of legislation impose duties directly on local authorities only. The duties are not placed directly on any other agencies. However the NHS, as well as other agencies, is covered by these duties indirectly, because it has statutory duties to co-operate with local authorities over safeguarding.

Children and young people

The legislation and guidance relevant to safeguarding and promoting the welfare of children includes the following:

1. London child protection procedures www.londonscb.gov.uk
2. The Children Act 2004 HM Government
   Internet link: http://www.legislation.gov.uk/ukpga/2004/31/contents
3. Working Together to Safeguard Children 2015: A guide to inter-agency working to safeguard and promote the welfare of children
   Internet link: http://www.legislation.gov.uk/ukpga/2006/47/contents
5. Recruiting safely - Safer recruitment guidance helping to keep children and young people safe
   Internet link http://www.cwdcouncil.org.uk/assets/0000/7158/safer_recruitment_guidance_Nov09.pdf
6. Information Sharing: Advice for practitioners providing safeguarding services to children, young people, parents and carers 2015

Date: 10th March 2016. Version 6. Approvals: (None this version). Page 16 of 22
7. Safeguarding Children and Young people: roles and competences for healthcare staff ('the intercollegiate document') 2014

8. The Care Quality Commission (Registration) Regulations 2009


A full exposition of statutory provisions relating to children’s safeguarding can be found in appendix B of the statutory guidance document Working Together to Safeguard Children 2015. There are some broad, fundamental safeguarding duties, namely; There is a duty on local authorities to “safeguard and promote the welfare of children within their area who are in need”. The concept of “need” is defined very broadly, covering any child whose health or development will be impaired without support, or who has a disability.

Local authorities also have a further duty to “take reasonable steps...to prevent children within their area suffering ill-treatment or neglect”.

All public sector agencies providing services to children, including local authorities and all NHS bodies, “must make arrangements for ensuring that their functions are discharged having regard to the need to safeguard and promote the welfare of children”

A child-centred approach is required. As far as reasonably possible, local authorities must ascertain the child’s wishes and feelings, and devise their support in consideration of those wishes and feelings. Local authorities do not have to provide the support themselves.

A local authority must enquire whether it needs to take safeguarding action if it has reasonable cause to suspect a child in its area is suffering, or is at risk of, significant harm. This duty also covers any child in police protection, or under an emergency protection order.

It is essential practice that all agencies recognise that safeguarding is everyone’s business. No individual agency can assume that safeguarding issues will be picked up by others. To confirm and illustrate this, there are the following duties on inter-agency co-operation:

If, in discharging its safeguarding duties, a local authority asks certain specified agencies for help, those agencies must help as long as it is compatible with their own duties, and does not hamper the discharge of their own functions. These agencies include NHS England, CCGs, and all NHS trusts.

Local authorities are under a duty to make arrangements to promote co-operation with other agencies, including NHS England and all CCGs, in order to promote the well-being of children in general, and to protect them from harm and neglect in particular. Those other agencies are under an express reciprocal duty to cooperate with the local authority.

The task of monitoring inter-agency co-operation falls to the local safeguarding children board (LSCB). Local authorities must establish an LSCB for their area. NHS England, CCGs, designated professionals and local providers should ensure appropriate representation on the LSCB. The local authority and the other board members owe to each other reciprocal duties of co-operation specifically in relation to the establishment and operation of the LSCB.

The objectives of an LSCB are to co-ordinate activities of board members to safeguard and promote the welfare of children, and to ensure the effectiveness of those activities. LSCBs also commission serious case reviews where abuse or neglect of a child is known or suspected, the child has either
died or been seriously harmed, and there is concern over how agencies and service providers have worked together

**Adults at risk of harm or abuse**

The legislation and guidance relevant to safeguarding adults at risk of harm or abuse includes the following:

**Care Act 2014**

Care and Support Statutory Guidance (Chapter 14 – Safeguarding)

Further practice materials to support implementation of the Care Act have been commissioned and will be found on the LGA website as they are published. There are some broad and fundamental safeguarding duties covering adult services, namely:

Local authorities must promote the adult’s “well-being”14. Within this broad concept, the authority must “have regard to the need to protect people from abuse and neglect”15

If a local authority has reasonable cause to suspect an adult in its area is suffering or is at risk of abuse and neglect, and has needs which leave him or her unable to protect himself or herself, then it must ensure enquiries are made in order to decide what action (if any) should be taken, and by whom (the “duty to enquire”16). Enquiries should be made by the most appropriate professional, and in some circumstances that will be a health professional. In discharging these duties, there are express reciprocal duties to co-operate on local authorities and their “relevant partners”, and that category includes NHS England, and all CCGs and health trusts in the local authority’s area.

Where the safeguarding action requires assessing an adult’s needs, or the preparation or revision of care plans, or care and support plans, the local authority is under a duty to consider if the adult needs an independent advocate. The trigger is when the adult would experience substantial difficulty in understanding or retaining relevant information, or weighing that information as part of the decision-making process, or communicating their views.

Each local authority must establish a Safeguarding Adults Board (SAB) in its area. Its main objective is to help and protect those adults in its area. CCGs, working with the health system, should ensure appropriate representation on the SAB. The local authority may include any other body it considers appropriate following consultation with other members.

A SAB can arrange a safeguarding adult review whenever it chooses. However it must arrange one where an adult has died from or experienced serious abuse or neglect, and there is reasonable cause for concern about how those agencies and service providers involved worked together to safeguard the adult21. Core partners are required to contribute to such reviews when requested.

Good information sharing practice is at the heart of good safeguarding practice.

The area is covered by legislation, principally the Data Protection Act 1998, and by court decisions on issues of confidentiality and privacy.

At its heart is the principle that information should be shared if that helps to protect children or adults, or to prevent a crime. In addition, there are some specific statutory provisions (for example relating to the operation of LSCBs, and 21 Section 44 Care Act 2014 SABs, relating to the statutory scheme for vetting and barring) and information sharing.
Vetting and barring

There is a statutory scheme for vetting people working with children and adults vulnerable to abuse or neglect. It is administered by the Disclosure and Barring Service. The system provides checks on people entering the workforce, and maintains lists of individuals who are barred from undertaking regulated activity with either children or adults at risk of harm or abuse.

Domestic Violence, Crime and Victims Act 2004

Statutory guidance places a duty on Community Safety Partnerships to make arrangements for Domestic Homicide Reviews. Health bodies are required to participate in these as requested.23

Fit and proper persons test

There are new legal requirements that board level appointments of NHS trusts, foundation trusts and special health authorities are “fit and proper persons”. This excludes individuals who have been involved in “any serious misconduct or mismanagement”. Clearly safeguarding falls within that definition.24

Duty of candour

Good safeguarding practice requires openness, transparency and trust. There is a legal “duty of candour” on health service bodies. This duty is to inform people (both in person and in writing) about mistakes or other incidents which have not produced the desired outcome, apologise where appropriate, and advise on any action taken as a result.

NHS England as a commissioning organisation

As a commissioning organisation NHS England is required to ensure that all health providers from which it commissions services (both public and independent sector) have comprehensive single and multi-agency policies and procedures in place to Safeguard and promote the welfare of children and young people and to protect vulnerable at risk of harm or abuse; that health providers are linked into the Local Safeguarding Children and Safeguarding Adults Boards and that health workers contribute to multi-agency working.
Appendix B

NHS Lewisham CCG Health Safeguarding Assurance Group

1. PURPOSE

The purpose of the Group is to:

- Promote and strengthen the arrangements for safeguarding children, young people and adults at risk receiving services from health providers within Lewisham, to assess the effectiveness of those systems and processes and to seek their continuous improvement.
- Gain assurance from Lewisham health services and other commissioned services by the NHS that robust monitoring of the working of these arrangements is in place.
- Ensure that health organisations fulfil their duty of partnership and contribute fully to the Lewisham whole system Safeguarding framework for Children, young people and adults at risk.

2. Duties

- To gain assurance that systems and processes are in place to safeguard children, young people and adults at risk.
- To produce regular reports to the Quality and Safety Committee and the Governing Body including an annual report.
- To act as a forum for sharing good practice and for collaboration on strengthening safeguarding arrangements for children, young people and adults at risk particularly training, supervision and communications.
- To scrutinise public declarations on safeguarding arrangements.
- To ensure clear lines of accountability within Lewisham relating to safeguarding.
- To ensure appropriate communication systems are in place between local partners, health commissioners and health providers.
- To ensure appropriate policies, procedures and guidance are in place, disseminated and adhered to and are updated regularly to reflect regional and national guidance.
- To inform the Governing Body of any risks and key issues relating to safeguarding.
- To provide a link with Lewisham Safeguarding Children Board (LSCB) and the Multi-agency Adult Safeguarding Board.
- To monitor safeguarding performance.
- To receive reports from the LSCB working groups and ensure appropriate actions are taken.
- To gain assurance on the completion of all recommendations from serious case reviews and internal management reviews, ensuring learning is disseminated.
- To quality review all serious case reviews and internal management reviews.
- To review the adequacy of resources available to ensure that the safeguarding functions are properly carried out.
- To oversee arrangements for the whole health system support visits and inspections as they arise.

3. Accountability

The Group is accountable to the Quality and Safety Committee who have responsibility from the Governing Body for the quality and safety of health services serving the population of Lewisham
4. Membership

Governing Body lead
CCG Medical/Nurse Director / Public Health Lead for SCR
Head of Joint Commissioning
C&YP Designated Dr for Safeguarding
C&YP Designated Nurse for Safeguarding & LAC
? C&YP Designated Doctor for LAC
C&YP Named GP
CCG Adult Designated Nurse
Lewisham Healthcare C&YP Named Dr, Nurse and Midwife
Lewisham Healthcare Adult Safeguarding leads
SLaM C&YP Named Dr and Nurse
SLaM Adult Safeguarding lead
BMI Blackheath Safeguarding lead
Representation from other health providers in Lewisham as appropriate particularly private health providers

In attendance
Safeguarding Administrator (minutes and papers)

5. Required frequency of Attendance

Attendance from core membership required at each meeting or a deputy

6. Reporting arrangements into the Committee

Providers will report via an agreed monitoring template to each meeting

7. Quorum

Governing Body lead
One named Dr
One named nurse
One member from adult safeguarding
One other member

8. Frequency of meetings

Quarterly

9. Support
Health safeguarding committee provided by the Safeguarding Administrator in Lewisham.

CCG Agendas and papers distributed to members 5 working days in advance of the meeting.

Minutes of the meetings will be produced and distributed to members within 7 working days of the meeting.

10. Review

Annual review of Terms of Reference.
ENCLOSURE 14
SOUTH EAST LONDON TREATMENT ACCESS POLICY (SEL TAP) 2016

MANAGERIAL LEAD/S:
Alison Browne Nursing and Quality Director, Lewisham CCG

1. RECOMMENDATIONS:
This is a revised South East London Treatment Access Policy (SEL TAP) for 2016. The Governing Body is asked to delegate review/approval to the Delivery Committee.

2. SUMMARY:
The six SE London CCGs have collaborated on this policy for numerous years. The policy has been regularly reviewed and updated to reflect changes in evidence base, national guidance or to provide clarification on identified issues. This work has been led by the SEL Public Health Commissioning Support Group and SEL Directors of Commissioning and Chief Finance Officers Group. A summary of revisions to the policy are listed below;

2.1 Review of Cosmetic Procedures policy and a comparison with SEL and Kent policy
• Evidence review: hair removal – no evidence of cost effectiveness, not to include into TAP, but there is a potential equity issue
• Audit of Botox for hyperhidrosis (King’s) – poor compliance with the TAP
Agreed changes: Age limit increased from 18 - 21 yrs.

2.2 Musculoskeletal pathway and link to smoking and obesity
• Review of evidence of stopping smoking on different treatment outcomes – evidence weak, not to be included into TAP
• Review of evidence on reduction in weight prior to surgery – weak evidence, not to be included into TAP

2.3 Hyperhidrosis (Botox)
• Audit of 50 patients and comparison with TAP criteria – poor compliance with TAP

2.4 Functional Electrical Stimulation (FES)
• Review of requests – increase observed, potential links with changes in neuro-rehab arrangements?
• Agreed to remove from the policy as these cases are not exceptional but should be part of the neuro-rehab pathway

3. SUMMARY OF CHANGES FOR 2016:
Change of the age limit for cosmetic procedures from 21 to 18 years to bring it in line with London and other national policies.

Removal of Functional Electrical Stimulation (FES) from the policy as this treatment is a part of the neuro-rehab pathway.
4. KEY ISSUES:
The policy provides access criteria for various interventions which may be controversial. However, these criteria are based on the current agreed evidence base, best practice and national guidance. Every policy review is accompanied by a very detailed critical appraisal of the literature which ensures that access criteria for a range of procedures are based on:

- evidence of effectiveness
- agreed care pathways with initial conservative therapy followed by surgery if necessary
- appropriate threshold for intervention

5. CORPORATE AND STRATEGIC OBJECTIVES
Core Corporate Objectives 2015/16
1. High Quality Care
2. Good Governance

6. CONSULTATION HISTORY INCLUDING MEMBERS ENGAGEMENT
- SEL Public Health Commissioning Support Group
- SEL Directors

7. PUBLIC ENGAGEMENT
- This year only minimal changes and updates were made to the policy, but when new sections are added or significant changes made to existing sections, SEL Stakeholder Reference Group will be consulted.

8. IMPACT ASSESSMENT
The impact on equity is unclear. The implementation of consistent criteria should improve equity across South East London. However, there is evidence that more articulate populations may be better able to negotiate the system when there are barriers to service access. Because of the nature of the procedures included, the proposals will impact on women more than men. At this point, these proposals do not appear to have any adverse impact on race equality as they will be applied consistently to all South East London communities.

9. RESPONSIBLE SEL MANAGERIAL LEAD/s CONTACT:
   Alison Browne Nursing and Quality Director, Lewisham CCG
South East London

Treatment Access Policy

2016

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

Treatment Access Policy

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

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

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

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

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

Review
This policy will be reviewed and updated annually.

PLEASE NOTE

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

Services Now Commissioned By NHS England

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

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

Details of services commissioned by NHSE can be found on their website http://www.england.nhs.uk/resources/spec-comm-resources/


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

Should you wish to submit an IFR for a service commissioned by NHSE please email them at england.ifrlondon@nhs.net
### ELIGIBILITY CRITERIA FOR SPECIFIC PROCEDURES

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#### Appendix - Codes

All patients requiring a consultant opinion for diagnostic or symptomatic advice should continue to be referred by General Practitioners e.g. skin lesions that may be malignant.
SECTION 1 – PROCEDURES REQUIRING PRIOR APPROVAL

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

1.1 COSMETIC PROCEDURES

General Remarks

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

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

Individual Procedures

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

i) Blepharoplasty (Eyelid Reduction)

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

ii) Cosmetic Breast Surgery

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

iii) Breast Augmentation

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

iv) Breast Reduction

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

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

The patient should also meet the following criteria:

- Body Mass Index (BMI) of 25 (kg/m2) or less
- bra cup size of H or more

v) Mastopexy (relocating the nipple and improving the shape of the breast)

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

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

vii) **Breast Implants**

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

viii) **Gynaecomastia**

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

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

ix) **Correction of Congenital Nipple Inversion**

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

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

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

xi) **Dermabrasion (Chemical Peel)**

This procedure is not available for skin rejuvenation. It does have a place in the treatment of severe scarring following acne or sometimes following trauma.

xii) **Face or Brow Lift**

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

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

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

---

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

This procedure is not available on cosmetic grounds.

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

This procedure is not available on cosmetic grounds to adults. An exception may be made for children under the age of 18 at the time of referral for significant prominent or bat ears.

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

This procedure is not available on cosmetic grounds.

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

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

 xviii) **Scar Revision**

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

 xix) **Tattoo Removal**

This procedure is not available on cosmetic grounds.

xx) **Removal of Birthmarks**

Available for children up to the age of 18 for permanent large or prominent lesions on face or neck.

xxi) **Other Benign Skin Lesions**

Other benign skin lesions eg skin tags, fibroepithelial polyps, dermatofibromata, seborrhoeic warts will not be removed on cosmetic grounds. However, if symptomatic and inflamed at the time of consultation, removal will be considered.

Epidermoid (Sebaceous) cysts are always benign and are not removed in the Dermatology Department. Some may become infected and symptomatic and referral to General Surgeons is indicated in these cases.

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

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

xxiii) **Viral Warts in Adults**

Properly compliant treatment with keratolytics is as effective as cryotherapy.

xxiv) **Cosmetic Genital Surgery**

This procedure is not routinely funded by the NHS.
1.2 NON-MEDICAL CIRCUMCISIONS

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

Medical Indications
Circumcisions should continue to be performed for medical indications only

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

1.3 ALTERNATIVE THERAPIES

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

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

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

All Other Complementary Therapies
The CCGs will not purchase these services in the Acute Sector.
1.4 REVERSAL OF VASECTOMY OR FEMALE STERILISATION

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

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

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

1.5 CAESAREAN SECTION FOR NON-CLINICAL REASONS

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

1.6 SURGERY FOR ASYMPTOMATIC GALLSTONES\(^3\)

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

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

1.7 HAIR REMOVAL

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

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SECTION 2 – PROCEDURES NOT REQUIRING PRIOR AGREEMENT

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

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

2.1 EXCISION OF OTHER SKIN LESIONS

General Remarks

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

i) Pigmented Lesions

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

ii) Tunable Dye Laser

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Funding of Interventional Treatment**
Treatment may be given providing the following criteria are fulfilled.

1. **There is documented evidence of at least one of the following:**
   a. Varicose eczema
   b. Lipodermatosclerosis or a venous ulcer
   c. A venous ulcer that has taken over two weeks to heal
   d. One or more episodes of documented superficial thrombophlebitis
   e. A major episode of bleeding from a varicosity.
   **AND**
   2. **The patient has followed the above pathway**
   **AND**
   3. **The diagnosis of varicose veins has been confirmed and there is evidence of truncal reflux**
   **AND**
   4. **The patient has a normal BMI, or there is evidence that NICE guidance on measures to lose weight have been followed over a period of at least one year.**
   **AND**
   5. **There is documented evidence that the patient is aware of the complications and limitations of the treatment**

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

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

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

**Initial Assessment**

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

**Referral to Hospital**

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

**Prescribing of medication**

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

**Timescale for treatment**

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

**ELIGIBILITY CRITERIA**

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

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

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

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

Couples who have been diagnosed as having male factor or female factor problems

or

have had unexplained infertility for at least 3 years, taking into consideration both age and waiting list times.

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

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

Women will be only considered for treatment if their BMI is between 19 and 30 (kg/m2). Women with the BMI >30 should be referred to the appropriate obesity management pathway.

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

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

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

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

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

Fertility treatment will only be offered to couples where the following two criteria are met:

a) where there are no living children in the current relationship
b) where neither partner has children from previous relationships.

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

**Eligible Couples will be offered:**

3 cycles of IUI, if clinically appropriate. Criteria for IUI include: mild male factor infertility, unexplained infertility and minimal to mild endometriosis.

or

1 full cycle of IVF +/- ICSI. Indications for ICSI include severe deficits in semen quality, obstructive azoospermia and non-obstructive azoospermia. The proportion of couples undergoing IVF who require ICSI would not be expected to exceed 40%.

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

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

Same Sex Couples

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

Where both partners are female, funding can be provided as long as the relevant criteria above are met. Infertility needs to be demonstrated in the partner who is seeking to become pregnant; that partner has to have undergone at least three attempts of IUI, but should not have had more than two previous attempts at IVF or ICSI (either NHS or privately funded). A final criterion for these couples is that they meet the HFEA requirements for parenthood and that both partners consent to be parents of the child. The HFEA guidance and a suitable statement for both partners to sign are available on request.

Single Women

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

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

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

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

Egg Donation/Donor Insemination

The CCG does not routinely fund these procedures

Sperm Washing (for HIV and Other Viral Infections)

As this is not a treatment for infertility sperm washing is not covered by this policy. NICE guidelines should be followed4.

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5 Cheshire and Merseyside Specialised Services Commissioning team Addendum to the Cheshire and Merseyside fertility Policy. May 07 Appendix 1 Legal Advice from Hill Dickenson

2.4 FERTILITY PRESERVATION TECHNIQUES

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

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

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

Note:

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

Storage

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

Post-storage Treatment

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

Self-funding following cessation of NHS funding

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

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

2.5 HYSTERECTOMY FOR HEAVY MENSTRUAL-BLEEDING

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

- There has been a prior trial with a LNG-IUS (levonorgestrel intra-uterine system) intra-uterine device (unless contraindicated) or other hormonal treatments in line with NICE guidance\(^7\), which has not successfully relieved symptoms
- AND
- Other treatments [such as Non-Steroidal Anti-Inflammatory Drugs (NSAIDs), Tranexamic Acid, Endometrial ablation and uterine-artery embolization] have failed, are not appropriate or are contra-indicated in line with NICE guidelines.

Contraindications to LNG-IUS are:

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

Rationale

- The Mirena® device has been shown to be effective in the treatment of heavy menstrual-bleeding.
- It is considerably cheaper than performing a hysterectomy, even if required for many years.

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

2.6 FILTERED / COLOURED LENSES

These are not offered for specific reading difficulties.

\(^7\) National Institute for Health and Care Excellence: Heavy menstrual bleeding: assessment and management, NICE Clinical Guideline Published: 24 January 2007 nice.org.uk/guidance/cgd4
2.7 COMMON HAND CONDITIONS

♦ Ganglion

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

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

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

♦ Carpal Tunnel Syndrome

Patients typically present with nocturnal dysaesthesia in the hands which wears off with activity. The presence of a positive Phalen’s (wrist flexion test) or Tinel’s sign confirms the diagnosis. Nerve conduction studies are NOT generally needed to confirm the diagnosis. In elderly patients the condition may develop insidiously. Conservative treatment may include adjustment of activities or posture with night splintage in neutral wrist position. Non-steroidal anti-inflammatory drugs and diuretics are occasionally of benefit. Steroid injections may be of value in uncomplicated cases (requires clinical experience). Refer:
- Acute severe symptoms (fewer than 5% of patients) uncontrolled by conservative measures, particularly pregnancy
- Mild to moderate symptoms with failure of conservative management (4 months)
- Neurological deficit i.e. sensory blunting or weakness of thenar abduction

♦ Dupuytren’s Disease

Nodular or cord-like thickening of the palmar skin. May tend to cause tethering of the digits with loss of extension range. Refer:
- Loss of extension in one or more joints exceeding 25 degrees
- Young patients (under 45 years) with disease affecting 2 or more digits and loss of extension exceeding 10 degrees.

♦ Trigger Finger

Snapping of the fingers as they are extended from a fully flexed posture, associated with a tender nodule in flexor tendon at base of finger or thumb. Conservative treatment may include rest from precipitating activities or NSAIDs. Injection of hydrocortisone into the tissue in front of the tendon at the level of the distal palmar crease will often settle early cases (requires clinical experience). Refer:
- Failure to respond to conservative treatment (maximum 2 injections)
- Fixed flexion deformity that cannot be corrected
2.8 TONSILLECTOMY

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

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

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

2.9 GROMMETS

CCGs will fund insertion of grommets (ventilation tubes) in

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

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

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

2.10 ADENOIDECTOMY FOR OTITIS MEDIA IN CHILDREN

Adenoidectomy combined with grommets may be considered in children who fulfil the criteria for grommets (see 2.8).
2.11 KNEE WASHOUT AND DEBRIDEMENT FOR OSTEOARTHRITIS

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

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

2.12 HAEMORRHOIDS

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

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

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

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

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

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

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

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

Please note: Botulinium toxin preparations are not interchangeable. Botox ® is the only preparation licensed for severe, axillary hyperhidrosis in adults. At time of writing, none of the available botulinum toxin preparations are licensed for the treatment of hyperhidrosis in children. If the patient is a child (aged < 18 years) but the clinician feels he/she has exceptional clinical circumstances, the request for funding should be taken through the Individual Funding Request process.

Pregnant women and nursing mothers should avoid treatment.
**APPENDIX: Codes**

**Blepharoplasty (Eyelid Reduction)**
OPCS 4 Procedure codes C131 C132 C133 C134 C138 C139

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

**Breast Augmentation**
OPCS 4 Procedure codes B312 B301 B303 B308 B309

**Breast Reduction**
OPCS 4 Procedure code B311

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

**Revision Mammaplasty**
OPCS 4 Procedure codes B314 B302

**Breast Implants**
OPCS 4 Procedure codes B312 B301 B303 B308 B309

**Gynaecomastia**
OPCS 4 Procedure code B311

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

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

**Dermabrasion (Chemical Peel)**
OPCS 4 Procedure codes S601 S602

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

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

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

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

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

**Scar Revision**
OPCS 4 Procedure codes S604

*Codes Appendix*
**Tattoo Removal**  
OPCS 4 Procedure codes S091 S092 S065 S068 S069  
ICD10 Z411 L818

**Removal of Birthmarks**  
ICD 10 diagnostic code Q825

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

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

**Viral Warts in Adults**  
ICD 10 diagnostic codes B081

**Non-Medical Circumcisions**  
OPCS 4 Procedure codes N303  
ICD10 Z412

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

**EXCISION OF OTHER SKIN LESIONS**

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

**Tunable Dye Laser**  
ICD 10 diagnostic codes Q825

**Varicose Veins**  
ICD 10 diagnostic codes I831 I839

**Dilatation and Curettage**  
OPCS 4 Procedure codes Q103

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

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

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**Codes Appendix**

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Carpal Tunnel Syndrome
ICD 10 diagnostic code G560

Dupuytren's Disease
ICD 10 diagnostic code M720

Trigger Finger
ICD 10 diagnostic code M653

Tonsillectomy
OPCS4 F341 F342 F344 F345 F346 F347 F348 F349

Grommets
OPCS 4 Procedure code D151
ICD 10 diagnostic code H650 H651 H652 H653 H654 H659

Adenoidectomy for Otitis Media in Children
OPCS 4 Procedure code E201 E208 E209
ICD 10 diagnostic code H650 H651 H652 H653 H654 H659

Knee Washout And Debridement For Osteoarthritis
OPCS 4 Procedure code W852:
In addition, an ICD-10 code from category M17-(arthrosis of the knee) would be recorded

Haemorrhoids
OPCS 4 Procedure codes H511 H512 H513 H518 H519 H521 H522 H523 H524 H528 H529 H531 H532 H533 H538 H539 H558 H559 H568 H569 H482

Surgery for Asymptomatic Gallstones
OPCS 4 Procedure codes J181 J182 J183 J184 J185 J188 J189 J211
ICD10 code K802
Main Issues discussed

The meeting was opened to all members of the Governing Body and management team to participate in a workshop on the future role of commissioners in the 2020 vision for a whole system model of care. Following the workshop element, the committee looked at development in the strategies for estates and information management and technology (IM&T).

Workshop: Future role of commissioners in the 2020 vision for a whole system model of care

This included an update on the Adult Integrated Care Programme (AICP) roadmap covering the 2020 vision and what this means for Lewisham CCG as a commissioner. This covered the overall objectives of the integration programme, the approach which is based on the whole system and on outcomes, key developments that cover primary care, children and young people’s services, and multi-disciplinary working, access to information and estates.

An overview of the financial context looked at funding allocations for the next 3 years, and the situation for provider organisations in health and local authority.

Discussions covered how the CCG may need to work differently and the characteristics of a transformational CCG.

Key themes that were identified included that outcomes need to be co-designed with the population, the need to enable innovation and transformation, the importance of data and analytic capabilities.

Estates and IM&T Strategies

The Committee agreed the IM&T Strategy that had been presented initially at its December meeting. Comments that were received had been incorporated into the updated version. More detailed plans and timelines to be developed.

The interim Lewisham Estates Strategy (LES) was presented. The LES will support the CCG’s commissioning strategies, development of community based care and NCNs and improvement in primary care services. Next steps will include a review of GP premises, and links to provider and local authority strategies.

3 March 2016
Delivery Committee

Thursday 17 December 2015

Present
Martin Wilkinson (MW) Chief Officer (Chair)
Dr David Abraham (DA) Senior Clinical Director
Dr Sebastian Kalwij (SK) Clinical Director
Dr Faruk Majid (FM) Senior Clinical Director
Dr Angelika Razzaque (AR) Clinical Director
Tony Read (TR) Chief Financial Officer
Marc Rowland (MR) Chair
Ray Warburton (RW) Lay Member

Attending
Mike Hellier (MH) Head of System Intelligence
Graham Hewett (GH) AD of Quality and Designated Adult Safeguarding Manager
Bobbie Scott (BS) Corporate Administrative Manager
Neil Stevenson (NS) Associate Partner (BGL), South East CSU

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

1. Welcome and Introductions

MW welcomed all to the meeting.

2. Apologies

Apologies were taken and noted.

3. Declaration of Interests (DoI)

There were no new interests declared.

4(a). Minutes of previous meeting

Minutes of the Delivery Committee meeting on Thursday 26 November 2015 were agreed.

4(b). Action Log

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

5. Matters Arising

There were no matters arising.
6. SEL CCG Collaborative Framework

MW reported that the SEL Collaborative Framework, agreed by CCGs in August 2012, had been refreshed to take account of experience since CCG authorisation and the new governance arrangements for primary care and OHSEL and asked the Committee to review and approve the revised Framework on behalf of the Governing Body. The Agreement sets out the framework for overseeing the implementation of collaborative arrangements of the six CCGs in SEL. Whilst it records the intentions of the six CCGs in SEL in relation to partnership working, the provisions are not legally binding. The following significant changes from the original Framework were highlighted.

- Section 6 – Enhanced hosting arrangements
- Section 8,9,10 and 11 – Inclusion of provisions for leaving, joining, grievances and termination
- Appendix 2 – Governance arrangements
- Section 5.1.3 – On-call arrangements
- Appendix 4 – The risk reserve budget set aside has been reduced from 0.5% to 0.25%

In response to RW’s question regarding whether it was a Framework for Chief Officers and Chief Financial Officers rather than CCGs as a whole, MR stated that it is a CCG Framework which allows CCGs to work in partnership in order to impact the health economy whilst remaining independent.

In response to RW’s question regarding the scope of the on-call arrangements, MW stated the purpose of the on-call arrangements across SEL is to manage surge capacity and provide a 24/7 point of contact for providers to escalate any potential or actual service failure. If there was an out of hours business continuity incident that affected Cantilever House the On-Call Director may respond initially but the incident would be managed by a Lewisham CCG Director once available.

In response to RW’s question regarding the risk reserve and whether this put the CCG’s position at risk, TR stated that it has not put Lewisham CCG’s position at risk. Each CCG has agreed to set aside 0.25% to manage risk. A CCG may request access to the risk reserve in order to meet its statutory financial duties. The first call by any CCG against the risk reserve would be from its own 0.25%. Bexley and Greenwich CCGs have accessed their own contribution to the risk reserve.

RW stated that health inequalities should be considered within the framework.

TR stated that the revised Framework will be tested by the change in the operating plan guidance and should include a review process to ensure it remains fit for purpose.

Regarding the provisions for leaving the Collaborative TR stated that they do not consider the wider implications should a CCG decide to withdraw its membership.

MW highlighted the list of references to constitutions and asked whether the CCG’s constitution references the Collaborative Agreement.

Action: GH to advise whether the CCG’s constitution references the Collaborative Agreement.

TR suggested that the table under 3.1.10 is changed to remove the reference to ‘Lewisham CCG strongly collaborates with Bexley CCG.’

The Committee APPROVED the final version of the SEL CCG’s Collaborative Framework subject to the comments above and delegated authority to the Chair of the Delivery Committee to agree any further minor amendments.
7. Report from sub-groups

Connect Care Programme Board (CCPB)

TR gave the report and highlighted the following:

- There has been good engagement from Lewisham GP practices. However feedback is still needed from the pilot practices.
- There is on-going work to improve the link with the feeder systems in Lewisham Hospital.
- Pilot users from Oxleas have been set-up with wider roll-out planned in early 2016.
- Concerns have been raised regarding the delay to the LBL roll out.

DA stated that Connect Care would have its biggest impact in the emergency department at LGT and asked that this is a key focus of those driving the increase in user numbers.

In response to RW’s question regarding the N3 network, TR stated that this was the standard network security across the NHS.

The Committee noted the report from the CCPB

FLAG

GH tabled the report of the FLAG meeting held on 10 December, which looked at issues relating to Mental Health and Community Services and highlighted the following:

- The SLaM quality dashboard was discussed and the following highlighted:
  - Complaints have reduced in 2015/16 Q2
  - Overall, friends and family test scores have improved
  - The vacancy rate continues to rise however sickness levels continue to reduce
  - Mandatory training compliance continues to improve
  - Safeguarding training levels continue to improve
- The LAS initial response to stakeholders to the CQC’s inspection findings was discussed. The Trust was rated “inadequate” and has been placed into special measures.
- The Community Services dashboard was discussed and recommendations for further development were made.
- A report of GP Raised Quality Alerts was received and it was noted that the number of quality alerts reported remains stable. A process has been agreed to provide a report to the Neighbourhoods on a quarterly basis to feedback on actions taken as a result of the quality alerts raised.
- The monthly Serious Incident Report was received. There were 7 serious incidents reported by the CCG’s main provider organisations from 1 to 30 November. LGT has received funding from NHS LA for work around recognising deteriorating patients.
- A verbal report was received from Healthwatch. Their main project focused on access to services, particularly engaging with communities that do not speak English as a first language. The following key themes have been identified:
  - Access to GP services
  - Communication with services
  - Poor staff attitudes
  - Access to translation and quality of translation – particularly Vietnamese speakers
- Healthwatch informed FLAG that members of the public had reported that the CCG and provider services were willing to listen to what they have to say but they get little feedback on how their views have made a difference.

- It was noted that there were a number of Quality Alerts related to two week cancer waits. Concerns were raised that the C Audit process was not working and GPs were not being informed when patients were being referred internally within the hospital.

The Committee noted the report from FLAG

Information Governance Steering Group (IGSG)
TR gave a verbal report of the IGSG meeting held on 14 December and highlighted the following:

- The risk register was considered. Key risks remain the use of mobile technology and a usage audit of work issued devices will be undertaken. The other key risk is the identification of data flows.

- The investigation into the IG incident previously reported has not yet been completed and will be brought back to a future meeting.

- It was noted that the CCG has appointed a Chief Information Officer jointly with LGT.

Information Management & Technology Steering Group (IM&T)
TR gave the report of the IM&T Steering Group meeting held on 8 December, and highlighted the following:

- The draft IM&T Strategy was considered and has also been considered by the Strategy & Development Committee. Comments were requested by mid-January prior to final agreement in February.

- It was noted that the Windows 7 rollout project had not been signed off due to the lack of an equipment inventory from the CSU. Concern was raised that Lewisham CCG did not receive a fair distribution of new to old equipment. This has been formally escalated to the CSU Managing Director.

- It was noted that the deadline for practices to return their signed GPSoC agreement is 31 December. A list was provided to Clinical Directors present of the 6 outstanding practices for direct follow up. Failure to sign up incurs a cost of £12k per practice per annum.

In response to RW’s question regarding the redress for the distribution of equipment, TR stated that as long as Lewisham CCG received what was agreed in the project plan there would be no redress. The CSU has requested that CCGs pay for the equipment that has been issued above what was outlined in the project plan.

Action: TR/Clinical Directors to follow up with practices who have not signed the GPSoC agreement.

The Committee noted the report from the IM&T Steering Group

Prescribing and Medicines Management Group
There had been no meeting of the Prescribing and Medicines Management Group since the November Delivery Committee.

System Resilience Group (SRG)
MW gave the report and highlighted the following:
- The current focus is on ‘Operation Aladdin,’ which is the system resilience plan for the period of 14 December 2015 – 17 January 2016. Typically performance against the 95% 4 hour A&E standard starts to decline from October each year until the week before Christmas. As public demand for urgent and emergency care services reduce over the festive period and organisations implement measures to discharge patients home, performance rallies slightly only to fall dramatically in the first week of January. This is known as the ‘double dip.’ The aim of Operation Aladdin is to reduce the impact of the ‘double dip.’

- Agreed additional measures include additional reablement capacity, opening additional community beds and additional social worker time for assessments.

- A Norovirus outbreak has affected QE closing beds and restrictions on visiting are in place.

- Performance has improved at the Lewisham Hospital site over the last couple of weeks.

MH highlighted the concern that if the ‘double dip’ extends too far into January electives could be cancelled. LGT are looking at using a private provider to ensure RTT targets are met.

In response to RW’s question regarding whether there are concerns once business as usual resumes, MW stated there is a year round system resilience plan that has been stepped up for Christmas. TR raised concerns about business as usual from April 2016 and highlighted that an additional £8.1m had been made available to the system for winter 2015/16.

In response to SK’s question regarding the impact of the Winter Assessment Team, MW stated that the lessons learnt report will be brought back to the relevant committee in the new year.

DA referred to the Care Homes event and highlighted the difficulties they were facing recruiting staff. DA highlighted that LAS conveyancing using alternative pathways was key. MW responded that the SRG had reviewed protocols around alternative conveyancing.

DA stated that the message that primary care is open should be communicated to the public.

The Committee NOTED the report from the SRG

8. Integrated Performance Report

TR introduced the month 8 integrated performance report and suggested that the discussion should focus on cancer 62 day from GP referral to treatment and RTT performance.

Cancer Performance Recovery Plan

MH gave an update on the Cancer Performance Recovery Plan for LGT and highlighted the following:

- A letter from the CCG was sent to NHS England on 30 November sharing the revised LGT Cancer Recovery Plan and revised trajectory. The letter stated that the CCG had ‘partly assured’ the Cancer Recovery Plan. The assurance is dependent on the improvement and/or development of a robust patient tracking list (PTL), without which the CCG cannot be assured of the data and associated trajectories within the plan.

- NHS England’s response asks for further assurance in four key areas (PTL management, urology, gynaecology and endoscopy capacity) and offers the support of the regional team to work with the Trust and CCG.

- LGT has commenced additional validation work on the PTL, as a result they have identified 306 patients that have been missed from the PTL, of these 44 are known inappropriate patients (duplications). There is the potential that the remaining approximately 260 patients requiring investigation may have cancer and may not have been treated appropriately, although they may
have been treated appropriately and not picked up on the PTL. The Trust is in the process of reviewing all medical records and diagnostic results for the potentially affected patients. Following that review patients will be contacted as required.

- The Trust has been asked to provide assurance that following the assessment of patient records whether any harm has come to any patient and corresponding mitigating action, that patients cannot be omitted from the PTL in the future and that the issue is confined to the search data parameters investigated by the Trust.

- The CCG will work with LGT to produce a revised cancer recovery and trajectory plans for submission to NHS England on 8 January 2016. The Trust has been offered financial support to secure a robust PTL.

In response to MW’s question regarding the audit of the 100 day root cause analyses, GH stated that there is still more work to be done. The audit found that the root cause analyses did not include a timeline or explanation of the delay. A meeting took place across SEL and it was agreed to meet once a month from January to review the quality impact and to seek assurance from the Trust that patients have not come to harm.

DA stated it was not clear where the clinical discussions regarding the recovery plan were taking place. MW suggested that a conversation is arranged between DA, FM, Esther Appleby and the Trust Clinical Cancer Lead in early January.

**Action:** Richard Whittington / FM to arrange a Clinical conversation regarding the Cancer recovery plan.

RW raised concern that the root cause is not known and systematic problems have not been identified. MW responded that some systemic issues are recognised and it is acknowledged that the Trust is financially challenged. TR agreed that a shorter plan focusing on the high impact actions would be preferable. MW responded that a more focused action plan had been requested.

**Performance**

TR gave an update on the RTT 18 week standard and highlighted the following:

- Kings has not yet resumed reporting. The Lewisham site has resumed reporting and the CCG is seeing a worsening position.

- There are significant issues in speciality pathways (Trauma and Orthopaedics, Gynaecology and ENT). The Trust is discussing the possibility of redirecting some of the activity through independent providers. The CCG has reaffirmed that the contract plan is sufficient to deliver the standard and where activity is under plan it should be brought up to plan as part of the mitigation plan.

In response to FM’s question regarding the need to tie in targets with demand management, TR stated that if the CCG had agreed a PbR contract for 2015/16 there would be underperformance on electives and over performance on non-electives. There is a need to consider referrals along with waiting lists and capacity. Had to CCG ensured that the capacity was there to deliver at the contracting stage the discussion with private providers regarding RTT could have started earlier. NS stated that this lesson will be taken into the 2016/17 contracting negotiations.

FM requested that a report on long waiting patients is submitted to FLAG so a review of whether patients have come to harm can be made.

**Action:** MH to submit a report on RTT long waiting patients to FLAG
RW stated that while the current focus is on RTT and cancer, complaint response times continue to be red across all main providers and requested a deep dive. TR responded that this had been discussed by the management team. The quality premium investment was made in 2014/15 and used to secure additional staffing; however a link between the investment and an improved performance has not been established. A change of approach was discussed and the suggestion made to offer staff rather than investment. GH reported that the Trust has established that the root of the delay lay with the PALS and Complaints office when the delay was previously thought to sit with the Clinical Teams. This is being addressed and an improvement is expected towards the end of the year. FM stated that it is an ethical as well as a quality issue and stated it should be a priority of the Trusts Board. RW stated that he would raise the issue with the LGT Trust Board Lay Member.

Risks
The risk register was reviewed.

RW stated that risk Q6 ‘provider services do not deliver against contracted performance and / or quality standards’, which includes the cancer target is amber due to the ‘bundling’ with other targets and given the above discussion should be red. MW responded that the risk was being reviewed by the Risk Management Group on 22 December.

Finance
TR gave the month 8 finance report and highlighted the following:
- The CCG is forecasting to deliver its planned surplus of £7.6m at year end.
- Budgets are on track with minor variances.
- There have been no changes to the CCG’s allocations in month 8.
- The CCG is projecting to spend up to the Cap on the LGT contract.
- The dip in the BPP Code reported last month has been recovered and the CCG is predicting that the standard will be met.
- The CCG does not have a high number of debtors nor is debt outstanding over a long period of time.

In response to RW’s surprise that the CCG’s main debtors were statutory public bodies, TR stated that Greenwich CCG and Health Education England invoices have now been paid and the CCG is confident that Lewisham Council will pay the amount owed relating to a staff recharge.

In response to RW’s question regarding how the statement of financial position should be read, TR stated that the statement compares the CCG’s financial position at 31 March 2015 with the CCG’s financial position at 30 November 2015. The CCG’s net worth has got worse and there has been a movement in working capital due to what the CCG owes and what debtors owe the CCG.

Continuing Healthcare Previously Unassessed Periods of Care
The October report on previously unassessed periods of care was noted.

The Committee NOTED the Integrated Performance Report

9. Quality Assurance and Escalation

GH gave a report detailing the processes that the CCG uses to seek assurance of the quality of services and highlighted the following:
- Assurance of the quality of services at LGT is sought at the monthly Clinical Quality Review Group (CQRG) which is chaired by the CCG’s Director of Nursing and Quality. The CQRG is a sub group of the Contract Management Board (CMB) and quality issues are escalated as required.

- Complaints response performance has been an enduring quality concern. Performance is monitored monthly at the CQRG and quarterly at FLAG. The issue of complaint response times performance was escalated by the CQRG to the CMB in June 2015. An improvement trajectory and plan is expected in January 2016 and improvement in performance is anticipated by the end of quarter 3 2015/16.

RW raised concern that there was no dialogue between FLAG and the CMB, MW responded that representatives from FLAG attend the CMB. GH highlighted that the Quality Assurance Framework will be updated following the governance review.

MW highlighted the importance of signing off recovery plans and trajectories with the Trust so that when these are not met more formal contracting mechanisms can be pursued.

RW raised concerns that the processes take a long time and asked what processes are in place for something that is urgent. MW responded that other levers such as risk and quality summits or the serious incident process would be used.

A Governing Body workshop on risk appetite for priority areas was suggested to inform the Committee’s judgement on the most appropriate way of tackling in year deviations from plan.

10. Key Items to be reported to the Governing Body

- Cancer Performance Recovery Plan
- Collaborative Agreement
- The importance of the risk appetite workshop to the work of the Delivery Committee.

11. Minutes from sub-groups

FLAG
The approved minutes of the FLAG meeting held on 12 November were taken for information.

14. Any Other Business

There was no other business.

18. Date of Next Meeting

The next meeting would be held on Thursday 28 January 2016.
Delivery Committee

Thursday 28 January 2016

Present
Martin Wilkinson (MW) Chief Officer (Chair)
Dr David Abraham (DA) Senior Clinical Director
Diana Braithwaite (DB) Commissioning Director
Dee Carlin (DC) Head of Joint Commissioning
Dr Faruk Majid (FM) Senior Clinical Director
Dr Angelika Razzaque (AR) Clinical Director
Tony Read (TR) Chief Financial Officer
Marc Rowland (MR) Chair
Ray Warburton (RW) Lay Member

Attending
Mike Hellier (MH) Head of System Intelligence
Lesley Aitken (LA) Board Secretary (notes)
Dr Martin Baggaley (MB) Medical Director, SLaM
Charles Malcolm-Smith (CMS) Deputy Director, Strategy and OD
Eileen White (EW) Head of Medicines Management
Richard Whittington (RWh) Deputy Director of Commissioning

Apologies
Alison Browne (AB) Nursing and Quality Director
Dr Sebastian Kalwij (SK) Clinical Director

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

2. Apologies
Apologies were taken and noted.

3. Declaration of Interests (DoI)
There were no new interests declared.

4(a). Minutes of previous meeting
Minutes of the Delivery Committee meeting on Thursday 17 December 2015 were agreed.

4(b). Action Log
All additional outstanding actions had been addressed and the action log updated.

Dec 8.1 This action can now be closed.
Dec 8.2 Report on RTT – this action to be monitored and carried forward to the next meeting.
Nov 9.2 This action was outstanding
Sept 6.2 This action to be carried forward
Sept 6.3 This action to be carried forward
Sept 9.2 DC stated that the Domiciliary Care contract had been awarded following EU rules. A full report, including lessons learned, would come to the Committee in February 2016. The first meeting with providers will be held on 28 January.

5. Matters Arising

There were no matters arising.

6. South London and Maudsley update

MW welcomed MB, SLaM Medical Director, to the meeting.

MB presented the results and actions from the 2015 CQC inspection into SLaM services and highlighted the following:

- That there were four CQC categories; Inadequate, requires improvement, good and outstanding. Overall the SLaM had been rated as 'good' with some areas requiring improvement.
- The outstanding areas included the Learning Disabilities service and engagement of staff.
- There was an inadequate rating for the safety of the acute wards for adults of working age and the psychiatric intensive care units (PICU).
- There was an action plan developed for the ‘must do’s’ which included improvements to;
  - the risk assessment processes,
  - inpatient care planning,
  - recording on restraint and estates issues including those relating to restraint equipment
  - food
- The difficulty in recruiting staff, particularly for nursing (Community Psychiatric Nurses) and the recruitment drive had been improved with the aim of having sufficient staff on acute wards with the correct skill mix.
- There were financial challenges, with forensic services losing money and the cost of the overflow into the private sector. Cuts in Local Authority spend had also had an effect.

MB circulated a report on the Thematic Review of suicide April 2012 – March 2015 and stated that though all suicides are taken seriously it was recognised that 75% of those committing suicide are not in contact with SLaM services. There is potential to work on preventative measures with public health and other partners.

The following comments were taken:

In response to RW pointing out that the CQC report showed that improvement was required on the wards for Older People, MB stated that there were problems with the structures of the wards and that previous actions flagged by CQC had not been achieved. In response there was a scheme to invest in the rebuilding of some of wards at the Maudsley.

In response to MW asking how the actions fit into the strategic plan, MB stated that there was a need to get the basics right in relation to quality and finances and in particular in the investment in intensive care and acute wards. For Lewisham the aim was for seamless, coherent pathways with better access to care. There is a continual move to enhance the community offering to reduce the demand on beds.
AR congratulated MB on the good rating but had concerns regarding the vacancy rate, what plans were in place for staff recruitment and retention? MB responded it was recognised that you need contented staff in order to deliver good quality care. The new HR Director had been looking at the staff survey and had already reduced the staff sickness rate. Work was ongoing on supporting BME staff and a process for developing and supporting those in key roles, such as team leaders, was being developed. A facilitated forum following the Schwarz ideals, empathy, care and compassion was open to all staff to speak of their experiences.

In response to a question from AR on reaching out to communities MB stated that the community teams were being enhanced. He acknowledged that more collaborative partnership work was needed. AR added that SLaM representation was required at the MDT meetings. DA agreed that closer working was needed if possible with the sharing of information, for example having a shared register. MB would welcome that and was aiming for a stronger borough focus.

In response to a comment from FM that there were ongoing issues with handwritten discharge summaries, and highlighted the following concerns: - that the diagnosis in discharge letter should be at the beginning, physical health checks were sometimes missed with mental health check; blood tests should be ordered by mental health staff; in relation to care plans, more detailed clarity was required; not appropriate to ask GPs to pick up safeguarding issues. In response MB said that he agreed with the safeguarding issue and asked FM for more detail, they are looking making the discharge summary more concise, improvements are being made with physical healthcare screening and there is a new pathology contract with an improved electronic system. FM would send his concerns to MB to be further discussed at the CQRG.

RW pointed out that the key indicators showed that only 29% of complaints were being addressed within 25 days. MB responded it was recognised that the process needed to be streamlined, currently it is being over complicated, a review has been commissioned.

**The Committee thanked MB for his report.**

7. Operating Plan

**QIPP**

DB circulated the Draft QIPP 2016/17 paper. She reported that the CCG needs to identify a QIPP saving of approximately £12m across all providers. So far £1.8m has been identified in reductions in emergency activity and £595,409 in outpatient activity. DB outlined the areas where the CCG needs to work with LGT and which can deliver benefits including:

- Using the CQUIN to support the transformation of community services
- Draft proposals from LGT totalling £1.3m for delivery of the home ward and rapid response team with the aim of reducing emergency activity.
- LGT offered support for Dermatology and Gastroenterology to assist clinical triage through RSS.
- Cancer 2WW – to specify the list of non-cancer related conditions which a transfer from 2 week to 18 week transfer is appropriate.
- An increase in Ambulatory Care will be offset by a reduction in emergency admissions

DB reported that the QIPP information will be triangulated with Right Care information for the next report. There has been a marked step change in emergency activity at LGT which has resulted in a deep dive in August 2015 and subsequent clinical audits.

The financial benefits and impact from each QIPP scheme has been risk assessed. A maturity RAG rating relates to whether business cases have been agreed as follows:
There is a gap of £9.5m to be identified.

TR stated that the CCG had agreed three year’s KPIs with LGT. MW added that there was more work to do to pinpoint further schemes but not to double count. DA asked for more detailed discussions with Clinical Directors on frequent attenders. He asked where the list of QIPP schemes came from, are they the most potential gain areas? DB responded that there has previously a summit had been held on the 3-4 big areas that the CCG need to focus on.

MW agreed that the item would be taken to a Clinical Directors meeting for further discussion to include clarity on what the CCG needs and how to best use community services.

**ACTION:** Diana Braithwaite/Martin Wilkinson

DB explained that the CCG was looking to procure the MSK service and direct access physiotherapy. This transactional QIPP is not shown in the paper. MW asked for a way of demonstrating quality QIPPs not just the financial savings.

TR stated that when the transactional QIPP is built in then the gap is around £6.5m. If the gap cannot be closed then there would be a need to stop investing money and move to an underlying deficit to use non recurrent monies.

It was suggested that a CD/SMT meeting be held to have a look at future years QIPP and how to use Right Care in the system

**ACTION:** Martin Wilkinson

**The Committee NOTED the report**

**Update on National Guidance and Process**

TR reported that the detailed planning guidance had not yet been received. He highlighted the following:

- The deadline of the 8 February submission was a challenge.
- Need to align action plan with LGT even though the CCG has to submit its plan three days before LGT.
- There are two plans; the Operating Plan and a System Wide Plan (SE London)

MW pointed out the size of the task and explained that the statutory responsibility for CCGs and providers remains with NHSE (and the CCG membership) and TDA/Monitor (merging to become NHS Improvement from April 2016) respectively but with greater emphasis at a regional level being placed on an assurance basis which is tripartite level and place based. At the February Delivery Committee
there would be a focus on understanding the capacity of the system to meet constitutional standards as part of developing the operating plan.

**ACTION: Martin Wilkinson**

TR reported that LGT had been written to, as a Trust which is under financial difficulty, by NHS Improvement and offered £16.6m from the Sustainable Fund in order to achieve a planned deficit of £20.8m. This has to be agreed by 8 February 2016. The CCG is to agree a recovery trajectory for areas such as A&E and Cancer.

**Contract Negotiations Update – Acute, Mental Health and Community**

TR reported that the contract negotiations had started. LGT’s plans show substantially more income from the CCG that the CCG was planning on spending. There was a tension between the different financial demands on Lewisham, Bexley and Greenwich. There needs to be further conversations with LGT on the increased price, protection for the lost income through winter resilience and QIPP.

DC stated that the mental health negotiations were in the early stages but that the pressure points and assumptions were known. The QIPP plans and gap had been shared with SLaM undertaking further work on activity, demand and capacity assumptions. This would be shared next week; it would be tight to meet the 8 February deadline. She added that the key areas would be:

- Improvement in the acute care pathway
- PICU particularly private sector usage
- Increased mental health services for Older Adults
- Cost of Occupied Bed Days (OBDs)
- Continued pressure on the placement budgets

TR added that there were different demands on the Trust especially now that there were three CCGs involved. The LGT Contract Negotiation Team consists of their Finance Director and finance team with no-one from a clinical or service background. A way needs to be found to hold those conversations separately.

The Draft Operating Plan will go to the Governing Body meeting in March for approval.

**8. Integrated Performance Exception Report**

**Performance**

TR introduced the month 9 integrated performance reports. He reported that RTT was now at 92% and that there concerns about the lack of reports from King’s and specialities at LGT.

Regarding Cancer waiting times; RWh explained that there were two principle issues; that the data shows that 80.5% of Lewisham patients were treated within 62 days of referral November 2015 which is an amber rating for which an exception report was received; and the problems with the Patient Tracking List (PTL). The original trajectory of 85% by September 2015, revised to January 2016 had been missed. A new trajectory was set for compliance by end of March 2016. The trajectory has been tested with LGT and GSTT and by NHSE who agreed that it will be achievable. RWh explained that some tumour groups will not meet 85%.

Regarding PTL, LGT reported that 900 patients had been lost on the system, they all had now been reviewed with some back on the PTL. LGT had raised it as a Serious Incident. There was assurance that all patients from September 2015 were on the list, LGT will be repeating the exercise checking back to April 2015.
Regarding the backlogs across London RWh stated that the 62 day target will not be met, there is an eight week tripartite process in place with weekly calls to NHSE, TDA and LGT to produce trajectories to show how progressing.

Lewisham is an outlier, going forward the commissioning intentions need to be agreed with LGT. Next the trajectory will be tested against patient experience. The Patient Choice Group at NHSE will look at the two week pathway process.

RWh continued all breaches are taken through the Clinical Quality Reference Group which is a subgroup of the CQRG.

In response from a comment from FM on a recent rejection from GSTT on a two week referral patient, as the risk was not deemed high enough, RWh said that this was unacceptable and should be taken away as a case example.

MW asked for the exception report to be refreshed.

DA stated that those patients removed from the tracker system and from the pathway still need clarification from GPs, patients must not be marooned without a diagnosis.

Referring to the Planning 2016-17 Risk to Delivery table MW said that the IAPT service is seeing the number of people that it should do, the six week trajectory is improving with over 62% in December. The IAPT recovery rate was 44% in January with the national rate being 45%. The IAPT alliance is being developed through the commissioning arrangements, the team will be asked when there will be an impact on the targets and how to divert patients, when necessary, onto other pathways.

**ACTION:** Dee Carlin

The 6 weeks wait data for Neighbourhoods to be tested with the Clinical Directors.

**ACTION:** Mike Hellier

The expectation of achieving the 4 hour standard of 95% needs to be tested at a Winter Resilience meeting.

**ACTION:** Martin Wilkinson

**Risk Register**

MW reported that Q6 relating the Operating Plan had been split into 6a) Cancer, 6b) A&E and 6c) RTT. The register would come back to the March meeting with the effect of the changes. Any further changes, such as pulling out other components e.g. finance, to be discussed at the Risk Management Group.

MW agreed that the target date needs to be known and revised with a link to the exception report. Risk tolerance will be discussed at the Governing Body workshop on 4 February.

**Finance**

TR presented the Finance Report at M9, he highlighted:

- The CCG was forecasting to deliver its planned surplus of £7.6m at year end.
- The Better Practice Payment Code (BPPC) target was being delivered
- The CCG has drawn down slightly below the planned cash expenditure
- QIPP delivery was on target
- Expenditure was well managed and low because of contract cap off.
- Overall debt is low with over 30 days debtors being very low
• The Audit Committee will be looking at the Statement of Financial Position at M9

MW praised the budget holders and teams for meeting the targets.

In response to a question from RW referring to financial risk TR confirmed that the CCG is required to hold 0.50% contingency. With regard to the Better Care Fund (BCF) metric there is an increase in emergency admissions which resulted in a red rating red which means that the performance element to the joint fund does not get paid.

In response to a concern from RW to performance worsening at LGT to 15% of complaints being answered in the agreed timescale, FM said that the issues are being discussed at CQRG. Further discussions will be held outside of the meeting.

Referring to the activity performance charts DA queried what the impact of the caps on contracts had on RSS. TR responded that it was not known what the impact will be on RSS. The charts are produced by CSU MDT and will come on a regular basis to the meeting. MW added that there has been feedback from the patient survey which is highlighting gaps. RW suggested that the charts are clarified by means of a report.

The Committee NOTED the Integrated Performance Report

9. Corporate Objectives

CMS gave the report and clarified that the Delivery Committee are responsible for overseeing two corporate objectives: high quality care – commissioning high quality care services today and; good governance – ensure robust governance and equalities arrangements are in place.

There are four areas with an amber rating which means it’s not on track to deliver against the planned trajectory but has mitigating actions in place including:

1. Secure quality through provider contracts - business cases to be developed to support out of hospital care for frail elderly
2. Operational grip – the Operating Plan to be agreed by May 2016
3. IM&T – the CCG’s IM&T is drafted and shared with Strategy and Development Committee
4. Commissioning Support Services – CCG has agreed CSU commissioning intentions.

The Committee NOTED the progress that had been made to deliver the CCG’s Corporate Objectives for High Quality Care and Good Governance up to the end of Quarter 3 in 2015/16

10. Report from sub-groups

Information Steering Group

TR reported from the 26 January meeting. The policies for; Information Governance (IG), IG Framework and the Staff Guide had been approved. The IG toolkit will go to the March Delivery Committee for sign off. Referring to the IG report on lessons learned it was confirmed that the data went to the right people by email, though all the recipients were not all on NHS net those at the council now had a secure email address. It was deemed this was a low risk as the data had not been breached.

Prescribing and Medicines Management (PMM)

EW reported from the meeting held on 16 December 2015. Since the previous PMM meeting there had been an application received from a practice nurse to the non-medical prescribing course and one
expression of interest. Acknowledging that the December meeting was not quorate there had been discussions around the pharmacists in GP practices pilot and the insulin passport safety check processes in Lewisham. EW added that discussions have been held between LIMOS providers and mental health.

In response to a question from DA on the overspend trend in Medicines Management, EW said that there were improvements and specific outlier practices have been offered support. TR verified that this was a national trend.

FLaG

In response to a question from RW on the variation of between 31% - 92% across practices on ease of getting through to a surgery, FM responded that a few practices have had problems and that an action plan was now in place. MW added that there was a targeted approach in primary care with the Primary Care Project Board pursuing.

The Never Events trends and lessons learned will be reported to the Delivery Committee through the FLaG report.

The Committee NOTED the reports

The Connect Care Programme Board report and System Resilience Group report were NOTED

12. Key Items to be reported to the Governing Body

Martin Baggaley’s visit
QIPP gap and forward plan
Operational Plan
Risk register with Q6 breakdown

13. Minutes from sub-groups

The approved minutes of the FLAG meeting held on 10 December 2016 were taken for information.

14. Any Other Business

There was no other business.

15. Date of Next Meeting

The next meeting would be held on Thursday 25 February 2016.
1. Welcome and Introductions

JM welcomed all to the meeting.

2. Apologies for Absence

Apologies were taken and recorded.

3. Declarations of Interests

There were no new interests declared.

4(a) Minutes of the previous meeting

The minutes of the meeting on 1 October were agreed as an accurate record.

4(b) Review of Action Log/Tracker

06.08.2015/6: Services currently mapped are GP practices, pharmacies (with various enhanced services) and children’s centres. The mapping of adult and children’s services to neighbourhoods would be an ongoing piece of developmental work, being taken forward by Anglika Razzaque and Mike Hellier. Action closed.
06.08.2015/7b & 7d: Actions that the Strategy & Development Committee requested be taken forward following the findings of the report on BME patients with long term conditions will be monitored by the Equality & Diversity Steering Group.

04.06.2015/7: Strategic Communications and engagement support has been commissioned for the CCG. The importance of public involvement in the development of the AICP work was emphasised. It was agreed to close this action as public involvement in the development of the AICP work was being overseen by JPEG.

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

5. **Matters Arising**

There were no matters arising.

6. **Public Engagement Group Chair’s Report**

RR gave the report of the PEG meeting held on 29.10.2015 and highlighted the following:

- The OHSEL Equalities Analysis was presented by the OHSEL programme team. A number of gaps in the engagement carried out by Lewisham were identified and at PEG’s request these have been included within the revised public document. The overall conclusion of the independent report is that the programme is in a good position to fulfil the requirements of the public sector equality duties.
- The first meeting of the Public Reference Group was held on 2 December. Development will include establishing the group and its purpose, understanding the commissioning cycle, and starting to support engagement on the commissioning intentions.
- The CCG Annual Engagement Report was taken for information. PEG recognised the amount of engagement work that is reflected in the report. The report will be published on the CCG website once feedback has been received from NHS England.

In response to TR’s question regarding the Memberoo acquisition, CM-S stated that Mina Jesa, Interim Head of Engagement is taking this forward and has been meeting with the IG lead.

The Committee NOTED the report from PEG.

7. **Joint Public Engagement Group Chair’s Report**

RR gave the report of the JPEG meeting held on 05.11.2015 and highlighted the following:

- The focus of the meeting was the OHSEL equalities analysis and the commissioning intentions equalities analysis. The commissioning intentions analysis was undertaken by Public Health. Potential negative outcomes under each workstream and positive actions or mitigations were identified.
- A summary account was received on the CCG’s AGM which took place on 30 September.
- An update from Healthwatch was received. The work with the Vietnamese and Polish communities was noted.

JM reported that unfortunately the Healthy Towns bid was unsuccessful however work will continue but not to the extent outlined in the bid.

The Committee NOTED the report from the JPEG.

8. **Primary Care Programme Board**
RR gave a verbal report of the first PCPB meeting held on 25.11.2015 and highlighted the following:

- The Integrated Urgent & Primary Care Model was endorsed
- The content of the Co-ordinated Care Service (LTCs) 2016-18 was endorsed.
- The priorities for the PMS Review were agreed.
- The Primary Care Equalities Objectives were approved.
- Comments were given to NHS England on the draft quality and performance report.

In response to JM’s question regarding whether a report from the Chair of the PCPB would be a standing item, AO stated that a written report in future would be submitted to the Strategy & Development Committee following every meeting.

9. **Equality and Diversity**

**Equality & Diversity Steering Group Chair’s Report**

SM gave the report of the EDSG meeting held on 11.11.2015 and highlighted the following:

- The meeting focused on three main areas: the CCG equality and diversity workplan, the Workforce Race Equality Standards (WRES) and equalities objectives.
- A report was received on progress towards completing the assessment against the Equality Delivery System (EDS) Goals. It was noted that the self-assessment of goal 4 (leadership) of EDS cannot be improved without the full engagement of the whole Governing Body.
- A review of whether the CCG’s providers are fulfilling their responsibilities for publishing the required information to comply with the WRES is being undertaken. Once further information has been obtained this will be passed to FLAG for further consideration.
- The two equalities objectives agreed are for support to patients with long-term conditions in primary care and concerns arising from the staff survey. It is planned that a further developmental equalities objective will be developed jointly with Adult Social Care regarding the implementation of Neighbourhood Care Networks.

In response to JMi’s question regarding how engagement of the Governing Body is going to be addressed, SM stated that this would be addressed by MR and MW. CM-S highlighted that the issue may not be that the leadership are not committed to the equalities objectives, but could be the difficulty in collecting the evidence to demonstrate the commitment. It was agreed that MR would email Governing Body members who had not completed the self-assessment.

**Action:** MR to email Governing Body members to offer support in completing the equality and diversity self-assessment.

**The Committee NOTED the report from the EDSG**

**Annual Equalities Report**

CM-S gave the report on the draft Lewisham CCG Annual Equality report providing an update on the EDS process for 2015, the EDSG progress and the WRES. The report will be signed off by the Governing Body and published on the Lewisham CCG website by 31 January.

CM-S requested comments on the draft report by 24 December.

AO left the meeting, RW and VM arrived.
10. **Benchmarking Performance and Monitoring Report**

MH gave the report on the CCG Outcomes Indicators published in September 2015. The analysis compared Lewisham CCG with ten like CCGs. The CCG Outcomes Indicator set are designed to help CCGs ensure its identified local priorities for improvement are correct and demonstrate the progress that the CCG is making on outcomes. The following was highlighted:

- The overall indicator for mortality (potential years of life lost from conditions amenable to healthcare) is not significantly above like CCGs, Lewisham continues to be significantly above a number of CCGs for neoplasms. JMi highlighted that the diagram does not demonstrate 'statistical significance.'

- The long term conditions indicator, unplanned hospitalisation for chronic ambulatory care sensitive conditions, has not statistically changed but it continues to track above like CCGs.

- The long term conditions indicator, emergency admissions that should not usually be admitted, has increased and is above like CCGs. This is also supported by data from the Dr Foster indicator, alternative care services, which shows there has been an upward trend, which has continued to August 2015. This indicator shows that Influenza and pneumonia and other vaccine preventable are high along with congestive heart failure and pelvic inflammatory disease in 2014/15.

- Having improved significantly on the indicator for people who are feeling supported to manage their condition indictor in 2012/13 this has now dropped below the 2011/2012 baseline.

- Premature mortality for liver disease has risen. JMi highlighted that this was mainly linked to alcohol consumption.

- The Dr Foster alternative care services indicator rises with age, which is as you would expect, except there is a higher admission ratios for ages 5-14 which is linked to asthma admissions. The ethnicity of emergency admissions indexed against population shows high indices for White British, Black Caribbean and White Irish. Other ethnic group may not be properly coded and is a small population. JMi highlighted the importance of setting age against ethnicity.

In response to SM’s question regarding the quality of coding by the Trust, RW responded that the contract includes the requirement to record ethnicity but it does not specify how this should be done.

TR stated that the increase in emergency admissions coincides with the opening up of additional capacity two years ago at Lewisham Hospital. The improvement in the flow of patients to meet the A&E 95% target has also led to an increase in activity, which is being reported at Delivery Committee. In financial terms the increase in 2015/16 would have equated to £2m if the CCG had a PbR contract with LGT.

JMi highlighted that Public Health was planning to do some work on pelvic inflammatory disease and suggested that it was worth doing some work on congestive heart failure as this relates to a small cohort of patients.

In response to MR’s question regarding the sample size of the GP survey, MH responded that around 2,500 people complete the survey each year.

SM asked the Committee whether it is assured that the CCG is taking the right actions that will positively impact on these outcomes. The Committee agreed that the current focus was correct however further work is needed on success measures for the different workstreams to ensure that the actions being taken will improve outcomes.

TR stated that the CCG was much better at building new initiatives than closing old ones which increases hospital admissions because capacity is not closed. The CCG needs to work with the Trust to close capacity and reduce its deficit. RW suggested a high level discussion about aligning the CIP and QIPP.
TR responded that the Trust has a £40m deficit; the CCG needs to agree a position to enable the Trust to sell land without closing services that are valuable to the CCG. It was agreed that this discussion would begin at the Part 2 Governing Body meeting as part of the contract negotiation strategy.

MW arrived.

11. Commissioning Intentions 2016/17

RW and VM gave the report outlining the indicative procurement plans for 2016/17 and asked the Committee to provide assurance that the plans reflect the strategic commissioning intentions and priorities of the CCG. The following was highlighted:

- The plan is indicative and not definitive.
- The procurement plan reflects the priorities previously determined by the Governing Body when agreeing the Commissioning Intentions.
- The procurements reflected are those which specifically related to the LGT contract. The CCG’s three key outcomes for community services are: quality, strong leadership and integrated community services.
- Running through the plan is market testing which is not a legal requirement and exists outside the competitive process. It is used to inform the service specification.
- The CCG has given notice that it intends to restructure and develop new specifications around: MSK Services (including physiotherapy), structured self-management programmes for long term conditions (DESMOND and LEEP) and lymphoedema.

JMi highlighted the recent work done by the self-care and self-management group and requested this be taken into consideration and stated public health would like to input into the specification for the self-management programmes.

In response to AR’s question regarding whether the Expert Patient Programme had been considered, RW stated that it has not been looked at specifically. SM responded that there was a business case relating to the Expert Patient Programme however there was an issue regarding the programme’s effectiveness for the Lewisham population. The self-care and self-management group has developed principles by which to commission self-care and self-management services and also identified gaps in current provision. RR requested that options for DESMOND are looked at creatively with regards to what is already happening in the community.

RW and VM left the meeting.

12. Healthy London Partnership

MW gave the report from the London Transformation Group. The ambition is to make London the world’s healthiest global city. The work of the Healthy London Partnership is focused on 13 transformation programmes.

In response to AR’s question regarding whether the CCG has assurance that the work is providing added value to SEL and Lewisham in particular, MW stated that the work is being reflected at SPG level but it is harder to see the impact at CCG level. JM stated it would be helpful to have a greater understanding of the outputs of the workstreams.

In response to JM’s question regarding when the provider development support package will be available for primary care, MR stated that packages should be available shortly.

TR reported that there had been an underspend on the partnership budget for 2015/16 and asked for clarity on the financial planning assumptions regarding the link between the 0.15% and £1.3m.
TR stated that clarity was needed on the end point of each workstream.

The Committee AGREED the proposed financial planning assumption of 0.15% for 2016/17 and 2017/18, AGREED the proposed governance arrangements and proposals for on-going commitment to the partnership and the proposed planning process and timetables for 2016/17.

13. IM&T Strategy

TR reported that the draft IM&T Strategy had been shared with Clinical Directors and the IM&T Steering Group for comment. The following was highlighted:

- IM&T is a key enabler of NHS Lewisham CCG’s ambition to change the way healthcare is managed and delivered into an integrated sustainable model, supporting our commissioning priorities including prevention and early intervention, Neighbourhood Care Networks and improving primary care

- The Strategy has six strategic objectives:
  1. IM&T that enables Integrated Care
  2. Self-care and Patient access to healthcare information
  3. Analytics/Intelligence that support business and commissioning
  4. Deploying GP Systems of Choice Capabilities to General Practices
  5. Screening and Early Diagnosis and Decision Support
  6. Reliable improved technical infrastructure

- The Strategy aims to achieve a number of national strategic targets including:
  - Online access for patients to GP health records along with being able to book appointments and request repeat prescriptions
  - Online access for patients to their hospital records
  - Ensure locally developed IT systems can communicate with each other
  - Using technology to give patients high quality and convenient care
  - Include a clinical information champion on the CCG Governing Body

In response to SK’s question regarding how the CCG is ensuring it keeps pace with developments in IT, TR stated that a key focus of the strategy is use of technology initiatives.

JMi stated further work is needed around intelligence and the link with Public Health, TR responded that the gap was recognised along with the need for an information strategy.

TR requested comments by the 8 January 2016. The IM&T Strategy would come back to the Committee for agreement at its next meeting.

14. Estates Strategy

TR reported that NHS England have tasked all CCGs with developing an outline estates strategy by the end of December. The CCG, LGT, SLaM and LBL have been reviewing Lewisham estate as part of the AICP and a survey has been undertaken on primary care estate. Essentia is supporting this work.

In response to AR’s question regarding whether the stocktake is taking into account population growth, TR stated that it was along with other predicted changes in the population.

The draft Strategy will be available for comment at the next meeting.
15. Service Redesign: Integrated Urgent & Primary Care Service

The scoping paper for the proposed Primary & Urgent Care Service was taken for information.

16. CAMHS Transformation Programme

The Mental Health and Emotional Well-Being Strategy and CAMHS Transformation Plan were taken for information.

17. Children and Young People’s Plan

The Equality Analysis Assessment on the Children and Young People’s Plan 2015-18 was taken for information.

18. Our Healthier South East London – Update

The OHSEL November programme update was taken for information.

19. Strategic Risks

The strategic risk register was reviewed. It was agreed that risk G8 needed to be reworded and the score reviewed once planning guidance had been received.

Action: Risk Management Group to review risk G8

20. Approved Minutes for Information Only

PEG: The approved minutes of the meeting held on 27.08.2015 were taken for information.

JPEG: The approved minutes of the meeting held on 03.09.2015 were taken for information.

Adult Joint Strategic Commissioning Group: The approved minutes of the meeting held on 02.09.2015 were taken for information

Adult Integrated Care Programme Board: The approved minutes of the meeting held on 02.10.2015 was taken for information.

Children and Young People’s Strategic Partnership Board and Joint Commissioning Group: The approved minutes of the meeting held on 19.10.2015 were taken for information.

21. Any Other Business

There was no other business.

22. Date of Next Meeting

Thursday 11th February 2016
Primary Care Joint Committees (PCJC)
10 December 2015

Meeting held at:
Deptford Lounge, Deptford Library, 9 Giffin Street SE8 4RJ

Minutes

Meeting Chair
Dr Greg Ussher (GU)

Executive Support
Tom Bunting (TB)

Bexley Primary Care Joint Committee

Attendees:

Sarah Blow (SB) Member CCG Chief Officer
Dr Nikita Kanani (NK) Member CCG Chair
Jon Winter (JW) Member Assistant Director of Communications (representing Sandra Wakeford)
Theresa Osborne (TO) Member CCG Chief Financial Officer (representing Keith Wood)
Dr Sid Deshmukh (SD) Member CCG Governing Body GP
Matthew Trainer (MT) Member NHS England – London (Director of Commissioning Operations)
David Sturgeon (DS) Member NHS England – London (Director of Primary Care)
Dr Richard P Money (RM) Observer Local Medical Committee

Apologies:

Sandra Wakeford Committee Chair (Lay Patient Public Involvement)
Keith Wood Committee Vice-Chair (Lay Governance)
Mary Currie CCG Governing Body Nurse
Teresa O’Neill Health and Wellbeing Board
Dr Jane Fryer NHS England (Medical Director for South London)
Anne Hinds-Murray Healthwatch (Bexley)

Bromley Primary Care Joint Committee

Attendees:

Martin Lee (ML) Member Committee Chair (Lay Patient Public Involvement)
Harvey Guntrip (HG) Member Committee Vice-Chair (Lay Governance)
Sara Nelson (SN) Member CCG Governing Body Nurse
Dr Angela Bhan (ABh) Member CCG Chief Officer
Dr Andrew Parson (AP) Member CCG Chair
Dr Jon Doyle (JD)  
Member  
Governing Body GP (representing Dr Ruchira Paranjape)

Matthew Trainer (MT)  
Member  
NHS England – London (Director of Commissioning Operations)

David Sturgeon (DS)  
Member  
NHS England – London (Director of Primary Care)

Linda Gabriel (LG)  
Observer  
Healthwatch (Bromley)

Apologies:

Dr Ruchira Paranjape  
CCG Governing Body GP

Dr Mukesh Sahi  
Local Medical Committee

Cllr David Jefferys  
Health and Wellbeing Board

Dr Jane Fryer  
NHS England (Medical Director for South London)

Greenwich Primary Care Joint Committee

Attendees:

Dr Greg Ussher (GU)  
Member  
Committee Chair (Lay Patient Public Involvement)

Jim Wintour (JWi)  
Member  
Committee Vice-Chair (Lay Governance)

Dr Iyngaran Vanniasegaram (IV)  
Member  
CCG Governing Body - Secondary Care Clinician

Annabel Burn (ABu)  
Member  
CCG Chief Officer

Maggie Buckell (MB)  
Member  
CCG Governing Body Nurse

Dr Ellen Wright (EW)  
Member  
CCG Chair

Matthew Trainer (MT)  
Member  
NHS England – London (Director of Commissioning Operations)

David Sturgeon (DS)  
Member  
NHS England – London (Director of Primary Care)

Dr Hany Wahba (HW)  
Observer  
Local Medical Committee (representing Dr Dermot Kenny)

Sam Jones (SJ)  
Observer  
CCG Director of Delivery and Service Transformation

Jade Landers (JL)  
Observer  
Healthwatch (Greenwich) (representing Leceia Gordon-Mackenzie)

Cllr David Gardner (DG)  
Observer  
Health and Wellbeing Board

Apologies:

Dr Nayan Patel  
CCG Governing Body GP

Dr Jane Fryer  
NHS England (Medical Director for South London)

Lambeth Primary Care Joint Committee

Attendees:

Sue Gallagher (SG)  
Member  
Committee Chair (Lay Patient Public Involvement)

Graham Laylee (GL)  
Member  
Committee Vice-Chair (Lay Governance)

Andrew Eyres (AE)  
Member  
CCG Chief Officer

Dr Adrian McLachlan (AM)  
Member  
CCG Chair

Dr Jenny Law (JL)  
Observer  
Local Medical Committee

Matthew Trainer (MT)  
Member  
NHS England – London (Director of Commissioning Operations)

David Sturgeon (DS)  
Member  
NHS England – London (Director of Primary Care)

Andrew Parker (AP)  
Observer  
CCG Director of Primary Care Development

Apologies:
Dr Hasnain Abbasi  
CCG Governing Body GP

Cllr Jim Dixon  
Health and Wellbeing Board

Catherine Pearson  
Healthwatch (Lambeth) 

Dr Jane Fryer  
NHS England (Medical Director for South London)

**Lewisham Primary Care Joint Committee**

**Attendees:**

Rosemarie Ramsey MBE (RR)  
Member  
Committee Chair (Lay Patient Public Involvement)

Ray Warburton OBE (RW)  
Member  
Committee Vice-Chair (Lay Governance)

Professor Ami David (AD)  
Member  
CCG Governing Body Nurse Member

Martin Wilkinson (MW)  
Member  
CCG Chief Officer

Dr Marc Rowland (MR)  
Member  
CCG Chair

Dr Jacky McLeod (JM)  
Member  
CCG Governing Body GP and Clinical Director

Matthew Trainer (MT)  
Member  
NHS England – London (Director of Commissioning Operations)

David Sturgeon (DS)  
Member  
NHS England – London (Director of Primary Care)

Ashley O’Shaughnessy (AO)  
Observer  
CCG Associate Director of Commissioning

Nigel Bowness (NB)  
Observer  
Healthwatch (Lewisham)

Dr Simon Parton (SP)  
Observer  
Local Medical Committee

Peter Ramrayka (PR)  
Observer  
Health and Wellbeing Board

**Apologies:**

Dr Jane Fryer  
NHS England (Medical Director for South London)

**Southwark Primary Care Joint Committee**

**Attendees:**

Richard Gibbs (RG)  
Member  
Committee Vice Chair (Lay Governance)

Ami David (AD)  
Member  
CCG Governing Body Nurse Member

Malcolm Hines (MH)  
Member  
CCG Chief Financial Officer (representing Andrew Bland)

Dr Jonty Heaversedge  
Member  
CCG Chair

Dr Emily Gibbs (EG)  
Member  
CCG Governing Body GP

Matthew Trainer (MT)  
Member  
NHS England (Director of Commissioning Operations)

David Sturgeon (DS)  
Member  
NHS England – London (Director of Primary Care)

Caroline Gilmartin (CG)  
Observer  
CCG Director of Integrated Commissioning

Dr Kathy McAdam Freud (KMF)  
Observer  
Local Medical Committee

David Cooper (DC)  
Observer  
Healthwatch (Southwark)

**Apologies:**

Joy Ellery  
Committee Chair

Andrew Bland  
CCG Chief Officer

Dr Jane Fryer  
NHS England (Medical Director for South London)

**Other attendees:**

Jill Webb (JWWe)  
NHS England – London (Head of Primary Care)

Richard Jeffery (RJ)  
NHS England – London (Director of Financial Management)
<table>
<thead>
<tr>
<th>Item</th>
<th>Introduction and apologies</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.</strong></td>
<td>GU welcomed members, observers and members of the public to the fourth meeting of the Primary Care Joint Committees of:</td>
</tr>
<tr>
<td></td>
<td>• NHS Bexley CCG and NHS England</td>
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<td></td>
<td>• NHS Bromley CCG and NHS England</td>
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<td>• NHS Lewisham CCG and NHS England</td>
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<td>• NHS Southwark CCG and NHS England</td>
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<td>GU informed members, observers and members of the public that the meeting was to be held in two parts, and that part one was a meeting held in public. GU advised that there would be two public open space items during the meeting (one close to the start and the other close to the end) instead of only one, as at previous meetings to date.</td>
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<tr>
<td></td>
<td>Apologies received in advance of the meeting:</td>
</tr>
<tr>
<td>Sandra Wakeford</td>
<td>Bexley Primary Care Joint Committee - Member Committee Chair (Lay Patient Public Involvement)</td>
</tr>
<tr>
<td>Keith Wood</td>
<td>Bexley Primary Care Joint Committee - Member Committee vice Chair (Lay Governance)</td>
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<tr>
<td>Marie Currie</td>
<td>Bexley Primary Care Joint Committee - Member CCG Governing Body Nurse Member</td>
</tr>
<tr>
<td>Teresa O’Neill</td>
<td>Bexley Primary Care Joint Committee - Observer Health and Wellbeing Board</td>
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<tr>
<td>Anne Hinds Murray</td>
<td>Bexley Primary Care Joint Committee - Observer Healthwatch (Bexley)</td>
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<tr>
<td>Dr Ruchira Paranjape</td>
<td>Bromley Primary Care Joint Committee - Member CCG Governing Body GP</td>
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<tr>
<td>Dr Mukesh Sahi</td>
<td>Bromley Primary Care Joint Committee - Observer Local Medical Committee (Bromley)</td>
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<tr>
<td>Cllr David Jefferys</td>
<td>Bromley Primary Care Joint Committee - Observer Health and Wellbeing Board</td>
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<tr>
<td>Dr Nayan Patel</td>
<td>Greenwich Primary Care Joint Committee - Member CCG Governing Body GP</td>
</tr>
<tr>
<td>Dr Dermot Kenny</td>
<td>Greenwich Primary Care Joint Committee - Observer Local Medical Committee (Greenwich)</td>
</tr>
<tr>
<td>Dr Hasnain Abbasi</td>
<td>Lambeth Primary Care Joint Committee - Member CCG Governing Body GP</td>
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<tr>
<td>Name</td>
<td>Joint Committee</td>
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<tr>
<td>Catherine Pearson</td>
<td>Lambeth Primary Care Joint Committee - Observer</td>
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<tr>
<td>Joy Ellery</td>
<td>Southwark Primary Care Joint Committee - Member</td>
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<tr>
<td>Andrew Bland</td>
<td>Southwark Primary Care Joint Committee - Member</td>
</tr>
<tr>
<td>Dr Jane Fryer</td>
<td>NHS England (London)</td>
</tr>
</tbody>
</table>

2. Declaration of Interests

The following members and observers reported changes to their declarations. In cases where the attendee was representing a member or observer at the meeting, the declarations were noted as new entries to the declarations of interest register.

<table>
<thead>
<tr>
<th>Name</th>
<th>Joint Committee</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Jon Doyle (representing Dr Ruchira Paranjape – CCG Governing Body GP)</td>
<td>Bromley Primary Care Joint Committee – Member</td>
<td>Add entries:</td>
</tr>
<tr>
<td>Jade Landers (representing Leceia Gordon-Mackenzie, Healthwatch (Greenwich))</td>
<td>Greenwich Primary Care Joint Committee – Observer</td>
<td>• GP Partner in South View GMS Partnership, Bromley</td>
</tr>
<tr>
<td>Dr Hany Wahba (representing Dr Dermot Kenny, Greenwich Local Medical Committee)</td>
<td>Greenwich Primary Care Joint Committee – Observer</td>
<td>• Member practice of the Bromley GP Alliance</td>
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<tr>
<td></td>
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<td>• South View Partnership holds contract from Bromley Healthcare to provide Visiting Medical Officer (VMO) services at Lauriston House</td>
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<td>• South View Partnership contracted to Bromley GP Alliance to provide GP support to transfer of care bureau, 16/11/2015 to 18/12/2015</td>
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<tr>
<td></td>
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<td>• Policy and Research Officer, Healthwatch (Greenwich)</td>
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<td></td>
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<td>• Metro are Healthwatch Greenwich’s contracts holder</td>
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<tr>
<td></td>
<td></td>
<td>• Full-time GP at St Marks Medical Centre, Plumstead. The practice has applied for an improvement</td>
</tr>
</tbody>
</table>
Grant to NHS England
(currently being considered and was to be covered on the agenda for this meeting)

- Member of Riverview LLP – part of syndicate for the regional area of Plumstead and Woolwich
- GP Appraiser for NHS England – is paid for the appraisals undertaken
- Medical Director of Grabadoc Healthcare Society Ltd
- GP Member of NHS Greenwich CCG

| Name              | Institution                                      | Remington
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<tr>
<td>Sue Gallagher</td>
<td>Lambeth Primary Care Joint Committee – Member</td>
<td>Removal of Stakeholder Governor of Guys &amp; St Thomas’s NHS Foundation Trust and Kings College Hospital NHS Foundation Trust – is no longer Governor at these Foundation Trusts</td>
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<tr>
<td>Dr Marc Rowland</td>
<td>Lewisham Primary Care Joint Committee – Member</td>
<td>Member of Lewisham 4 Health Limited</td>
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<tr>
<td>Dr Simon Parton</td>
<td>Lewisham Primary Care Joint Committee – Observer</td>
<td>Member of Lewisham Healthcare Limited</td>
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3. **Minutes of the last meeting, held on 29 September 2015**

The minutes were agreed to be a correct record subject to the following amendments:

Lewisham Joint Committee stated that Rosemarie Ramsey was incorrectly referred to as an observer member (representing Healthwatch). Her correct title at that time was Lay Member designate.

Lewisham Joint Committee stated that Denver Garrison was incorrectly referred to as an observer member (representing Healthwatch). Denver Garrison should have been referred to as a member of the public.
It was noted that Frances Hook was incorrectly referred to as a member of Healthwatch (Greenwich) and that this should be corrected to read as “Representative for Keep Our NHS Public (Greenwich).”

**Action log**

Referring to the action tracker for the committees, TB noted that all four of the actions with "open" status (as shown on the version of the actions log at the previous meeting), as well as the two actions that were assigned at the previous meeting had been closed.

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<tr>
<td>No written questions from the public had been received in advance of the meeting. Jennifer Quinton-Chelley enquired as to whether the three-month extension for the completion of the PMS contracts review programme (applied for by all six south east London CCGs, to ensure a full and appropriate level of engagement with patients and public) had been granted by NHS England. GU advised that this matter would be covered in full under item 7 on the agenda (London PMS Contracts Review programme).</td>
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**For discussion**

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<th>5.</th>
<th>Quality, Performance and Finance</th>
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<tr>
<td><strong>Month 7 Finance report</strong></td>
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<tr>
<td>RJ introduced the Primary Medical Services Financial report for month 7 (circulated as Enclosure D).</td>
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<td>The overall financial position for South East London Primary Medical Services was showing an overspend of £1.2m (0.9%) against issued budgets for the 7 months to 31st October. This position comprised small overspends on PMS and GMS budgets with a large shortfall on the QIPP delivery target, which was shown separately.</td>
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<td>Year to date accruals: compared with previous years NHS England (London) had been able to write-back £900k, which were used to offset against some of the overspend that had led to the year to date £1.2m deficit.</td>
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<td>The forecast outturn was a £1.6m deficit (0.7%) after further mitigation. This forecast was driven by the QIPP shortfall but included further non-recurrent mitigations to be realised before the end of the financial year. This will be net of all of the non-recurrent mitigations. This position is in line with the primary care position across the whole of London, at all levels of co-commissioning arrangements (levels 1, 2, 3). The position for each south east London CCG was detailed in the report.</td>
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<td>Capitation report: the numbers for this aspect had been shown in a separate table at the request of one of the CCGs. This was useful in illustrating how the registered populations for primary care had moved over the reporting period, across the patch. There has been a year on year growth of 0.8% in south east London’s weighted population from April 2014 to April 2015. The capitation report showed a growth of 1.3% to 1st October 2015 (quarter 3). Demographic growth had been funded on an aggregate basis at 1.3% in the 2015-16 financial plan. There was considerable variation across the south east London CCGs in terms of growth and reductions.</td>
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At present NHS England (London) is managing primary care contracting across the whole of London (with the exception of the level 3 CCGs). The variable level of risk when viewing London as a whole or at SPG level, as opposed to individual CCG areas is considerable (ie the level of risk at individual CCG level from year to year can show much greater levels of risk or benefits within these budgets than at the higher level).

QIPP initiatives: NHS England wrote to all London CCGs in October regarding covering the £3.2m gap (of the target £20m QIPP). Andrew Bland replied to NHS England on behalf of London CCGs. In line with that collective CCG response, NHS England has stated that it will do all it can working across Primary Care to mitigate the QIPP shortfall and to meet any further pressures. Whilst this will largely involve non-recurrent actions, there will be some further recurrent benefits from 2015-16 schemes, and the rate reviews. This will be reviewed again at Month 9, and NHS England (London) has indicated some level of confidence that it will be able to cover the £3.2m gap for London in-year via its non-recurrent resources, as well as (potentially) further accruals from 2014-15, any of the non-recurrent resources in the medical budget (and across the rest of its primary care budget).

A Primary Care Technical Group has been established with Chief Financial Officer representation from all London CCGs and London SPG leads to work with NHS England to understand the co-commissioned/delegated pressures and to recommend options for budget-setting for 2016-17. Subject to the Comprehensive Spending Review settlement and allocations, there is likely to be a QIPP requirement for 2016-17 of 1-1.5% (similar to 2015-16), including any brought-forward recurrent pressures. RJ advised that a fuller position on this would be known by the time of the NHS England Primary Care Management Board meeting taking place on 17 December. The Finance Technical Group will be working through the detail of all aspects of this over the coming months.

Lewisham Joint Committee:

MR raised a question on behalf of the Lewisham CCG Governing Body regarding the justification of having a QIPP for primary care, at a time when resources are being transferred from secondary to primary care. RJ responded by pointing to the significant savings (over £2m) that had been made in the previous two years by NHS England (London) via standardisation of the transactions process. RJ noted that on the transactional side it was unlikely that further financial savings could be made as over £50m had already been made in this period across the primary care budget for London. Therefore NHS England (London) had deemed it necessary to look at making savings from other budget areas. MR followed up on the response from RJ on this point, by pointing to considerable difficulties that these efficiencies on QIPP would cause locally in primary care.

RW queried the release of £912k of accruals from 2014-15 and requested an explanation of this figure as stated in the report. RJ responded by advising that at the end of the 2014-15 financial year the accounts were closed off in accordance to a tight time schedule within NHS England. At that point RJ submitted a best estimate of the costs that were still to come through the system. For a number of items, particularly on QOF and premises costs, there are often long delays on making those settlements and it is only at this stage in the following financial year that that those costs have largely come through the system – and that therefore NHS England (London) could now report a more certain position on the amount of unspent monies from 2014-15 for write-back.
**Bexley Joint Committee:**

RM enquired as to the proportion of the QIPP shortfall (£3.2m - of the total £20m across London) for south east London CCGs that individual south east London CCGs would be liable to meet. RJ responded by advising that NHS England cannot break this down to CCG level responsibility and that it would not be an even distribution across CCGs. Furthermore, some of the shortfall sits outside Medical Services.

**Lambeth Joint Committee:**

SG asked for clarity that NHS England (London) had achieved £50m on transactional savings during the past two years (as stated in the response to the first question from Lewisham Joint Committee, above), and asked for further clarification on how this had been achieved. DS replied, stating that efficiencies had been achieved across a range of areas in 2013-14 and 2014-15, but predominantly in the areas of practice list maintenance across London (in certain parts of London this had not been undertaken for some considerable time, and so this had brought up significant levels of efficiencies gained); efficiencies brought about from reducing variation across a range of schemes deployed by individual practices across London (ie ensuring that Out of Hours deductions were being made in the appropriate means); and efficiency improvements that had been realised in the collections of clinical waste. All of these improvements had been brought about across London and had contributed to the transactional efficiency saving of £50m as stated.

DS further emphasised the point made earlier by RJ, that as further efficiencies are very hard to find, the onus was now on the transformation side to deliver the QIPP savings required to meet the financial gap, and that London is considered to be over-target for primary care. DS advised that the 2016-17 model for allocations had not been set yet but that it would be unlikely to change significantly. The NHS England (London) team had made some recommendations for inclusion in the model (including factors of English not being first language, turnover and deprivation) – and that these would be reviewed by the Primary Care Management Board for NHS England (London) at its next meeting, on 17 December.

**Quality and Performance report**

JW introduced the Quality and Performance report (circulated as Enclosure E). These reports are produced on a quarterly basis by NHS England (London) to indicate quality and performance markers for general practice across London. The previous iteration of this report was at the SE London PCJCs meeting on 6 August. This was the second showing of the report, and the format of it had been altered somewhat since that meeting. A significant number of helpful comments and contributions had been received by the NHS England (London) team from CCGs across London since August. These had informed this second iteration, although not every single comment had been factored into the present iteration due to time constraints.

The report includes the following data sets: GP Patient Survey, Quality and Outcomes Framework, and Friends and Family returns at CCG, SPG, London and national levels (where this is possible), and has begun to include some analysis of the data presented, and indications of trends of the performance and quality data. The data is refreshed at varying intervals (not always quarterly and in some cases annually), therefore each data set is date-stamped to indicate when it had last been refreshed. It also includes a summary of GP contract variations (these had previously been reported separately), in line with NHS England’s Operating Model. This data can be found at the back end of the report.
NHS England (London) has had to redact two of its data sets from this report (Electronic Declarations - to confirm that practices meet certain standards contained in the report - and General Practice Outcomes Standards (GPOS)), because clearance by NHS England (Central team) is required to present these information sources at an aggregated level, as they are not currently available in the public domain. It is hoped that this information will be included in future iterations of the report.

A summary of CQC practice inspection outcomes is planned to be included in this report, once the CQC have carried out inspections of a greater number of practices in south east London and pan-London, so that the comparison of this data will be more meaningful. Any contractual issues that are reported as a result of CQC inspections will be covered in either Part 1 south east London PCJC meetings (or in Part 2 meetings if a decision is required).

JWe also advised that a full narrative comprising an analysis of the data as reported would be presented in future iterations of the report. This would refer to the “So what?” factor – ie the actions and their intended measurable impacts that co-commissioners have agreed in response to quality and performance issues that are contained in the report. The report will potentially also benefit in future from the added inclusion of information that is exclusively held by CCGs regarding general practice quality and performance.

A range of further comments and suggestions were made at the meeting:

**Lewisham Joint Committee:**

RW raised four points regarding the format of the reporting:

- The report would benefit from a bigger font being used as it is quite difficult to read in places. JWe agreed to look into this.
- It is not absolutely clear whether the variances shown in the report are “positive” or “negative” in terms of quality/performance. JWe explained that the benchmarking data on the report is darker the shading of the blue indicates a lower level of quality or performance against London and national performance.
- There is a need to indicate on the data how protected characteristics are affected – this is particularly relevant in some of the more diverse communities in south east London (and elsewhere in London).
- The reporting time period for the graphs needs to be included. JWe believed this was included within each section but agreed to check.

**Southwark Joint Committee**

JH noted the complexity of the data, as borne out by the report. JH then referred to a paper published in the last week by Dr Mark Ashworth (a GP in south east London), which had identified that poor patient experience is directly correlated with low prescriptions of rate of antibiotics (which is something that is generally strongly encouraged within general practice). This paper could be seen as a good illustration of the often complex and competing dynamics involved with primary care quality.

**Bromley Joint Committee:**

ML referred to two apparent trends from the reporting, and enquired as to any thoughts on these as follows:
- The reporting for CCG and south London patient satisfaction did not compare favourably with the national comparisons. JWe pointed out that this is a well-established position, owing much to the complexities and diversity of the patient populations in and across London. This appeared to be a key reason in explaining why London did not score favourably against the national benchmarks.
- Noted that the reporting showed that of the patients polled, there was a significantly higher rate of trust toward nurses than toward GPs.

**Lambeth Joint Committee:**

- AM noted that the colour coding clearly indicates the standard deviation away from the mean, but the direction away from the mean is less clear. JWe stated that the darker shades of blue and the further away from the mean indicate a lower level of achievement. AM replied by suggesting that this explanation would indicate that south London CCGs did not score above the mean for any of the indicators on patient satisfaction. JWe and DS agreed to look into this to confirm.
- SG asked if, for the patient satisfaction data sets, it be possible for the report to show the percentage of patients as well as the percentage of practices. It would be more useful if commissioners could see the percentage of populations that are dissatisfied in the various different categories, as the practices vary so much in size. JWe and DS agreed to look into this to confirm.
- SG asked if the report could include clinical effectiveness indicators, or do they not exist nationally? JWe replied that there are many clinical indicators in existence but some indicators have been redacted (ie E-Declaration and GPOS, as noted by JWe in her introduction). There is also a need to work with CCGs to gather further datasets that can be included as part of this reporting (including clinical indicators) and JWe advised that this would be a focus for the ongoing development of the report.
- SG enquired as to the consequences for practices that do not submit returns on the Friends and Family data. JWe replied by advising that it is now a contractual requirement for practices to offer this survey to patients and to gather and submit this data. This is a recent development, and NHS England (London) is going through a process via the practices and LMCs to help and encourage the collection and reporting of this data by practices on a monthly basis. All practices are mandated to submit this data by the end of 2015-16.

GU remarked that the report had improved notably, though it remained as a work in progress, and that it is constantly being informed and improved by the many helpful comments that had been contributed so far, including at this meeting. JWe undertook to factor in the comments received at the meeting to the further development of the report.

6. **Primary Care Premises Infrastructure**

JWe led this item, which was informed by three documents, which comprised Enclosure F:

(i) NHS England Primary Care Infrastructure Fund Progress report (November);
(ii) Update report on London Improvement Grant Fund (2015-16 applications), produced for NHS England (London) Finance, Investment, Procurement and Audit Capital sub group (reports to the Primary Care Transformation
These papers give an overview of GP-led bids for premises development and improvement. The first tranche of the £1bn four year investment programme in primary care infrastructure across England was announced in December 2014. This culminated in the approval of 721 GP bids, with 182 in London with an estimated capital value of around £34m. The progress of London’s programme, in common with all other regions, has been challenging as a result of a range of issues and risks. These are detailed in its monthly delivery reports to the national PCTF Programme Board. London region’s November 2015 report provides an update on what are currently 214 schemes that are either formally approved, completing their due diligence, withdrawn or deferred (to 2016-17). It also provides the financial profile of London schemes, the associated risks and issues and confirms that it is continuing to work to identify new schemes to mitigate underspend, which comply with PCTF 2015-16 and the recently announced 2016-17 criteria. This programme will roll forward into 2016-17 and is being renamed as the Primary Care Transformation Fund, which will be CCG-led and in line with strategic commissioning priorities.

Alongside this national investment programme, London region also agreed to identify capital from its main 2015-16 capital programme to support what are called ‘London Improvement Grant’ bids, in response to the London Health Commission report ‘Better Health for London’, published in October 2014. This identifies the need for significant investment in the infrastructure of GP premises, to enable primary care commissioners to realise their strategic plans and providers to respond to them. The London Improvement Grant (IG) report provides details of the prioritisation process used to identify 124 out of 369 schemes, which have been approved in principle based on initial technical due diligence requirements, for 2015-16 London IG funding. It also provides the process and timetable for completion of due diligence; a summary of the feedback received from London LMCs about the region’s prioritisation process; a further batch of schemes that could be supported and delivered in year if further London capital programme slippage is identified; and confirms that a bid for 2016-17 capital will be submitted to progress the remaining IGs that meet the identified criteria. Practices will be notified during the week commencing 14th December about the status of their bid; and schemes that receive approval should be able to complete by 31st March 2016, subject to them completing their due diligence requirements in line with the specified timetable.

At the end of October 2015, NHS England wrote to all CCG Accountable Officers and clinical leads to confirm the approach to funding the remaining three years of the PCTF. The national letter (the third paper of the set for this item) clarifies that CCGs (rather than Practices) will be invited to submit bids by the end of February 2016, which should be reflective of their local interim estates strategies that need to be available by the end of December 2015. CCGs will also be responsible for the long term affordability of approved schemes. We reported that the London region had opted to produce system-wide Strategic Estates Plans (ie at south east London level) by March 2016. The bulk of the fund will continue to be deployed to improve premises and digital and technological developments in general practice, with access criteria similar to year 1, but with an additional criterion of improving seven day access to effective care. We also advised that schemes will no longer need to be completed in the financial year in which they are approved.
Updates on interim Estates Strategy Developments:

MH reported that every CCG is developing its own local estates strategy, which will eventually all be approved via the governance processes per CCG. Additional support and funding has been made available through the Healthy London Partnerships, as Estates is one of the thirteen transformation work streams within this, to help assess local estates.

In addition an estates work stream has been established within the Our Healthier South East London strategy programme. The estates work stream group held its first meeting in workshop format recently, and another meeting is scheduled to take place in the coming weeks. This group is not set up to approve each CCG’s estates strategy, but rather to take an overview and share learning and good practice, as well as enabling the agreement of the South East London strategy, which will be agreed in March 2016, as per the above.

A number of questions were raised by the Joint Committees:

**Bromley Joint Committee:**

ML requested clarification that the report is recommending that criteria 8 and 9 should be applied, and to encourage more practices into the London Improvement Grant Scheme, and if so what is the timescale for this. JWe advised that NHS England (London) Finance, Investment, Procurement and Audit sub-committee had received the above paper, that identified a number of other schemes/practices as being deliverable (over and above the 128 listed as already having been approved) and that should be prioritised for inclusion in-year, provided that these have CCG support. NHS England (London) will begin work on those additional schemes in about a weeks’ time (foremost to check on CCG support for them). The more immediate priority is to issue the 128 notifications out for those approved schemes. All London Improvement Grant schemes must be completed by the end of March, therefore NHS England (London) is selecting schemes that can be completed in this timeframe, noting that bids for more funding will be made for 2016-17 to cover those that are viable over a longer timeframe.

**Greenwich Joint Committee:**

DG sought to clarify the role of local authorities in the development of the estates strategy, as this was not obvious from reading the paper. Given the importance of agreeing an overarching plan that might include co-location, DG enquired as to what is the strategic push from the local NHS to increase this role and collaboration. MH advised that the south east London estates group has invited all local authorities to the meetings of the working group and are ensuring a wide distribution of information and meeting papers across all relevant local authority staff in order to be as inclusive as possible in terms of providers and local authorities. It is up to each CCG to ensure this takes place at the borough-level. EW advised that a local authority representative from Greenwich has been involved in the Estates Group in that borough.

**Bexley Joint Committee:**

TO asked when the more detailed guidance would be issued by NHS England (to inform the 29 February submission of bids). JWe advised that the guidance was planned to be issued before Christmas. The deadline for submission of estates strategies is end of December 2015. The intention from Department of Health is that these strategies should be reviewed and refined in the intervening two months prior to
submission of final bids. JWe added that the application process had been simplified compared with the GP-led process of year 1 of the PCIF.

Lambeth Joint Committee:

AE noted that the vast majority or all of the approved schemes in the report appeared to be focused on physical estates improvement capacity and asked had there been any schemes approved that are focused on digital capacity. JWe replied by stating that digital schemes submitted in 2015-16 had been scarce, but that it was anticipated that there would be more IT/digital focused schemes in 2016-17, and that the bidding process will support this. The focus had been on physical capacity projects, but the IT/digital schemes that are expected in future will dovetail with the infrastructure capacity schemes already approved.

Lewisham Joint Committee:

PR noted the timeline for completion of a range of minor capital schemes by the end of March 2016 and enquired as to what procurement methods were being deployed in order to achieve that. JWe advised that every scheme in this programme is GP-led and that GPs would determine the procurement requirements for the bids. There is a requirement for practices to obtain at least three quotes in doing so, and to ensure that the changes required will deliver what is needed and be cost effective.

RW queried whether there is any indication of the limit of the financial allocations for the bids to be approved, at a CCG level. JWe advised that in the first year there were no financial limits set for CCGs as this was and remains a GP-led process. Over 1,000 GP practices bidded for schemes and there were 721 successful schemes originally approved nationally. There are a range of factors that explain the differing levels of bids coming in from different areas. Some of the levels of bidding has been reflective of the level of investment historically in a given area, ie in an area with high investment the volume and value of bids was seen to be lower by comparison with areas with lower investment. JWe explained that moving forward there would be indicative allocations across the different regions – but at a regional level rather than CCG-level. This will give some flexibility over funding allocations, which is helpful as many of the costs in bids are estimated capital costs (which can be significantly different from the final cost of a scheme).

7. London PMS contracts review programme

RG (Southwark Joint Committee) opened the item by describing the intended approach regarding management of any conflicts of interest for the south east London Primary Care Joint Committees brought about by the PMS review and the decisions relating to commissioning intentions that would need to be made at this forum at future meetings. This approach had been tested with RG’s counterparts in each of the SE London CCGs in advance of this meeting.

There is a potentially large conflict of interests inherent in the review and approval of commissioning intentions for the PMS contract premium in this forum due to the attendance of several GP Commissioners in each joint committee. Whilst there is a clear need to manage that, this must also be balanced against the requirement to ensure good quality clinical input into the decisions and the design of services. RG referred to good national guidance available on this issue, as well as local CCG policies and Joint Committee Terms of Reference, that each serve as reference
points. The latter of these point to the ability of Joint Committees to ask GPs to withdraw from any conversation from which they are deemed to be substantially conflicted, which can then be managed by other (unconflicted) members, provided that the joint committee(s) in question remain quorate in doing so.

The question RG posed for this item was whether or not the recommendations the Joint Committees were being asked to consider represented a substantial conflict for CCG GP members, or not. The answer to that was accepted by the Joint Committees as being “no” – on the proviso that the discussions at this item stayed within the limits set by the recommendations, as set out in the cover paper circulated in advance for it. These recommendations were as follows:

1. Note this update (*within the cover paper*)
2. Confirm their intention to utilise the extension period for engagement with residents, members and partners
3. Endorse the implementation approach outlined for their borough (appended documents)

RG noted that there would be a need to revisit this question in advance of items on the PMS contract at future meetings, to continue to assure the Joint Committees on this matter of conflicts of interest.

Prior to introducing the paper (update on PMS contract Review programme, which had been circulated as Enclosure G), DS advised the Joint Committees of several significant updates that had emerged since the distribution of the paper.

The London PMS contract offer (based on the Strategic Commissioning Frameworks (SCF), issued by NHS England (London) last year, and supported by CCGs as the direction of travel), had been earlier today agreed by London SPG leads and by the NHS England (London region) Primary Care Management Board. This had been developed following a period of consultation and various iterations. DS advised that this would shortly be taken back to individual CCGs. Main areas to note from previous iterations was a scaled down option for KPIs and the prominence of access to services. DS stated the total value of the London premium is now slightly over £7. There is flexibility for individual CCGs to add to the offer that will be required by NHS England (London).

The final document is being consulted on with LMC at the same time as it will be reviewed by CCGs. The initial meeting with London-wide LMCs (as well as surrounding LMCs from Surrey, Kent and Essex) is scheduled for 18 December. These meetings will focus on how the contract will be delivered rather than the SCF content, which had already been agreed. DS confirmed that the component of the premium will be agreed with London-wide LMCs for and on behalf of all 32 boroughs in London.

All London SPGs had applied for a three-month extension for the review process. DS confirmed that this extension request had been granted by NHS England (London) via its Primary Care Management Board earlier on the day of this meeting, meaning that the deadline for signing of PMS contracts will be 30th June 2016. DS advised that there are some conditions that NHS England (London) has applied to this extension, namely that London commissioning plans per CCG must be submitted by 19 February, and that reviews must be completed by 31 March 2016. The definition of the completion of the PMS review is that commissioning intentions are agreed and in place (including the direction of travel for equalisation across all contract types, but particularly GMS). From there the process will be toward meetings with individual practices and agreeing
all contract documentation in the period to 30th June.

A range of questions were raised at the meeting:

Bexley Joint Committee:

NK referred to signing up to the London offer being about equalisation of the PMS offer to all patients across London regardless of which borough the practice they are registered with is located in. NK asked how we can ensure that this is fair across London and in place for CCG boroughs with lower premiums. DS acknowledged that delivery of this over the planning period was a real challenge. There are 17 streams within the strategic framework that were agreed as the patient offer for London. DS noted that CCGs would be aiming to deliver the strategic framework, but that the PMS review was never understood to be able to meet the full needs of all CCGs/boroughs.

SD asked what processes are in place to prevent practices moving to GMS rather than PMS. This question had been raised by member PMS practices that were considering their options, given that the premium offered is the same for PMS and GMS practices, with the latter being protected by a national contract. DS replied by stating that co-commissioners do not want the PMS practices to go back to GMS contracts. PMS specifications will better reflect local population needs and give commissioners greater influence and flexibility to serve their populations in this way. Co-commissioners’ intentions are to preserve the premium, whilst ensuring that patients are not disadvantaged if they are not registered with a PMS practice. Therefore the challenge for co-commissioners is how to get the monies to invest in order to offer to GMS practices what is effectively an enhanced service that will mirror the premium components within the PMS contract.

JWe added that some CCGs (depending on the mix of GMS and PMS practices in each borough) will not be able to equalise as quickly (or at all) – as this will be predicated on them having sufficient funding to do so. Therefore it will take considerably longer for some CCG areas to offer the PMS premium to GMS, which was a consideration that PMS practices wishing to revert to GMS should be advised to take into account.

Greenwich Joint Committee:

HW noted that the PMS review does not take into consideration the levels of deprivation and diversity in different borough areas when setting the premium. HW asked why this was the case. DS replied by stating that CCGs have to use their own allocations and work within these limits, in accordance with the direction of the SCF for London. Following correspondence between NHS England (London) and CCGs last year, there was found to no appetite for pooling resources across borough boundaries amongst the south east London CCGs. HW replied by stressing that this was a missed opportunity to impact on the quality of health improvement for patients, as levels of deprivation had been used previously when setting the premium, and that it had been long recognised that achieving quality health improvement for patients in areas of higher deprivation was significantly more difficult for GPs in those areas as compared with GPs in non-deprived areas. DS advised that the weightings were attributed via the Carr Hill weighted formula, which was applied at a national level to ensure an equitable distribution of resources. NHS England (London) is seeking a revision of the formula to take greater account of deprivation (factors including high turnover of staff, and English not being first language amongst workforce). DS also pointed to certain KPIs in the premium that had been included from this year’s London offer, that were intentionally added to encourage practices to address health inequalities.
EW requested a clarification on the breakdown of the total London offer (£7 premium) and whether this was inclusive of all elements of the London offer including KPIs. DS advised that this was the total and that it reflected the total cost of delivering the London offer for practices, although there would be an opportunity for CCGs to supplement this at a local level. JW advised that the first priority was to issue the offer. The full detail will be available to view by CCGs as part of this.

**Lewisham Joint Committee:**

SP thanked NHS England (London) for the scheduling of the forthcoming meeting with the Lewisham LMC regarding the PMS review and for the information re the London offer disseminated in advance of it. SP also thanked Lewisham CCG for the local engagement on this matter, stating that this engagement was very much appreciated by the LMC. SP requested that when the second offer comes through to the CCG and London-wide, and to the LMC, whether the LMC could receive CCG sensitive data to be able to assess how practices in Lewisham are performing against the KPIs being proposed, to ensure that when there are discussions with the LMC, it can ensure that the KPIs are relevant, achievable for and across the borough. DS agreed that NHS England (London) would share the information on performance of practices on the proposed KPIs with LMCs with the second London offer in advance of the meeting, although this is not currently available as it had only been agreed today. DS also advised that NHS England (London) would be writing to individual practices to set out the current levels of income for that practice in each component part of the PMS contract as per the London offer (that are each subject to the review). DS confirmed that London-wide LMCs and CCGs would be aware of the content of this letter in advance of it going out to individual practices.

SP also reiterated the concern raised by SD in relation to the potential for practices to opt to move to GMS national contracts as opposed to PMS contracts.

To summarise the item, and in line with the approach as agreed at the start, GU referred back to the recommendations for this item within the cover paper as to:

i. Note this update (*within the cover paper*)

ii. Confirm their intention to utilise the extension period for engagement with residents, members and partners

iii. Endorse the implementation approach outlined for their borough

The Joint Committees noted and were each in agreement with all three points.

**For Decisions**

8. **NHS Bexley CCG: Bexley Group Practice Premises relocation Project Initiation Document**

JW introduced the paper (Enclosure H), a request for funding to produce a feasibility study for Bexley Group practice to move premises. Bexley Group practice currently comprises five sites (three in Welling and two in Belvedere). The ultimate aim of the practice is to merge three buildings which are each not fit for purpose into a new proposed building and to retain the two premises at Belvedere.

The feasibility study will enable the CCG to submit a bid for 2016-17 Primary Care Transformation funding, based on clear evidence that the proposal is in line with Bexley CCG’s emerging interim estates intentions. The scheme is deliverable in 2016-17.
Bexley Joint Committee gave its approval for the recommended approach, to support the practice’s feasibility study proposal, at a cost of £11,616.00.

NHS England gave its approval.

**NHS Bexley CCG: Westwood Surgery Contract Breach**

JWe introduced the paper (Enclosure I), which recommended that the joint committee approve the issue of a breach and remedial notice to the practice. This recommendation was informed by a rating of “Inadequate” of the practice by the Care Quality Commission (CQC) following an inspection it carried out on 28 July 2015. NHS England had reviewed evidence in the CQC inspection report and had identified the three contract breaches as set out in Enclosure I.

JWe acknowledged that although the required actions had already been addressed by the practice, it was still appropriate to issue the notice due to the three contract breaches.

Bexley Joint Committee gave its approval for the recommended approach.

NHS England gave its approval.

**NHS Greenwich CCG: Plumstead/Tewson merger**

JWe introduced the paper (Enclosure J) that requested that the Joint Committee consider a proposed merger between Plumstead Health Centre practice and Tewson Road surgery following the receipt of a draft business case which the practices have submitted. JWe reported that the draft business case was compelling in terms of reduction of financial overheads, combining workforce resources, and rationalising space. Furthermore, co-commissioners are supportive of the proposed merger as it aligns with strategic priorities to support larger, more resilient practices, and equity of population based services.

The practices would like to implement the merger from 1st July 2016 or sooner if practical. JWe advised that there were a number of issues regarding clarification and discussion with the practices before a formal recommendation to PCJC could be made. NHS England’s recommended approach is to approve the proposed merger in principle, to take place on 1st July 2016 or sooner if practical, on the condition that the practices agree to undertake to work through the issues highlighted in Enclosure J, in order to provide a final business case that can be endorsed at the February 2016 Greenwich Primary Care Joint Committee meeting.

Greenwich Joint Committee gave its approval for the recommended approach.

NHS England gave its approval.

**NHS Greenwich CCG: Greenwich protected learning time (LIS)**

JWe introduced the paper (Enclosure K), which recommended that the Joint Committee approve the protected learning time Local Incentive Scheme for all practices in Greenwich, on the condition that all practices are encouraged to participate, and that the outcomes are suitably monitored and reviewed. Greenwich Joint Committee gave its approval for the recommended approach.
NHS England gave its approval.

**NHS Bromley CCG: Green Street Green list closure**

JWe introduced the paper (Enclosure L), which asked the Joint Committee to consider a request from Green Street Green GP practice to close its practice list for a period of three months to allow for required training for newly recruited clinician staff. The application had been made as a result of the impact of increased registrations following difficulties experienced by a neighbouring practice, and of patient safety concerns resulting from a recent high turnover in their clinical staffing.

JWe advised that the request has the support of Bromley Local Medical Committee.

The recommended approach as set out in Enclosure L and its supporting papers, was that the agreement to the closure of the list should be conditional upon the practice producing and agreeing an action plan to address a set of key issues (identified in the paper) with NHS England (London).

Bromley Joint Committee gave its approval for the recommended approach.

NHS England gave its approval.

**Report on decisions taken by NHS England on behalf of CCG**

9. **Locum reimbursements under London’s Discretionary Funding SOP**

The Joint Committees noted the content of this paper (which was circulated as Enclosure M). There were no questions or issues raised following the review of the paper.

**Decisions taken outside of the committee to be reported**

10. **NHS Lambeth CCG: Violent Patient Service**

JWe introduced the paper (Enclosure N), which reported that an urgent unplanned meeting of the voting members of the Lambeth Primary Care Joint Committee had taken place on 11th November. The meeting had considered the options available to NHS England (London), following notice served by one of the current three providers of the Violent Patient Service. Five options were presented to the Lambeth Primary Care Joint Committee – these were not detailed in Enclosure N, but are available on request. The preferred option of Model 2.1.1 of the Violent Patient Scheme options paper (as reviewed at the unplanned meeting of the Lambeth Primary Care Joint Committee on 11th November) had been approved by the Primary Care Joint Committee, as well as the process to invite practices within the South of the South East and South West locality to express an interest in hosting the Violent Patient Scheme in order to provide full coverage in all three localities in Lambeth.

JWe advised that the request has the support of Lambeth Local Medical Committee.

The Lambeth London Primary Care Joint Committee noted this report.

**NHS Bromley CCG: Winter Resilience Local Incentive Scheme**

JWe introduced the paper (Enclosure O), which reported that an urgent unplanned meeting of the Bromley Primary Care Joint Committee had taken place on 19th
November. The meeting had been convened to consider Bromley CCG’s Winter Resilience Local Incentive Scheme (LIS), to enable its implementation with effect from 1st December 2015.

The full set of papers that were reviewed at the urgent unplanned meeting are available on demand. The scheme had been approved by the Bromley Primary Care Joint Committee on the condition that the risks highlighted are actioned as set out in Enclosure O and that the schemes are suitably monitored and reviewed, with appropriate action taken to mitigate unexpected variation.

It was noted that the Bromley Local Medical Committee had been consulted on this course of action.

The Bromley Primary Care Joint Committee noted this report.

Public

11. Public Open Space

The following questions were raised by members of the public at the meeting:

Mark Webb asked: Is the personal safety of frontline NHS staff, the number one priority for the NHS in south east London, and if not, why not?

A number of Joint Committee members present contributed to the response to the question.

SB (Bexley Joint Committee) advised that there was a zero tolerance approach to violence toward every NHS staff member. Whilst the issue was not a specific priority in south east London strategies, it is a priority for all for all NHS organisations at a local and national level, and is a matter taken very seriously by all NHS organisations in south east London, particularly those that carry out frontline duties. In cases of violence and aggressive behaviour towards NHS staff, south east London commissioners and provider organisations will take necessary action including prosecutions.

JWe (NHS England) commented that this matter linked in with one of the items covered earlier at the meeting, in that NHS England (London) runs a Violent Patient Service in each borough. These services ensure that there is provision for GPs to report threatening behaviour and/or violence towards NHS staff in GP Practices, and so that NHS England (London) can utilise its statutory responsibility to make General Practice as safe as possible for its staff.

AE (Lambeth Joint Committee) commented that as well as ensuring that NHS services and facilities are safe for NHS staff, all NHS organisations are duty-bound to also ensure that they are safe for members of the public.

Jacqueline Best-Vassell asked a two-part question: (i) What were the benefits and the thinking behind transferring QIPP from secondary to primary care, when there seems to be a lot of objection on this from local primary care providers and commissioners? (ii) When looking at overspends across different local areas, the questioner asserted that it is clear that the largest areas in population size are often also those with the most deprivation. Therefore, to ensure that services to local patients do not suffer, there should be equity of distribution across areas, and there should be a more collective approach across the six boroughs to aid this.

RJ (NHS England) responded by stating that there had not been a transfer of QIPP
from secondary to primary care. CCGs each have their own challenging financial position and therefore their own QIPP targets to meet (noting that CCGs’ spend is predominantly on acute/secondary care). RJ also stated that, as per discussions in item 5, the efficiencies achieved around transactional QIPPs during the last two years had now been exhausted, and therefore the focus was to look at the whole amount of spend and ensure that all opportunities for efficiencies across the whole system were being maximised, whilst at the same time investing in primary care to enable it to help deliver some of the savings required in secondary care. In that light, whole health economies are being reviewed together rather than as separate budgets, organisations and services, and that this was very much in line with the Government’s Five Year Forward View.

MR (Lewisham Joint Committee) commented that the value of taking financial resources out of primary care in the aim of achieving efficiency was a contested point, and that all financial efficiencies achieved should remain within primary care for reinvestment in services. This point was reiterated by SP, who referred to a movement of £1.2m out of primary care that had not been reinvested (during the PCT era), and a concern for south London of resources being removed from primary care in future (in the context of the PMS review), asserting that all resources should be retained in primary care in order to carry out its intended role of reducing pressure and overspends within acute services.

MW confirmed that the decision relating to the £1.2m movement of funds away from primary care had been a PCT decision, and not a decision taken by the CCG or NHS England (London).

DS advised that the principles of the PMS review were such that any monies that are currently spend in Personal Medical Services will be retained in general practice.

MR also commented on the second issue raised by the questioner, by referring to the great complexities associated with this issue. MR offered to discuss this in more detail with the questioner away from the meeting.

DS advised that the comparative historical position on primary care spend across boroughs was a position inherited by NHS England (London) when it took over the lead on primary care contracts from Primary Care Trusts (PCTs) at the start of 2013-14. Therefore it followed that there was not necessarily a rationale as to why one borough’s expenditure was greater than that of another borough. Furthermore DS advised that at present there was no model in place to look at patient need at the individual borough level (only at London-level), but that as part of the emerging transition to co-commissioning and full delegation in boroughs, that local borough-based models would be established to respond to the needs of local populations and that alongside the national model this would give a greater sense of where over or under provision of resource allocations were in existence.

AE noted that spend on primary care represents approximately 10% of the total expenditure made by CCGs and NHS England (London) across community-based and hospital-based care. Concerning the equity of distribution of resources, AE explained that the direction was to look across all of the NHS allocations supporting populations and not just single components, such as resources for primary care. This was in line with the key principles of the Five Year Forward View for the NHS to join-up care and support for individuals and to secure improved population-wide health outcomes.

JH (Southwark Joint Committee) reflected on the responses made to the first part of
the question by clarifying that at present the budgets for the different parts of the local health economies sat within different organisations, and that it was hoped in future this would be managed on a whole health system basis, potentially enabling CCGs to move more of their resources into services in the community setting.

JH commented on the second issue raised by recognising that from a review of the financial reporting alone, the notion of an inequitable distribution of resources (or that resources were not distributed based on key factors such as deprivation) could be arrived at. However JH emphasised that across south east London there are a range of collaborative programmes (such as Community Based Care) that are focused on ensuring consistency of quality for all patients in south east London. Commissioners were very aware of the importance of addressing concerns around deprivation, and referred to the point made by DS (above) around moves toward understanding deprivation and the resources required to respond to it in all localities across London, which should provide important answers to this question.

Jennifer Quinton-Chelley asked if practices were able to retain underspends from one financial year to the next, in order to deliver on other priorities for their patients.

RJ advised that NHS underspends were managed on a whole system basis, ie an underspend in one area would be used to offset an overspend in another part of the health system in London. RJ said that NHS England (London) is looking across the whole of primary care in London to try to address the shortfall on primary medical services, and noted that London as a region was just about managing to stay in financial balance, but that other regions in England were in a far worse position, and this, alongside the fact that the acute provider sector was in such a heavily challenged financial position meant that any financial surpluses in any part of the system would necessarily used to offset overspends elsewhere. The ultimate risk that this sought to mitigate was the possibility of the Department of Health’s budget reaching a deficit.

In terms of the position at an individual practice level, DS advised that NHS England (London) held a contract with individual practices under which it pays practices the amount of money they are entitled to receive in order to meet the needs of their patients, as well as the costs associated with their premises as they deem appropriate.

At the end of the second public open space, GU advised the members of public present that they also have the opportunity to address written questions to the Joint Committees in advance of these meetings and that these requests would receive written answers. The advertisements for these meetings (as shown on CCG websites) would provide a contact email address to send questions to (this is tom.bunting@nhs.net) and a timeframe in advance of the next meeting in order to have a response issued at the meeting.

Other business

12. Any other business

GU reiterated the message from previous meetings, that the meetings of the south east London Primary Care Joint Committees are a “work in progress” and that there is ongoing work to improve all aspects of how they are managed, and thanked each Joint Committee for the feedback (on how to improve the meetings) that had already been received, and encouraged further feedback on an ongoing basis. This had been sent in by Chairs of the Primary Care Joint Committees and any further feedback on an ongoing basis would be welcomed and acted upon.
<table>
<thead>
<tr>
<th>For information</th>
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<tr>
<td>13. Glossary of Terms</td>
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<tr>
<td>The Joint Committees noted the contents of the Glossary of Terms. No updates had been received since the last meeting.</td>
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<table>
<thead>
<tr>
<th>Date of Next Meeting</th>
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<tr>
<td>11 February 2016, 6-8.30pm at Kia Oval, Surrey County Cricket Club, SE1 5SS</td>
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Close
<table>
<thead>
<tr>
<th>Name</th>
<th>Affiliation</th>
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<tbody>
<tr>
<td>Gary Beard</td>
<td>NHS England</td>
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<tr>
<td>Sharon Fernandez</td>
<td>NHS England</td>
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<tr>
<td>Leslie Aitken</td>
<td>NHS Lewisham CCG</td>
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<tr>
<td>Bobbie Scott</td>
<td>NHS Lewisham CCG</td>
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<tr>
<td>Bob Skelly</td>
<td>South Southwark Patients and Participation Group</td>
</tr>
<tr>
<td>Mark Webb</td>
<td>Camberwell resident and member of SE5 Forum</td>
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<tr>
<td></td>
<td>(Tenant’s Association in Camberwell)</td>
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<tr>
<td>Martin Dadswell</td>
<td>Member of the public</td>
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<tr>
<td>Tamsin Bacchus</td>
<td>Save Lewisham Hospital Campaign</td>
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<tr>
<td>Jacqueline Best-Vassell</td>
<td>Lambeth and Southwark MIND, works for South</td>
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<td></td>
<td>London and Maudsley NHS Foundation Trust, is on</td>
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<td></td>
<td>Lewisham Patients and Participation Group</td>
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<tr>
<td>Juney Muhammad</td>
<td>Service Manager, South London and The Maudsley</td>
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<td></td>
<td>NHS Foundation Trust</td>
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<tr>
<td>Jennifer Quinton-Chelley</td>
<td>Peckham resident, member of the Acorn and</td>
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<tr>
<td></td>
<td>Gaumont GP Patients and Participation Group,</td>
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<td></td>
<td>member of Southwark Pensioners Action Group and</td>
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<td>Southwark Pensioners Forum</td>
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MEETING NOTES

Clinical Strategy Committee
Thursday 20 August 2015
Room 519, 160 Tooley Street
Co-Chair – Amr Zeineldine (for CCGs) and Jane Fryer (NHS England)

Members in Attendance
Amr Zeineldine: Chair CCB and CSC
Sarah Blow: Bexley CCG
Howard Stoeate: Bexley CCG
Andrew Parson: Bromley CCG
Adrian McLachlan: Lambeth CCG
Andrew Bland: Southwark CCG
Annabel Burn: Greenwich CCG
Louis Levy: Patient and public voice
Mark Easton: Programme Director
Ellen Wright: Greenwich CCG
Jonty Heaversedge: Southwark CCG
Peter Gluckman: Independent Chair, SE London Stakeholder Reference Group

Apologies
Martin Wilkinson: Lewisham CCG
Jane Fryer: NHS England
Marc Rowland: Lewisham CCG
Nada Lemic: Director of Public Health, NHS Bromley CCG, SE London Public Health Lead
Angela Bhan: Bromley CCG
Andrew Eyres: Lambeth CCG
Zoe Lelliott: Acting Managing Director, Health Innovation Network

Other Attendees:
Daniel Moore: Programme Team (Minutes)

DECISIONS FROM THIS GROUP MEETING

<table>
<thead>
<tr>
<th>ID</th>
<th>Type</th>
<th>Risk / Issue / Action / Decision Description</th>
<th>Owner</th>
<th>Meeting</th>
<th>Agreed Date</th>
<th>Due Date</th>
<th>Status</th>
<th>Comments</th>
</tr>
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<tbody>
<tr>
<td>53</td>
<td>Action</td>
<td>A full version of the consolidated strategy with the change log was to be shared with CBC members</td>
<td>DM</td>
<td>CSC</td>
<td>20/8/15</td>
<td></td>
<td>Closed</td>
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OUTSTANDING ACTIONS FROM PREVIOUS GROUP MEETINGS

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<tr>
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ACTIONS CLOSED AT THIS MEETING

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1. Welcome and Apologies
1.1 The chair welcomed members to the meeting
1.2 It was requested that the membership at the previous meeting be revised to remove the duplication.
1.3 It was confirmed that the minutes were otherwise correct and that they should be forwarded to CCG Governing Body meetings

2. Community Based Care Update
2.1 Andrew Bland provided an update about the role of the Community Based Care (CBC) delivery group and how it is linked with the London Transforming Primary Care programme and standards
2.2 A plan has been developed and shared with the implementation executive group. CCGs have linked this in with reporting to the London team. This plan has now been validated and was submitted in July

3. Consolidated Strategy
3.1 CSC considered received feedback from the CBC meeting regarding the consolidated strategy. This is summarised below:

- The consolidated strategy was presented along with a summary of the feedback received through governing bodies and other stakeholders. CCB noted the changes that had been made as a result. It was requested that a full version with the change log was shared with CBC members. (Action 53)
- Agreed that the revised versions should be posted on the website as a ‘single point of truth’
- CSC approved the strategy as recommended by CCB

4. Date of next meeting
4.1 Thursday 17th September, 10:45-12:45