AGENDA
A meeting of the Governing Body Part I

Date: 11 January 2018
Time: 10.00 am - 12.30 pm
Venue: Cantilever House, Eltham Road, London SE12 8RN
Chair: Dr Marc Rowland

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

Voting Members

Dr Marc Rowland (Chair)  Chair
Dr David Abraham  Senior Clinical Director
Alison Browne  Registered Nurse
Dr Charles Gostling  Clinical Director
Anne Hooper  Lay Member
Dr Sebastian Kalwij  Clinical Director
Shelagh Kirkland  Lay Member
Dr Faruk Majid  Clinical Director
Dr Jacqueline McLeod  Senior Clinical Director
Professor Simon MacKenzie  Secondary Care Doctor
Dr Angelika Razzaque  Clinical Director
Tony Read  Chief Financial Officer
Ray Warburton OBE (Vice-Chair)  Lay Member
Martin Wilkinson  Chief Officer

Non-Voting Members

Aileen Buckton  Executive Director, Community Services, Lewisham Council
Dr Danny Ruta  Public Health Director, Lewisham Council
Dr Simon Parton  Local Medical Committee Chair
Dr Magna Aidoo  Healthwatch Lewisham Representative

Quorum

The Governing Body will be deemed quorate when a minimum of 7 members, 4 of which must be Clinical Directors, one must be either the Chief Officer or Chief Financial Officer and two must be independent members (Lay Members, Secondary Care Doctor or Registered Nurse). A member who is present at Governing Body meeting and is conflicted by a particular agenda item will not contribute to the quoracy of the meeting for the duration of that agenda item.

Chair: Dr Marc Rowland  Chief Officer Martin Wilkinson
Order of Business

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

<table>
<thead>
<tr>
<th>Time</th>
<th>Item</th>
<th>Papers</th>
<th>Presented by</th>
</tr>
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<tbody>
<tr>
<td>1. 10:00</td>
<td><strong>Welcome and Introductions</strong></td>
<td>1 - 4</td>
<td>Chair</td>
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<td>2.</td>
<td><strong>Apologies for absence</strong></td>
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<td>3.</td>
<td><strong>Declarations of Interest</strong></td>
<td>5 - 6</td>
<td>Chair</td>
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<td></td>
<td><em>Members should discuss any potential conflicts of interest with the Chair prior to the meeting</em></td>
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<td></td>
<td>Declarations made by the Governing Body are listed in the register.</td>
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<td></td>
<td>For agenda item 19; <strong>NHS Walk-in Centre and improving provision and access to primary care</strong>, the Governing Body is asked to note the conflict of interest for Dr Sebastian Kalwij which has been discussed with the Chair. This does not affect the quoracy of the meeting.</td>
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<td>4.</td>
<td><strong>Minutes of the last meeting</strong></td>
<td>7 - 22</td>
<td>Chair</td>
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<td><em>To agree the minutes of the last meeting and review the action log</em></td>
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<td>5.</td>
<td><strong>Matters arising</strong></td>
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<td>6. 10:15</td>
<td><strong>Chair's Report</strong></td>
<td>23 - 26</td>
<td>Dr Marc Rowland</td>
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<td></td>
<td><em>To receive and note for information</em></td>
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<td>7. 10:20</td>
<td><strong>Chief Officer's Report</strong></td>
<td>27 - 32</td>
<td>Martin Wilkinson</td>
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<td></td>
<td><em>To receive and note for information</em></td>
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<td>8.</td>
<td><strong>Audit Committee Chair’s Report</strong></td>
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<td><em>There was no Audit Committee meeting held since the last Governing Body meeting, therefore no report to be presented.</em></td>
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| 9. | **Finance and Investment Committee Chair's Report**  
*Due to the confidential nature of the business discussed at the meeting held on 13 December 2017 this will be reported to Part II of the meeting.* |   |   |
| 10. | **Primary Care Commissioning Committee Chair's Report**  
*There was no Primary Care Commissioning Committee meeting held since the last Governing Body meeting, therefore no report to be presented.* |   |   |
| 11. | **Public Engagement and Equalities Forum Chair's Report**  
*To receive and note the report from the meeting held on 5 December 2017* | 33 - 34 | Anne Hooper |
| 12. | **Questions in relation to agenda items from members of the public** |   |   |

### INTEGRATED GOVERNANCE

| 13. | **Integrated Governance Committee**  
*Chair's Report from the meetings held in November and December 2017*  
*To receive and note for information* | 35 - 58 | Martin Wilkinson |
| 14. | **Board Assurance Framework (BAF)**  
*To receive the report and agree the revised risk scores for specific risks and to agree that there are adequate controls in place to mitigate the risks to the Corporate Objectives and where existing controls have not reduced the current risk score to the target risk score there are credible action plans* | 59 - 108 | Martin Wilkinson |
| 15. | **Annual Report and Accounts 2017/18**  
*To approve the process and authorise delegated responsibility to the Audit Committee* | 109 - 112 | Tony Read |
16. **11:15**  
**NHS Lewisham Safeguarding Children Annual Report 2016/17**  
*To receive and approve the Safeguarding Children Annual Report 2016/17*  
113 - 138  
Dr Faruk Majid

17. **11:25**  
**Clinical Supervision Policy**  
*To receive and approve the policy*  
139 - 156  
Dr Faruk Majid

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### STRATEGY AND PLANNING

18. **11:35**  
**Strategy and Development Workshop Chair's Report**  
*To receive and note from the meeting held on 7 December 2017*  
157 - 158  
Dr David Abraham

19. **11:40**  
**NHS Walk-in Centre and Improving Provision and Access to Primary Care**  
*To receive and agree the recommendations*  
*This report will follow in a supplementary agenda*  
Dr David Abraham and Dr Jacky McLeod

**Conflict of Interest:** There is a direct conflict of interest on this item for Dr Sebastian Kalwij, Clinical Director as a GP and Partner at the Amersham Vale Training Practice and an indirect conflict for the Clinical Directors of the Governing Body and the LMC representative due to all practices in Lewisham being shareholders of One Health Lewisham through which Extended Access is commissioned.

20. **12:00**  
**Annual Equalities Report 2017**  
*To receive and approve the LCCG Annual Equalities Report to be published on 31 January 2018*  
159 - 226  
Martin Wilkinson

21. **12:15**  
**Potential Audit and Risk Management Issues**  
Chair

22.  
**Any Other Business**

23. **12:20**  
**Questions from members of the public in relation to agenda items**
Approved Committee minutes for information only:
- Integrated Governance Committee (October 2017)
- Strategy and Development Workshop (October 2017)
- Health and Wellbeing Board (September 2017)

Date of next meeting: Thursday, 8 March 2018, 10.00 am

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

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

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

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

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

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

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

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

8. In making this decision the chair will consider whether the meeting is quorate, in accordance with the number and balance of membership set out in the CCG’s standing orders or the relevant terms of reference. Where the meeting is not quorate, owing to the absence of certain members, the discussion will be deferred until such time as a quorum can be convened. Where a quorum cannot be convened from the membership of the governing body, committees, 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.

9. These arrangements will be recorded in the minutes.
**GLOSSARY OF TERMS**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AAS</td>
<td>Admission Avoidance Service</td>
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<td>ACRA</td>
<td>Advisory Committee on Resource Allocation</td>
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<td>ACS</td>
<td>Accountable Care System</td>
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<td>ADASS</td>
<td>Association of Directors of Adult Social Services</td>
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<tr>
<td>AEC</td>
<td>Ambulatory Emergency Care</td>
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<tr>
<td>A&amp;E</td>
<td>Accident and Emergency</td>
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<td>AfC</td>
<td>Agenda for Change</td>
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<td>AHP</td>
<td>Allied Health Professional</td>
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<td>AHSC</td>
<td>Academic Health Science Centre</td>
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<td>AHSN</td>
<td>Academic Health Science Network</td>
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<td>AICP</td>
<td>Adult Integrated Care Programme</td>
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<td>APMS</td>
<td>Alternative Provider Medical Services</td>
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<td>AQP</td>
<td>Any Qualified Provider</td>
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<tr>
<td>ASTRO-PU</td>
<td>Age, Sex, Temporary Resident Originated Prescribing Unit</td>
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<tr>
<td>CBC</td>
<td>Community Based Care</td>
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<td>CBT</td>
<td>Cognitive Behavioural Therapy</td>
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<td>CCG</td>
<td>Clinical Commissioning Group</td>
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<td>CCNT</td>
<td>Children’s Community Nursing Team</td>
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<td>CEMACH</td>
<td>Confidential Enquiry into Maternal and Child Health Officer</td>
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<td>CIP</td>
<td>Cost Improvement Programme</td>
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<td>CLG</td>
<td>Clinical Leadership Group</td>
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<td>CNST</td>
<td>Clinical Negligence Scheme for Trusts</td>
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<td>CIC</td>
<td>Committee in Common</td>
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<tr>
<td>CIO</td>
<td>Chief Information Officer</td>
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<td>CIPD</td>
<td>Cost Improvement Programme</td>
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<td>CIPG</td>
<td>Clinical Leadership Group</td>
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<td>CIPG</td>
<td>Clinical Review Group</td>
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<tr>
<td>CRL</td>
<td>Capital Resource Limit</td>
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<td>CPA</td>
<td>Care Programme Approach</td>
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<td>CPD</td>
<td>Continuing Professional Development</td>
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<td>CPN</td>
<td>Community Psychiatric Nurse</td>
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<td>CPR</td>
<td>Child Protection Register</td>
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<td>CQUIN</td>
<td>Commissioning for Quality and Innovation</td>
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<td>CQB</td>
<td>Criminal Records Bureau</td>
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<td>CSS</td>
<td>Commissioning Support Unit</td>
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<td>CSP</td>
<td>Commissioning Strategy Plan</td>
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<td>CSR</td>
<td>Comprehensive Spending Review</td>
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<td>CQRG</td>
<td>Clinical Quality Review Group</td>
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<tr>
<td>CRG</td>
<td>Clinical Review Group</td>
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<td>DES</td>
<td>Direct Enhanced Service</td>
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<td>D2A</td>
<td>Discharge to assess</td>
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<td>D3A</td>
<td>Delayed transfer of care</td>
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<td>DAAT</td>
<td>Drug &amp; Alcohol Action Team</td>
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<td>DGH</td>
<td>District General Hospital</td>
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<tr>
<td>DH or DoH</td>
<td>Department of Health</td>
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<td>DTC</td>
<td>Delayed transfer of care</td>
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<tr>
<td>E&amp;D</td>
<td>Equality and Diversity</td>
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<td>ECS</td>
<td>Enhanced Care and Support</td>
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<td>ED</td>
<td>Emergency Department</td>
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<td>EDS</td>
<td>(NHS) Equality Delivery System</td>
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<tr>
<td>EDT</td>
<td>Emergency Discharge Team</td>
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<td>EI</td>
<td>Early Intervention</td>
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<td>EIA</td>
<td>Equality Impact Assessment</td>
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<td>EIP</td>
<td>Early Intervention in Psychosis</td>
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<td>EMIS</td>
<td>Practice Information System</td>
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<tr>
<td>ENT</td>
<td>Ear, Nose and Throat</td>
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<tr>
<td>EPR</td>
<td>Electronic Patient Programme</td>
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<td>EPRR</td>
<td>Emergency Planning Response Register</td>
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<td>EPS</td>
<td>Electronic Prescription Service</td>
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<td>ESR</td>
<td>Electronic Staff Record</td>
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<td>EWTD</td>
<td>European Working-Time Directive</td>
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<td>FCE</td>
<td>Finished Consultant Episode</td>
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<td>FHS</td>
<td>Family Health Services</td>
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<tr>
<td>FIMS</td>
<td>Financial Information Management System</td>
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**Page 1**
Information Management System
FLAG For Learning and Action Group
FNP Family Nurse Partnership
FOI Freedom of Information
FOT Forecast Outturn
FT Foundation Trust

GAD Government Actuary’s Department
GDC General Dental Council
GDS General Dental Services
GMC General Medical Council
GMS General Medical Services
GOS General Ophthalmic Services
GP General Practitioner
GPI General Practitioner Interactive
GPS Government Procurement Services
GPSI or GPwSI General Practitioner with a special interest
GPSoC General Practitioner Systems of Choice
GSTT Guy’s & St. Thomas’ NHS Foundation Trust

HCA Health Care Assistant
HCAI Healthcare-Associated Infection
HCAIs Healthcare Acquired Infections
HCAS High Cost Area Supplement
HEMS Helicopter Emergency Medical Service
HIA Health Impact Assessment
HIEC Health Innovation and Education Cluster
HMO Health Maintenance Organisation (USA)

HoNOS Health of the Nation Outcome Scales
HRG Healthcare Resource Group
HRG4 Healthcare Resource Group version 4
HSC Health and Social Care (Northern Ireland)
HSJ Health Service Journal

HTA Health Technology Assessment
HV Health Visitors
HWB Health and Wellbeing Board
IAPT Improving Access to Psychological Therapies (programme)
IC Information Commissioner
ICAS Independent Complaints Advocacy Service
ICD International Classification of Diseases
ICDT Integrated Contract and Delivery Team
ICE Integrated Communication and Engagement
ICO Integrated Care Organisation
ICP Integrated Care Pathway
ICT Information and Communication Technology
ICU Intensive Care Unit
I&E Income and Expenditure
IFRS International Finance Reporting Standards
IG Information Governance
IMCA Independent Mental Capacity Advocate
IM&T Information Management and Technology

IP Information Prescriptions
IP Inpatient
IPR Individual Performance Review
IRP Independent Reconfiguration Panel
IST Intensive Support Team

JCP Jobcentre Plus
JHWS Joint Health and Wellbeing Strategy
JNC Joint Negotiating Committee
JSNA Joint Strategic Needs Assessment
KPI key Performance Indicator
KSF (NHS) Knowledge and Skills Framework
LA Local Authority
LCFS Local Counter Fraud Specialist
LDC Local Dental Committee
LES Local Enhanced Services
LETBs Local Education and Training Boards
LGA Local Government Association
LGT Lewisham & Greenwich NHS Trust
LIFT Local Improvement Finance Trust
LMC Local Medical Committee
LSMS Local Security Management Specialist
LOC Local Optical Committee
LPC Local Pharmaceutical Committee
LSP Local Strategic Partnership
LSL Lambeth, Southwark & Lewisham
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
NHS SBS NHS Shared Business Services
NHSLA NHS Litigation Authority
OD Organisational Development
OGC Office of Government Commerce
OHSEL 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
RFD Ready for discharge
RO Responsible Officer
RRL Revenue Resource Limited
RRT Rapid response Team
RSM Internal Audit Provider
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
SOP Standard Operating Procedure
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
TAP Treatment Access Policy
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
<table>
<thead>
<tr>
<th>Name</th>
<th>Current position held in the CCG</th>
<th>Governing Body Member</th>
<th>Clinical Director</th>
<th>Practice Lead</th>
<th>Professional Interest</th>
<th>Nature of Interest</th>
<th>From</th>
<th>To</th>
<th>Action taken to mitigate risk</th>
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<tbody>
<tr>
<td>Dr Charles Gostling</td>
<td>Clinical Director</td>
<td>Yes</td>
<td>Yes</td>
<td>n/a</td>
<td>Direct &amp; Indirect</td>
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<td>2015</td>
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<td>Dr Simon Mackenzie</td>
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<td>2015</td>
<td>2017</td>
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<td>Raymond Warburton</td>
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<td>n/a</td>
<td>Yes</td>
<td>n/a</td>
<td>Direct</td>
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<td>2015</td>
<td>2017</td>
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<td>Yes</td>
<td>n/a</td>
<td>Direct and indirect</td>
<td>Direct</td>
<td>2015</td>
<td>2017</td>
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<td>Martin Wilkinson</td>
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<td>Direct</td>
<td>2015</td>
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<tr>
<td>Dr Marc Rowland</td>
<td>Clinical Director</td>
<td>Yes</td>
<td>Yes</td>
<td>n/a</td>
<td>Direct and indirect</td>
<td>Direct</td>
<td>2015</td>
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<td>Dr Simon Parton</td>
<td>Governing Body Member</td>
<td>n/a</td>
<td>Yes</td>
<td>Yes</td>
<td>Direct</td>
<td>Direct</td>
<td>2015</td>
<td>2017</td>
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<td>Dr Faruk Majid</td>
<td>Clinical Director</td>
<td>Yes</td>
<td>n/a</td>
<td>n/a</td>
<td>Direct</td>
<td>Direct</td>
<td>2015</td>
<td>2017</td>
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<td>Dr Angela Wilcox</td>
<td>Governing Body Member</td>
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<td>Direct</td>
<td>2015</td>
<td>2017</td>
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<tr>
<td>Dr Jacky Offord</td>
<td>Clinical Director</td>
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<td>Dr Simon Parker</td>
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<td>Peter Williamson</td>
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<td>Dr Raymond Warburton</td>
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<td>Dr Mathew Williams</td>
<td>Governing Body Member</td>
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### Notes
- **Governing Body Member**
- **Clinical Director**
- **Practice Lead**
- **Nature of Interest**
- **From**
- **To**
- **Action taken to mitigate risk**

### Exclusions
- To exclude from decision-making processes which would have impact on service developments and/or income for practice
- To declare at the beginning of each meeting where the future of services delivered at the Waldron Centre are discussed
- To declare at the beginning of each meeting where a service will be tendered for
- To declare at the beginning of each meeting where the extent of service developments and/or income for practice
- To declare at the beginning of each meeting where services will be tendered for
- To declare at the beginning of each meeting where service developments and/or income for practice
- To declare at the beginning of each meeting where services will be tendered for

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### Key Points
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- To declare COI at the beginning of each meeting where service developments and/or income for practice

### Other Points
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- To declare COI at the beginning of each meeting where services will be tendered for
- To declare COI at the beginning of each meeting where service developments and/or income for practice

### Additional Details
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Governing Body meeting

Minutes of the meeting of the Lewisham Clinical Commissioning Group (LCCG) Governing Body held on Thursday, 9 November 2017 at Cantilever House, London SE12 8RN

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

In Attendance

From Lewisham CCG;

Ms Diana Braithwaite Director of Commissioning and Primary Care, LCCG
Mr Russell Cartwright Head of Communications and Engagement, LCCG
Mr Mike Hellier Head of System Intelligence, LCCG
Ms Deborah Iles PA to Chair, Chief Officer and Chief Financial Officer, LCCG
Ms Valery Lawrence Communications Manager, NELCSU
Mr Charles Malcolm-Smith Associate Director, Strategy and Organisational Development, LCCG
Ms Susanna Masters Corporate Director, LCCG
Ms Victoria Medhurst Associate Director, Integrated Governance, LCCG
Ms Hannah Reeves Corporate Services Administrative Manager (notes), LCCG
Mr Ashley O’Shaughnessy Deputy Director, Primary Care, LCCG
Ms Teresa Rodriguez Engagement Officer, LCCG

There were 8 members of the public present for the meeting.

Apologies
Ms Alison Browne Registered Nurse, LCCG
Dr Simon Parton LMC Chair
LEW 17/113 Welcome and Announcements

Dr Rowland welcomed all to the Governing Body meeting.

LEW 17/114 Declarations of Interest

For agenda item 16, Public Consultation of the future of the NHS Walk-in Centre and improving provision and access to primary care, the Governing Body is asked to note the conflict of interest for Dr Sebastian Kalwij. This has been discussed with the Chair and it has been agreed that Dr Kalwij will leave the meeting for this agenda item and will not take part in the discussions or decision making.

For agenda item 10, Primary Care Commissioning Committee Chairs Report, the Governing Body is asked to note the conflict of interest for Dr Angelika Razzaque who is a Partner at the Queens Road Practice, discussed during this item.

Dr Rowland reminded the Governing Body that all Clinical Directors as local GPs have an indirect conflict of interest due to all practices being shareholders of One Health Lewisham, the Federation of Lewisham GPs.

LEW 17/115 Previous Minutes

The minutes of the Governing Body meeting held on 14 September 2017 were taken as a true record subject to the following:

LEW 17/97 – Dr Gostling stated that the emphasis of his point was that the Board should not be ‘blinded’ by the outstanding rating as the rating does not reflect the feeling in Primary Care.

LEW 17/116 Action Log and Matters Arising

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

Updates were given on the open actions and the log was reviewed. It was agreed that for any outstanding actions it would be prudent to act outside of the meeting cycle in order to take forward the action, rather than leave until the next meeting before updating.

LEW 17/117 Chair’s Report

Dr Rowland gave his report and highlighted that:

- The LCCG Annual General Meeting had been a success and he wanted to reiterate his thanks to all involved. He commended the increased public involvement but would also welcome any feedback to improve attendance going forward.
- The constitutional changes, which are a result of the SEL CCG Commissioning Review, are currently being agreed by the Membership.
A successful Board to Board meeting with South London and Maudsley NHS Foundation Trust was held, with tangible actions being agreed.

The Governing Body NOTED the report

LEW 17/118  Chief Officer’s Report

Mr Wilkinson gave the report and highlighted the following:

- The Better Care Fund plan has been approved. Mr Wilkinson thanked all involved.
- The initial reports regarding the implementation of new recording methods for ambulance response time had gone well so far, however there will be a gap in monitoring reporting whilst this is embedded. This will be monitored via the Integrated Governance Committee.

The Governing Body NOTED the report

LEW 17/119  Audit Committee Chair Report

Mr Warburton summarised the highlights from the Audit Committee meeting held on 31 October 2017:

- The Committee had undertaken a deep dive into workforce, noting that according to RSM’s intelligence, who are our Internal Auditors, the largest categories of high priority actions being undertaken by NHS trusts are about HR and staffing issues, followed by financial management.
- RSM reported that controls for developing and monitoring QIPP schemes were sound, which resulted in an internal audit opinion of ‘substantial assurance’. RSM also reported that the CCG can take ‘reasonable assurance’ that the controls in place to manage procurement are suitably designed and consistently applied.
- The Committee was informed by TIAA that their training programme for CCG staff and Governing Body Members in 2017 / 18 is in place.
- The Committee reported that, in relation to RSM’s Assurance Map, close attention needs to be paid to governance, audit and assurance risks which may arise from the implementation of the SEL Collaborative Review.
- Mr Read reported that Grant Thornton has yet to issue the final version of the Annual Audit Letter for 2016/17. Mr Read confirmed he will follow this up and once received, the letter will be circulated to the Governing Body.
- Finally, Mr Warburton noted that TIAA is advising the CCG with regards to the provision of personal attack alarms, following security alerts concerns sexual assaults in the Lewisham area.

The Governing Body NOTED the report

LEW 17/120  Report of the Chair of the Finance and Investment Committee (FIC)

Professor Mackenzie, as Chair of the FIC, provided a verbal report of the following from the meeting held on 26th September 17 and the follow up teleconference held on 19th October 2017. He highlighted:
• There are significant risks, which were reported from an early point in the year, to the delivery of the CCGs financial targets for 2017 / 18. The expenditure pressures are being driven by unplanned expenditure in CHC, acute hospital activity, mental health activity and prescribing costs. Significant pressures are reported due to the LGT cost and volume contract, with the volume and cost of activity is higher than planned.
• The Committee reported that the CCGs QIPP delivery position significantly deteriorated between Month 4 and Month 5, also noting that recovery actions were behind target. The Committee considered that the Governing Body should strengthen ties with the membership to help deliver QIPP initiatives, especially considering the increased pressure expected in 2018 / 19.
• The Committee approved contract extensions to the RSS contract and GP streaming pilot contract.
• It was reported that the FIC would be taking a ‘harder’ look at any investment requests, considering the current climate.

The Governing Body NOTED the report

LEW 17/121 Primary Care Commissioning Committee (PCCC) Chair’s Report

Ms Kirkland, as Chair of the PCCC, highlighted the following key issues from the meeting held on 24th October 2017:

• It had been agreed by the Committee that no formal action would be taken against Lewisham Medical Centre or the Triangle Practice, in relation to ‘requires improvement’ ratings from CQC inspections in 2016. Lewisham Medical Centre is delivering the actions in place and has been re-inspected. It is believed that this practice will now be rated ‘good’. The Triangle Practice has given assurance that the remaining outstanding actions have been addressed.
• The Committee received the Healthwatch GP Patient Information Audit and has provided initial responses to the recommendations.
• The Committee had noted the update on the Outcomes & Achievements of the 2016 / 17 coordinated care service, with very positive outcomes and achievements noted with the exception of CYP immunisation uptake and patient participation levels.
• It was agreed that more work is required to increase awareness of Primary Care services available.

The Governing Body NOTED the report

LEW 17/122 Public Engagement and Equalities Forum (PEEF) Chair’s Report

Ms Hooper, Chair of PEEF, gave the report from the meeting held on 3rd October 2017 and highlighted the following main areas discussed:

• The importance of developing themed priorities for public engagement for the CCG, to be considered at the Strategy and Development workshop.
• Ms Hooper thanked all for their participation, help and attendance at the AGM.
• Ms Hooper extended her thanks to Healthwatch for all the reports and confirmed that recommendations would be monitored through the PCCC or IGC meetings.
• The PEEF highlighted the need to ensure that the CCG plans and priorities are relevant and clear to the local population.
The Governing Body queried whether Healthwatch might help the CCG to identify what the public understand as ‘the other options’ for avoiding hospital admissions.

The Governing Body NOTED the report

**LEW 17/123 Questions for Members of the Public**

**Q** In relation to the Hurley Group practice closure; it has been noted that letters have not been sent out to Patients.

**A** Mr Wilkinson confirmed that LCCG is aware of an issue surrounding the sending of letters erroneously, which has caused a delay. To ensure all patients have the 12 week period to register at another practice, the CCG has extended the contract. The CCG will be seeking compensation, due to the error occurring at the outsourced organisation and therefore the CCG is not liable.

**LEW 17/124 Integrated Governance Committee (IGC)**

Mr Read reported on the meetings of the IGC held on 28th September 2017 and 26th October 2017. He highlighted the following:

**Quality**

- The IGC had received the Healthwatch quarterly report, which identified similar trends to previous reports regarding GP appointments, although the report noted an increase in positive comments which were attributed to the additional capacity created by the extended access service and the increased uptake in online access.
- The IGC received the Healthwatch survey regarding discharge processes, noting both the positive work of the nurses in the discharge lounge but also noting the need for more joined up services within the Trust for patients including links with Doctors and medicine delays. The IGC agreed they would like to monitor the action plans in place following this report.
- The IGC considered the Lewisham and Greenwich NHS Trust Care Quality Commission report that resulted in the Trust receiving ‘Requires Improvement’ rating overall. The Committee considered the key concerns and agreed that the action plan requires monitoring, through the Clinical Quality Review Group and the A&E Delivery Board.

**NHS Constitutional Standards**

- The CCG is significantly below the Cancer Waiting Times Relating to GP Referral to Treatment within 62 days standard, at 67.9%. The Inter Provider transfers between Lewisham and Greenwich Trust and the tertiary centre by day 38 stood at around 77.8%, which is below the 85% standard. The Committee reviewed the action plans and breach analysis for South East London and Lewisham patients, the Committee concluded it was not assured that progress to the standard will be achieved.
- The A&E 4 hour performance did not achieve the standard in September 2017 at 89.9%, it also did not meeting the improvement plan trajectory for the first time since May 2017.
- The Committee noted that whilst there are challenges to the 18 week incomplete standard, the CCG is amber rated against its recovery plan, which is over two years. The Committee also noted that NHS England has asked for assurance on over 52 week waiting patients. The
Committee confirmed they are not content that these waits are happening and noted further focus on 40 plus weeks in the future.

- The Governing Body was informed that with the reported constitutional standards, a lot of work is on-going; however there is not sufficient evidence to signify that LCCG will hit the targets.

**Finance**

- At month 6 the CCG is forecast to deliver an in year break even position and a cumulative surplus of £9.38m for the year. There is significant contract over-performance and QIPP delivery is slipping. Available mitigations have been incorporated into the forecast outturn at month 6, but there remains considerable risk.
- The IGC agreed that the finance and QIPP performance is increasingly risky and remitted the position to Finance and Investment Committee to scrutinise further.

**Mr Warburton questioned:**

1. Does the CQC report and A&E figures take into consideration how the two major South East London hospitals (UHL & QEH) work together?

Mr Read replied, stating that there are differences across the two sites in performance, as well as differences in providers at both sites therefore any solutions will have to take this into account.

2. In relation to the non-assurance for the Cancer waiting targets, Mr Warburton queried whether the CCG felt it had sufficient understanding of the underlying problems and whether the correct action plans are in place?

Mr Read replied, stating that it would appear that Lewisham and Greenwich NHS Trust are comparatively ‘good’ at meeting the higher transfer rates, i.e. transfer within 38 days; however it would appear that this does not translate into higher treatment rates at day 62. Mr Read stated that the cause of this difference is unknown at this point and the IGC are concerned regarding the detrimental effect this will have on Lewisham patients. Mr Wilkinson added that it is thought this may be due to diagnostic issues at GSTT and that the CCG needs to think of the issue as a South East London wide system, rather than individual CCGs.

3. If all reserves are committed and mitigations have been deployed, what can the CCG do in both the short and long term and if this cannot be rectified what will be the outcome / what will happen?

Mr Read replied, stating that in the shorter term there is no prospect for any additional income, so it would become imperative to protect any existing underspends and for the CCG to not make any unbudgeted investments without extensive consideration. Mr Read stated the CCG will need to reduce spend as much as possible whilst also recovering the QIPP plans.

In the longer term, Mr Read stated it would be important to transform high quantities of small saving QIPP schemes into fewer, larger schemes – especially to sustain given the limited staff capacity of the CCG. Mr Read added that overall transformation and the move towards Community Based Care will support this.
If the CCG cannot rectify its current position, Mr Read informed the Governing Body, then NHS England might deploy a Turnaround Director and external support to manage the CCG.

The Governing Body NOTED the report.

**LEW 17/125 Corporate Objectives and Board Assurance Framework (BAF)**

Mr Wilkinson reported that:

- The refreshed Q3 and Q4 Corporate Objectives have been reviewed and agreed by the Integrated Governance Committee.

The Governing Body approved the refreshed Corporate Objectives.

Mr Wilkinson reported on the Board Assurance Framework, highlighting that:

- Four strategic risks for ACS are still in development
- Workforce risks had been discussed at Audit Committee, providing assurance to the Governing Body.
- QIPP in year risk has increased
- A&E system wide current risk score has been decreased as the system had demonstrated improvements in October 2017.

Mr Warburton requested that the SMT review the actions associated with the cancer risk. The Governing Body Members agreed in general that target risk scores should be reviewed to ensure that they are appropriate and achievable by the delivery of the listed actions in the BAF.

**ACTION: Senior Management Team**

**LEW 17/126 Strategy and Development Workshop Chair’s Report**

Dr Abraham presented the report from the Strategy and Development Workshop held on 5\(^{th}\) October 2017. He highlighted the following:

- The draft vision for Community Based Care was received and discussed. It was agreed that the vision will state that CBC will be proactive & preventative, accessible to all and co-ordinated. The group also received an update on the development of an Accountable Care System, including the delivery of integrated strategic commissioning across the CCG and LBL. The group was informed that two priorities, frailty and the transition from Children and Young Peoples Services and Adult Services, will be used as a way to test of the new way of strategic commissioning.
- The group noted the positive outcomes following the Multi-Disciplinary Working Pilot carried out in Neighbourhood 1.
- The group received and endorsed the draft Public Engagement Plan.

The Governing Body NOTED the report

**LEW 17/127 Public Consultation of the future of the NHS Walk-in Centre and improving provision and access to Primary Care.**

Dr Kalwij has a potential financial and direct conflict of interest due to being a GP and partner at the Amersham Vale Training Practice, as summarised in the cover sheet for the
item. To manage this conflict of interest, Dr Kalwij is being asked to leave the meeting as a Governing Body member for this agenda item.

Also, all Clinical Directors of the Governing Body, including the Chair, and the LMC representative have a pecuniary conflict of interest due to all practices in Lewisham being shareholders of One Health Lewisham, the Federation of Lewisham GPs, through which GP Extended Access is commissioned. However, it is considered that the Clinical Directors and LMC’s expertise will be a useful contribution to the GB discussion of this agenda item. Therefore, to manage this conflict of interest, there is no further action required in the arrangements to discuss this agenda item.

Dr Kalwij left the Governing Body meeting at this point and did not take part in the discussions or decision making for this agenda item.

The Governing Body were joined by Diana Braithwaite, Director of Commissioning and Primary Care, to consider the recommendation that the Governing Body defer its response to the feedback from the consultation and thereby a decision on the future of the NHS Walk-in Centre and improving provision and access to Primary Care until the next meeting of the Governing Body on 11th January 2018.

Ms Braithwaite reported to the Governing Body that:

- In line with the public sector duty to consult, pre-consultation on the proposal and plans for formal public and stakeholder consultation were reviewed and endorsed by the Healthier Communities Select Committee on 20th July 2017.
- A formal and comprehensive public, patient and stakeholder consultation programme was developed to enable views and comments to be sought. The public consultation launched on 8th August 2017 and ended on 30th October 2017. Over the 12 week period the CCG conducted an extensive and transparent programme to support the formal consultation.
- The CCG provided an update on the consultation to the Healthier Communities Select Committee, where the most critical area of concern raised related to the perceived adverse impacts on the A&E department at UHL, if the Walk-in Centre were to close over the winter.
- The CCG recognises that there is little academic evidence to suggest that the closure of the Walk-in Centre would directly lead to increased A&E attendances beyond manageable levels. It is stated that Walk-in Centre activity for 2016/17 equalled 29,528 attendances which, when applying the Pinchbeck Study methodology and calculations, would equate to an estimated 4 to 8 attendances per day at A&E departments, located within reasonable and accessible proximity. This does not necessarily result in increased attendances at the A&E department at UHL.
- Ms Braithwaite also took the opportunity to reiterate the level of minor ailments presenting at the Walk-in Centre, which could be better addressed at other available Primary Care services.
- It was agreed that more work is required to inform the Lewisham population regarding other available services, such as GP extended access or Pharmacy services. Dr McLeod added that further promotion of technological options should also be explored, such as video consultations and symptom checkers as well as informing patients about self-management.
- It was highlighted that the GP Extended Access service is open between 8am and 8pm 7 days a week, with GP and Nurse appointments available for Lewisham registered patients. It was also highlighted that appointments for children under 5 years are now available.
- The Governing Body heard that in 2018 it is expected that appointment availability will increase with 25,000 appointments being available.
• It was reported that key themes have emerged from the consultation responses, so the CCG requires more time to review these.
• Ms Braithwaite confirmed that a full Equalities Impact Assessment had been carried out, which highlighted two key areas where there could be a negative impact and therefore mitigation is required, these areas are (i) People who reside in the borough and are not registered with a Lewisham GP and therefore would be unable to access the alternative GP Extended Access service and (ii) People who live in another borough and are registered with a GP Practice in another borough or elsewhere in the country and therefore are unable to access the alternative GP Extended Access Service.
• When undertaking the EIA the CCG held a Homeless summit which highlighted positive actions and recommendations, which are included in the report and this is supported by the 2 schemes supporting hostels in the borough.
• Ms Braithwaite also recommended that more work be undertaken to promote and educate regarding temporary registrations, available at GP Practices, which would be able to help some of the transient Lewisham population (such as students).
• Ms Braithwaite informed the Governing Body of some misleading information which had been circulated, stating that the impact on A&E is likely to be around 11,000. It was confirmed this figure is incorrect and according to the Pinchbeck study methodology would be closer to 2,500.

Mr Warburton queried the original intent of the Walk-in Centre and was informed that there had been a National Policy request, which had been implemented to ‘stimulate’ the market; however, since this, it had been highlighted that the Walk-in Centre duplicated other services on offer and does not support the direction of travel for the wider Lewisham Health and Social Care system.

Ms Braithwaite informed the Governing Body that, over the next 3 months, work would focus on:
• Evaluation of the consultation results
• Publish responses
• Review of GP Extended Access service capacity and awareness raising
• Ensure that:
  o GP Streaming is in place
  o The Primary Care assessment pilot is underway
  o A working group is to be set up to help support rough sleepers. Working group including charities and religious organisation representation to take forward recommendations from the homelessness summit.
• A Patient Advice and Liaison Service (PALs) will be in place
• Messages regarding access to be circulated before winter
• A Review of the capacity of the GP Practices situated within the Waldron Centre
• Sessions for practitioners and ‘gate keepers’ such as Reception staff to be available to increase awareness of available services and access to Primary Care.

It was confirmed that the Primary Care Commissioning Committee will oversee the on-going engagement work and help track on-going monitoring.

The Governing Body noted the report and agreed the recommendation to defer the decision until the meeting on 11th January 2018 and as a result – to extend the existing WiC contract until 31st March 2018.

Dr Kalwij re-joined the Governing Body meeting at this point.
LEW 17/128  Proposals for Over the Counter (OTC) Self Care and Cessation of Supply of Anti-Malarial Medicines Consultation – report and outcome

Dr Kalwij introduced the report on the Over the Counter (OTC) Self Care and Cessation of Supply of Anti-Malarial Medicines Consultation

The Governing Body was asked to approve the proposals and recommendations set out in the report, these are highlighted as:

1. To proceed with plans to no longer support routine prescribing for self-care medicines and malaria prevention medication for travel.
2. To provide resources to support GPs when considering whether it is acceptable or appropriate to ask a patient to purchase their medications
3. To deliver a public media campaigns to sign post to the public to further information and advice on self-care, malaria prevention information and alternative healthcare services
4. To evaluate and monitor the impact of these changes

The Governing Body were joined by Eileen White, Head of Medicines Management at LCCG, who highlighted that:

- Education for GPs, Pharmacists and the public will be a high priority, which will include working with the public and others to reach out to harder to reach groups / people.
- Alternative options will be publicised; such as the Malarial prevention tablets that are available without a prescription.
- The Governing Body queried whether Healthwatch would be able to assist, potentially reaching out to airlines to help to publicise the options available to travellers.

The Governing Body approved the proposals and recommendations regarding OTC self-care and cessation of supply of anti-malarial medicines.

LEW 17/129  Potential Audit and Risk Management Issues

There was no specific audit or risk management issues to be discussed at this point.

LEW 17/130  Any Other Business

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

The Governing Body noted that it was possible this would be the last Governing Body Meeting in the current CCG format and gave thanks to Mr Wilkinson and Mr Read. It was noted that it would be likely that the current format would continue until year end, with new arrangements in place from 1st April 2018.

LEW 17/131  Questions from Members of the Public

Q In relation to the deferred decision regarding the Walk-in Centre, Cllr Joe Dromey enquired whether the time requested would result in an extension to the contract or would a new temporary contract be put in place?
Mr Wilkinson confirmed that this extension of the contract does not trigger the procurement process, however there was an increasing risk of a procurement challenge by repeatedly extending a contract. Mr Read added that LCCG in this instance it is clear this is a short term temporary solution, which creates time for LCCG to fully consider the issues raised in the consultation.

Cllr Joe Dromey also asked why the CCG were so confident that the closure will not result in dramatically increased attendances at A&E departments?

Mr Wilkinson stated that from the results seen so far from engagement with the public, including the Homeless Summit. Also now there were alternative services in place and these services, correctly publicised, would result in A&E attendances being avoided. Mr Wilkinson also confirmed that LGT have stated they are content with the mitigating plans being put in place, along with the extension of the contract until 31st March 2018.

It was reiterated that, despite deferring the decision, the public consultation is now closed and no further comments can be submitted. The time between this decision and the next meeting of the Governing Body will be used to further review the received responses.

Mr Brownlow, Lewisham Pensioners Forum, asked the Governing Body if it felt the fight against malaria is taking too long and whether the cessation to prescribe anti-malarial medicines is the right direction to be taking?

It was confirmed that the World Health Organisation has reported that incidents of malaria have decreased, as have the number of deaths from malaria. Reported cases in Lewisham have received and these proposals will bring Lewisham on par with the rest of the UK.

The Governing Body were thanked for meeting with the Save Lewisham Hospital campaign group and were urged to ensure that all future arrangements for health and social care in Lewisham are kept local with local accountability.

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

- Audit Committee
- Integrated Governance Committee
- Strategy and Development Committee
- Health and Wellbeing Board

The next meeting of the Governing Body would be held on Thursday 11 January 2018; 10:00 – 12:30 at Cantilever House, Eltham Road, London SE12 8RN.
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### GOVERNING BODY MEETING ACTION LOG

### OPEN ITEMS

<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>17/125</td>
<td>The target risk scores on the Board Assurance Framework (BAF) to be reviewed to ensure that they are appropriate and achievable with the risk and action warranting the scores.</td>
<td>Senior Management Team</td>
<td>November 2017</td>
<td>January 2018 GB meeting</td>
<td>To be closed</td>
<td>This is addressed in the BAF presented in the Governing Body papers at item 13</td>
</tr>
</tbody>
</table>

### Actions closed at the November 2017 meeting

<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>17/95</td>
<td>The response times for actions on this log would be reviewed. With reports being circulated in between meetings where relevant.</td>
<td>Susanna Masters</td>
<td>September 2017</td>
<td></td>
<td>Closed</td>
<td>This has been completed and would be ongoing</td>
</tr>
<tr>
<td>17/96</td>
<td>To confirm arrangements on the responsibilities of the newly appointed Senior Clinical Director and Clinical Director.</td>
<td>Dr Marc Rowland</td>
<td>September 2017</td>
<td>October 2017</td>
<td>Closed</td>
<td>Responsibility of Senior Clinical Director has been confirmed in accordance with the CCG Constitution</td>
</tr>
<tr>
<td>17/79</td>
<td>Corporate Objectives to be circulated to members following presentation at the IGC in September.</td>
<td>Martin Wilkinson</td>
<td>September 2017</td>
<td>Circulated on 27 October</td>
<td>Closed</td>
<td>Circulated to the Governing Body on 27 October. Final version discussed and agreed at IGC on 26 October 2017.</td>
</tr>
<tr>
<td>17/100</td>
<td>Information on current consultations to be sent to independent elected members.</td>
<td>Diana Braithwaite</td>
<td>September 2017</td>
<td></td>
<td>Closed</td>
<td>The consultation information has been sent to independent elected members</td>
</tr>
<tr>
<td>17/103</td>
<td>Comparison report for extended waits for LGT and GSTT</td>
<td>Tony Read/Mike Hellier</td>
<td>September IGC</td>
<td></td>
<td>Closed</td>
<td>IGC at its October meeting received from ICDT a breakdown of breaches by reasons and by tumour group.</td>
</tr>
<tr>
<td>17/72</td>
<td>A seminar on contract grip to be</td>
<td>Martin Wilkinson</td>
<td>July 2017</td>
<td>January</td>
<td>Closed</td>
<td>A Governing Body workshop to</td>
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</tr>
<tr>
<td>17/74</td>
<td>The Health Champion model evaluation from Greenwich CCG to be shared.</td>
<td>Dr Danny Ruta</td>
<td>July 2017</td>
<td>Circulated October 2017</td>
<td>Closed</td>
<td>The Evaluation of Riverside pilot was circulated. A full report with impact on frequent attendance would not be available until a year after implementation. Interim reports on patient benefits and case studies after 6 months would be developed to be shared with the CCG.</td>
</tr>
<tr>
<td>17/79</td>
<td>A focus on a list of engagement priorities, linked with health priorities to come to the Governing Body and other committees for discussion.</td>
<td>Anne Hooper/Susanna Masters</td>
<td>July 2017</td>
<td>November Governing Body</td>
<td>Closed</td>
<td>September and October PEEF meetings and October Strategy and Development Workshop, with involvement of GB members, have identified engagement priorities linked to the CCG strategy and priorities.</td>
</tr>
<tr>
<td>17/81</td>
<td>An update to come to the IGC from the Equality and Diversity Steering Group on issues in the Workforce Equality Standards (WRES) in relation to BME staff at SLaM</td>
<td>Martin Wilkinson</td>
<td>July 2017</td>
<td>November Governing Body</td>
<td>Closed</td>
<td>A report to go from the 21 Sept Equality and Diversity Committee to the 26 October IGC. To be reported back to the Governing Body through the IGC Chair’s report in November.</td>
</tr>
<tr>
<td>17/82</td>
<td>The provider workforce risks to be reviewed and taken to the Audit Committee in October.</td>
<td>Martin Wilkinson</td>
<td>July 2017</td>
<td>31 October Audit Committee</td>
<td>Closed</td>
<td>A report was considered at the Audit Committee on 31 October 2017</td>
</tr>
<tr>
<td>17/84</td>
<td>A report to come back from the Provider</td>
<td>Aileen</td>
<td>July 2017</td>
<td>November</td>
<td>Closed</td>
<td>It was raised at the Board to</td>
</tr>
<tr>
<td>Alliance Group in respect of the SLaM WRES.</td>
<td>Buckton/Dee Carlin</td>
<td>Governing Body meeting</td>
<td>Board session with SLaM on 1 November with a brief explanation of actions being taken given at the time and a demonstration of their Board’s priority to improve their position against the WRES. The Corporate Directors for the CCG and SLaM are connecting to share the appropriate information on actions and necessary assurance over the Trust’s progress.</td>
<td></td>
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</tbody>
</table>
Happy New Year to everyone! This year starts with considerable change as outlined later. This brings a lot of opportunities for Lewisham CCG to achieve its aim of further developing integrated health and social care in Lewisham and basing this on our population’s needs and the health outcomes it should aim for. We have laid the foundation for this with our co-operative working with Lewisham and Greenwich Trust, South London & Maudsley, One Health Lewisham (the Lewisham GP Federation) and the London Borough of Lewisham. This is set to accelerate this year and will also involve closer working with Greenwich and Bexley CCGs in particular.

At the start of a new year it is common for chairs in many organisations to write that it will be a ‘challenging’ year. This is true for Lewisham CCG. There are great opportunities but finances are tight and we will need to focus on the most effective use of our resources.

**Financial Update**

Like a lot of the NHS at present, Lewisham CCG’s finances are under increasing pressure. This has come about through a mixture of many years of no and low growth to our funding which has not kept pace with NHS price inflation and population related and other activity growth. In simple terms demand for services continues to grow while the money we have is increasing slower than demand is.

At this stage of the year we are reporting that our finances are on plan both year to date and forecast to the year end. However this has required us to use our budgetary reserves and we have a range of identified and significant financial risks for which we have no mitigation should they happen during the last quarter of the year. This creates a real risk to our ability to achieve our financial targets this year. That, in turn, makes next year’s financial plans even tougher to deliver and we will need to find ways to deliver more savings than we have delivered in this year and every year since 2013. For 2018/19 the savings requirement to achieve our allocated budget of £473 million is £20 million, which is £6m higher than the current year’s target.

The Governing Body and I are clear that we should do nothing to compromise the quality and safety of patient care. We do, of course, have a statutory duty to manage within our funding. This will inevitably involve difficult decisions for the Governing Body to ensure we can continue to use the money available to meet the needs of people living in Lewisham in the best possible way.
All health and social care workers in Lewisham are living with the challenge of delivering care to our population in this unprecedented period of financial and workload pressure. Their response, as individuals and, increasingly as larger groups, has been positive and resilient. The innovative responses we are developing are beginning to bed in with the implementation of systems to deliver primary care at scale, in and out of hours within our neighbourhoods, closer working with secondary care and the continued improvement of community services increasingly aligned with social and mental health care and other examples. However we will need to continue to work closely with local residents and clinicians to continue to transform health and care services across Lewisham.

In the medium and long term we expect changes in the way the CCG will work with NHS providers and Lewisham Council which will improve health outcomes, improve patient care and, in particular, help support our more frail patients in their communities and avoid unnecessary stays in hospital.

**London Devolution Memorandum of Understanding (MOU)**

The London Devolution Memorandum of Understanding, which will devolve more powers and freedoms to London, has now been signed. The MOU will not be a quantum leap but a small step to helping London link up prevention in its broadest sense and health and social care to give our population better services. It also looks at Estates and seeks to ease the problems with the new ways of working across health and social care.

**South East London CCG Commissioning Review**

There have been a number of appointments to the new executive leadership arrangements for the south east London CCGs, some of which involve changes to the membership of our Governing Body.

I am delighted to report that Martin Wilkinson is staying with us as Managing Director and will continue to be a member of the Governing Body.

Joining the Governing Body will be Andrew Bland who has been appointed to the new role of Accountable Officer for Bexley, Bromley, Greenwich, Lewisham and Southwark CCGs. This will be in ‘designate’ capacity for the remainder of the financial year and will formally take effect from 1st April 2018 to enable transition from current arrangements. Andrew will also continue to be responsible for the ‘at scale’ functions across the six south east London CCGs, and he will become the south east London STP lead within the existing STP ‘Leadership Quartet’ with more immediate effect; taking over from Amanda Pritchard, Chief Executive of Guy’s and St Thomas’ Hospital NHS FT, who will continue as a member of the Quartet. Andrew Eyres will remain the Accountable Officer for Lambeth CCG and for Croydon CCG.

Sadly Tony Read will be leaving the Governing Body as he has been appointed as the Director of Financial Strategy for the SEL CCGs so we will still be working with him regularly. David Maloney, currently Chief Finance Officer at Greenwich CCG will
become the Director of Finance for Lewisham and Greenwich CCGs. These changes also do not take effect until 1st April 2018.

**CCG Constitution Changes**

There are some changes to the CCG constitution required as a result of the above review. These are principally the addition to the Governing Body of the Managing Director for Lewisham, and also to create a new Clinical Director post to maintain the balance of CCG membership representatives and non-membership representatives on the Governing Body. After consultation these changes have been agreed by the CCG membership.

**Chief Executive of Lewisham and Greenwich NHS Trust**

I am pleased to say that Ben Travis has been appointed as Chief Executive of Lewisham and Greenwich NHS Trust with effect from April 2018.

Ben is currently Chief Executive of Oxleas NHS Foundation Trust. Under his leadership, Oxleas has achieved an impressive CQC rating of good or outstanding across every single service domain while remaining in financial balance.

**Mental Health**

Following the SLaM board to Board with us and the Lambeth Living well meeting the Health and Wellbeing board had Black Thrive along to talk to us. The increase in all mental health problems in especially African Caribbean men from 11 years age upwards such as admissions, compulsory detentions and late presentations are unacceptable and we are looking at establishing a Black Thrive group as well as a Thrive group in Lewisham to help us address this.

Dr Marc Rowland

January 2018
Chief Officer’s Report  
Governing Body meeting – January 2018

1. Introduction

As a new year begins, it is timely to reflect on both the challenges of the past year and, more importantly the achievements. These have been delivered through the commitment and hard work of staff, members, our provider, local stakeholders, and of course working with local people. I, along with the rest of the Governing Body, would like to take this opportunity to thank everyone for their efforts and dedication and look forward to continuing our work together to further improve health and care for local people.

There has been so much achieved in the last year and good work across the CCG, including Lewisham achieving the highest percentage of practices in London participating in the GP online scheme with more than 20% of patients using GP online to book their appointments. We achieved the highest vaccination rate in London for the pneumococcal over 65s cohort and Lewisham was rated as ‘outstanding’ for dementia diagnosis rates and post diagnosis care planning. This is only a taster and what has been achieved and you’ll find more case studies in the annual equalities report being considered today.

The new year also brings new or renewed resolutions. Mine is to get a little fitter and the CCG is also joining in by signing up to Lewisham’s Sugar Smart campaign, and with supportive healthy living interventions being planned for staff over the coming months by our Staff Engagement Group.

Our NHS is 70 this year, so it will be a year to acknowledge, commend and applaud developments and innovations across the whole sector. I will keep you posted about plans for the local events and activities when these are developed further.

2. South East London Review

Since the Governing Body meeting in November we are pleased to announce that recruitment for the south east London leadership team has commenced, with a number of roles now appointed to. The Chair’s report covers those that affect the membership of this Governing Body.

In addition, a number of further appointments have been made to fill the Managing Director, Director of Finance, Director of Commissioning Operations and STP Programme Director posts. The other appointments are as follows:

- Theresa Osborne, Managing Director for Bexley CCG
- Dr Angela Bhan, Managing Director for Bromley CCG
- Neil Kennett-Brown, Managing Director for Greenwich CCG
• Malcolm Hines, Director of Finance for Southwark, Bexley, and Bromley CCGs
• Christina Windle, south east London Director of Commissioning Operations
• Julie Lowe, Sustainability and Transformation Partnership (STP) Programme Director

The above appointments will be in a ‘designate’ capacity until the end of the financial year and will formally take effect from 1 April 2018, with the exception of the Greenwich Managing Director role which has become substantive immediately and the STP Programme Director which has taken over from an interim appointment. These appointments are key in the implementation of the CCG review, and delivery of our individual, collective and STP level goals. All of the appointed individuals are known to the south east London CCGs, and will therefore bring extensive experience and knowledge to these new roles.

Recruitment to Chief Financial Officer (CFO) for Bexley, Bromley, Greenwich, Lewisham and Southwark, and the south east London Director of Quality will recommence in January, as well as advertising for the Southwark Managing Director with the aim of appointing to these posts by mid-February.

In parallel to the recruitment, the review continues to engage with stakeholders to progress the design of the CCG functions that can be optimally organized and led or coordinated ‘at scale’ across multiple CCGs e.g. finance, assurance, acute contracting and quality. Updates to governance arrangements are also underway, this includes developing a memorandum of understanding for the south east London shared roles, review of the CCG schemes of delegation and consideration of the governance structure and logistical arrangements to support increased collaboration and further combine transformational and operational discussions where appropriate. The review has also initiated discussions with the CSU regarding service provision going forward. Updates and any change proposals in these areas will be brought to Governing Bodies in March for approval.

3. Accountable Care System in South East London

South East London has submitted a formal expression of interest to become one of the second wave of pilots of accountable care systems (ACS) to NHS England. The ACS model will mean we can build on and further develop a strong Lewisham system within a wider SE London system. Also becoming a pilot should provide us with additional resources and support. This will enable us to accelerate our local integration and financial recovery work, explore the opportunities offered by our population health work, particularly across the LGT footprint, and share experiences with neighbouring boroughs and across SEL.

4. Board to Board with the South London and Maudsley

At the last Governing Body meeting, Dr Marc Rowland reported that there had been a very successful board to board with SLaM and the CCG on 1st November 2017. Since this meeting we have identified four priority areas where a joint commitment has been made to work together to take forward the following actions:
1. Provider Alliances – to agree the next phase of the mental health provider alliance, learning from the Lambeth and Southwark’s mental health approaches, to deliver holistic and person centred approach and to improve health and care outcomes for Lewisham people
2. Coordinated Care - to develop multidisciplinary, holistic team working at a neighbourhood
3. Workforce - to identify and realise the opportunity of providing key workers houses in Lewisham to improve the recruitment and retention of the local health and care workforce
4. Estates - to agree the interim and long term plans to relocate the Ladywell Centre to secure the future provision of acute mental health inpatient beds by SLaM within Lewisham Borough

5. **Corporate Objectives 2018/19**

The purpose of Corporate Objectives is to set out the commissioning areas where the CCG plans to make significant progress and achieve specific results to deliver the CCG’s Operating Plan, including our local priorities to take forward integrated strategic commissioning as part of the development of the local Accountable Care System (ACS) during 2018/19.

The current Corporate Objectives for the second half of the financial year 2017/18 are:

1. Urgent and Emergency Care - whole system A&E Improvements
2. Contract Management - contract grip and secure change in contracts
3. Financial Delivery - of statutory requirements and QIPP programme
4. CCG Development - to take forward Accountable Care System (ACS)

It is proposed that these Corporate Objectives are refreshed by the Clinical Directors and Management Team to reflect the progress achieved up to December 2017 and the planned progress for the last Quarter (January 2018 to March 2018). It is anticipated that the above four key areas will be similar for the first six months of 2018/19. Also during February, work will be undertaken to identify the risks associated with the delivery of Corporate Objectives by the Risk Management Group. This risk assessment will inform the Corporate Risk Register and the development of the Board Assurance Framework (BAF). The draft Board Assurance Framework for 2018/19 will be presented to the Governing Body in March 2018 for its consideration and approval.

It is planned that the refreshed corporate objectives are considered and agreed by the Integrated Governance Committee in February 2018.

The Governing Body are asked to agree to delegate to the Integrated Governance Committee the approval of 2018/19 Corporate Objectives, on behalf of the Governing Body.


Lewisham CCG is assessed overall for the 2017 Emergency Preparedness, Resilience and Response (EPRR) Assurance as achieving a ‘Substantial’ level of
compliance. This is a positive outcome for the CCG and confirmation of our continuing efforts around EPRR.

6. **Sugar Smart pledge**

The CCG has now joined Sugar Smart Lewisham. This is a joint campaign with the Jamie Oliver Food Foundation and the food charity Sustain to tackle the issue that we consume too much sugar. Alongside a range of other local organisations that are part of the Sugar Smart campaign we aim to promote healthier, low-sugar alternatives to communities in the borough. Our specific pledges are to:

- tell our employees and the public that we are developing and implementing a Sugar Smart policy
- change the type of foods and drinks we offer and promote in order to make healthy food and drink more affordable and accessible
- spread the message about reducing the amount and profile of products high in fat, salt and sugar, to our customers, employees, suppliers and others and publicise our involvement in Sugar Smart.
- Actively promote free drinking water e.g. by putting in a drinking fountain
  How we will do this: We will promote the benefits of drinking water over sugary drinks. Water is freely available to all staff and visitors.
- Provide information on healthy food e.g. posters, flyers, training
- Sign up to the Healthy Workplace Charter
  How we will do this: We will work together with our staff and staff engagement group as well as through our social media channels to spread the word.
- Work with suppliers and encourage them to sign this policy themselves

More information is available on the Lewisham council website [here](#).

7. **Urgent and Emergency Care (UEC) Improvement Plan**

Executive officers from Southwark, Lewisham, Greenwich and Bexley CCGs, along with Lewisham and Greenwich Trust colleagues, formally met with NHS England and NHS Improvement Regional colleagues on 18th December to formally review progress against the improvement plan as well as plans for Christmas and New Year period. This was a positive meeting in terms of delivery to date and plans going forward with a recognition of the challenges faced by our system and the wider SEL system. The note from this meeting once received will be shared with the Integrated Governance Committee.

Following the meeting confirmation was received of a non-recurrent financial allocation to our system of national agreed funding announced in the November Budget. This is being used to enhance staff cover for planned escalation beds (i.e. Hawthorne Ward at UHL) to allow for sicker patients to be cared for in these environments, as well as increasing the number of beds available further including some paediatric capacity. A further allocation of funding to mental health Trusts are being used locally to support a mental health crisis services with an assessment team across Lambeth, Southwark and Lewisham for four months to work alongside the London Ambulance Service to try to avoid patients in a mental health crisis being conveyed to a hospital if the crisis can be managed appropriately in the community.
Funding is also being used for mental health staff to help reduce mental health bed occupancy levels. All of this national funding is being used alongside that already funded locally against our UEC Improvement and winter plans.

8. **Current system winter pressures**

Responding to winter pressures, and levels of sickness in the new year period, the national emergency pressures clinical panel set up to advise on pressures and clinical risk recently announced the extension until end January of deferral of all non-urgent inpatient elective care to free up both bed and clinical capacity for the sickest patients. This does not apply to cancer operations and time-critical procedures needed to prevent rapid deterioration in a patient’s condition. The measures also include CCGs temporarily suspending sanctions for mixed sex accommodation breaches.

The immediate new year week has seen our local system challenged to stay on top of the demand, along with many other areas. Staff worked exceptionally hard in difficult circumstances to maintain safe urgent and emergency services across the system, whilst within the hospitals there were compromises to patient experience and delays with both ambulance handover and too long taken to find a bed for some patients who needed one. Close operational management by Lewisham and Greenwich Trust (LGT) and support from the whole system has somewhat recovered the position although remains fragile with high bed occupancy levels at both LGT hospitals, including the use of additional escalation beds. CCG and Social services staff regularly attended daily meetings and wards to review the situation and support patient flow and discharges. This included supporting the streaming staff at the front door to signpost suitable patients to other services to ease congestion within Urgent Care Centre (UCC) and Emergency Department (ED), including booking an appointment with their own GP or with the GP Extended Access service based at UHL. Extra clinical staff were brought in to provide cover particularly within ED and UCC, including help with monitoring of patients waiting for a bed.

9. **Launch of ‘Use the Right Service’**

On Monday 18th December NHS Lewisham, working with Lewisham Health and Care Partners, launched a campaign to help Lewisham residents in Neighbourhood 1 ‘Use the Right Service.’ 30,000 leaflets and posters have been distributed to schools, GP practices, libraries, leisure centres, community groups, transport hubs and more. In addition, working with Lewisham & Greenwich NHS Trust, Lewisham Council, One Health Lewisham and South London and Maudsley NHS Foundation Trust, we are publicising the Use the Right Service using our websites and social media.

The wards of Brockley, Evelyn, New Cross and Telegraph Hill were the focus of the pre-Christmas distribution and the campaign will be rolled out across the borough of Lewisham upon completion of the campaign-to-date analysis which is currently under way.
Use the Right Service

Self care
Stock your medicine cabinet
Visit www.nhs.uk

Minor cuts and grazes
Bruises & minor grazes
Coughs and colds

Pharmacy

Minor illnesses
Headache
Stomach upset
Bites and stings

NHS 111

Feeling unwell?
Unsure?
Asthma?
Need help?

GP Advice
Out of Hours
call 111

Persistent symptoms
Chronic pain
Long term conditions

A&E or 999
Emergencies only

Choking
Chert pain
Blacking out
Serious blood loss

Martin Wilkinson
4 January 2018
Main Issues discussed

The main areas for discussion were the evaluation of CCG Annual General Meeting (AGM), a review of the consultation and engagement on changes to prescribing guidelines for over the counter and anti-malarial medicines, and further development of the CCG public engagement strategy.

- Annual General Meeting

The forum reviewed the feedback report from the CCG AGM held on the 20th September, including equalities data, recommendations for prevention and early action in Lewisham and proposed CCG actions. Attendance increased by 70% compared to the previous year, particularly for representatives but also for the public (by 32%). The feedback on the theatre forum and patient story parts were particularly positive. The outcomes from the theatre forum production will be shared with the relevant forums and groups, including the CCG primary care commissioning committee, public health, local medical committee, One Health Lewisham, and Lewisham Community Education Provider Network (CEPN). Improvement suggestions for future AGMs were reviewed and included changing the time of day, different catering provision, promoting more to under 45s, and maintaining the creative and interactive elements of the event.

- Consultation Review: changes to prescribing in Lewisham

The forum received a summary of the consultation process and survey responses, and reviewed what had worked well and lessons learnt for future engagement and consultation exercises. The consultation captured a broad range of people in Lewisham including people with protected characteristics. Text messaging and social media campaign produced an increase in respondents to the survey, while face to face engagement adds value and increases the potential for future connections.

- Public Engagement Strategy and Plan

The forum discussed and identified amendments to the draft overarching narrative and three themes which will be used to underpin our public engagement work, and which has been developed following discussions at PEEF and Strategy and Development Workshop. It reflects the Lewisham vision for community based care. The narrative will be developed further to ensure that it communicates clearly the current context for change in health and care, achievements and challenges. During January and February there will be further involvement with the Governing Body, Strategy & Development Workshop, CCG Public Reference Group, and CCG readers panel so that the final strategy is signed off for implementation from April 2018.
Challenges

The forum highlighted the need to ensure that CCG plans and priorities were relevant and clear to our local population, and acknowledged the financial challenges in health and care.

Quality & Safety

The evaluation and recommendations arising from the AGM in particular highlighted areas for development in patient experience to support prevention and early action, for instance in GP consultations.

Inequality & Fairness

The need to be sure that the variety of groups and communities in Lewisham are engaged was emphasised to ensure that their different needs and views are met, and reviewed in the attendance at the CCG AGM and participation in the prescribing consultation.
1. Quality

At its November 2017 meeting the Committee received Lewisham and Greenwich NHS Trust dashboard reports on Acute Care and Community services.

The Committee noted the position on the CQC breaches with the Trust having recently submitted its recovery plan to the CQC following a Quality Summit.

The Committee registered its concern about a number of ‘off track’ items from its review of the dashboard reports and agreed that Martin Wilkinson, as Chair, would write to the Chief Executive of Lewisham and Greenwich NHS Trust asking for recovery action plans with timescales and quantified outcomes on the following four priority areas

- sepsis (antibiotics within 90 minutes – adult inpatient)
- VTE assessments
- Daily fridge checks
- Investigating and responding to complaints and incidents

Subsequent discussion also highlighted timely and effective discharge information.

The approach would involve Clinical Directors and the Integrated Contracts Delivery Team, who lead on acute contract management for the CCG. A letter has been sent and a reply letter from the Chief Executive has duly been received and circulated to IGC Members.

At its December 2017 meeting the Committee received quality dashboard reports relating to South London and Maudsley Mental Health Foundation Trust and Care Homes and Residential Care Homes.

The outcome of the latest CQC inspection for South London and Maudsley Mental Health Foundation Trust was discussed. Concerns were raised on prone restraints and mandatory training, with the former not showing any improvement given the Trust’s focus and plans.

It was noted that the Care Homes dashboard showed improvement, especially relating to a previously red rated home.
2. NHS Constitutional Standards

The key performance exceptions are:

2.1 Cancer Waiting Times relating to GP Referral to Treatment within 62 days. The CCG performance improved to 83.3% in October 2017 following a dip in performance for the quarter July 2017 to September 2017. The Committee received a detailed report on Cancer Waiting Times from the Integrated Contracts Delivery Team Lead for Cancer Waiting Times and Lewisham and Greenwich NHS Trust’s Divisional General Manager for Long Term Conditions and Cancer. The Committee noted the plans for improvement and the plan to achieve 82.85% across South East London providers by March 2018. There are tumour group plans and each NHS Provider has a plan as well as agreed shared plans to improve inter-trust referral times. Further plans are in the process of being agreed for 2018/19. A summary set of slides on the plans to March 2018 and current status is attached at Appendix 3 to this report.

2.2 A&E 4 hour performance (review) did not achieve the standard in November 2017 at 89.3%. It also did not achieve the improvement plan trajectory. However, the performance put Lewisham and Greenwich NHS Trust above the middle of the acute trust league table for London.

In November 2017 the Committee received a report on the current status on actions to improve A&E 4 hour performance, including consultancy support to ensure all actions are in place and effective. The Committee noted there is a review to be conducted by NHS England and NHS improvement in late December 2017 to feed into the agreement of improvement plans for 2018/19. The Committee requested that workforce vacancy and agency rates be added to the scorecards.

The Committee reviewed the current level of delivery on Ambulatory Care initiatives and discussed the current lower than anticipated level of GP referrals to the Ambulatory Care Unit. The Committee remitted this to the Clinical Director and Senior Management Team to determine and pursue the best way to progress this with clinical colleagues.

2.3 18 Weeks – While there are challenges to the 18 weeks incomplete standard, the CCG is amber rated against its recovery plan, which is over two years. The number of Lewisham patients waiting over 52 weeks stood at 7 for October 2017.

2.4 Improving Access to Psychological Therapies - It was noted that while people receiving Psychological Therapies treatments had a much improved level of recovery – one of the best levels for any CCG in the country – there had recently been a dip in the numbers of people receiving treatment beginning within 6 weeks. This performance is expected to recover in the quarter January 2018 to March 2018.

2.5 Electronic Referrals to acute trusts had improved year on year to 49% in September 2017. However, this is below the CCG’S plans and is below the standard of 80% required from October 2017. This issue was remitted to the Clinical Director and Senior Management Team meeting to agree and enact plans for improvement.
Graphs of performance on A&E 4 hour and Cancer Waiting Times standards in 2017/18 to date with A&E measured against the planned trajectory are at Appendix 1.

3. Finance

At Month 8 the CCG is forecast to deliver an in year break even position and a cumulative surplus of £9.38m for the year. There is significant contract over performance and QIPP delivery is below plan. Available mitigations have been fully deployed into the forecast outturn at Month 8 and there remains considerable net risk to the delivery of the CCG’s 2017/18 financial plans, i.e. risk is greater than available mitigations. The CCG headline financial position is provided in Table 1 below.

Table 1: Financial Headline Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Plan / Target</th>
<th>Forecast Outturn</th>
<th>Forecast Variance</th>
<th>Relevant Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned In-year Surplus</td>
<td>£nil</td>
<td>£nil</td>
<td>£nil</td>
<td>3</td>
</tr>
<tr>
<td>Planned Cumulative Surplus</td>
<td>£9.38m</td>
<td>£9.38m</td>
<td>£0.00m</td>
<td>3</td>
</tr>
<tr>
<td>Acute Expenditure</td>
<td>£234.18m</td>
<td>£240.87m</td>
<td>(£6.69m)</td>
<td>3.1</td>
</tr>
<tr>
<td>Total Expenditure</td>
<td>£468.07m</td>
<td>£468.07m</td>
<td>£0.00m</td>
<td>3</td>
</tr>
<tr>
<td>Risk Adjusted Surplus</td>
<td>£9.38m</td>
<td>£9.38m</td>
<td>£0.00m</td>
<td>5</td>
</tr>
<tr>
<td>Underlying Position</td>
<td>£6.92m</td>
<td>£0.31m</td>
<td>(£6.61m)</td>
<td>5</td>
</tr>
<tr>
<td>Better Practice Payments Code</td>
<td>95.0%</td>
<td>97.4%</td>
<td>2.4%</td>
<td>6</td>
</tr>
<tr>
<td>Cash Drawdown</td>
<td>£466.00m</td>
<td>£466.00m</td>
<td>£0.00m</td>
<td>6</td>
</tr>
</tbody>
</table>

In December 2017 the Committee received a report on Financial Performance and QIPP plans and a current risk rating for each project for 2018/19 and the degree of challenges to the CCG’s underlying financial position and the associated financial sustainability of the CCG. It was agreed that there be further review of the 2017/18 position and sustainability into 2018/19 at the Finance and Investment Committee in January 2018.

4. Board Assurance Framework

The Committee reviewed the Board Assurance Framework and endorsed the amended risk scores as was discussed at the Governing Body in November 2017. The Committee discussed that some of the risks identified were issues, but there is no reporting mechanism for this through to the Governing Body.

In addition the Integrated Governance Committee reviewed and inputted to:

- The Safeguarding Supervision Policy
• The Information Governance Committee Terms of Reference and progress towards the Information Governance toolkit standards.

• The Individual Funding Requests Report for the quarter April 2017 to September 2017.

5. Emergency Preparedness, Resilience and Response

It was noted by the Committee that following the NHS England Assurance process for Emergency Preparedness, Resilience and Response (EPRR), Lewisham CCG had been given a rating of ‘substantial’ and some actions were required to maintain this rating.

Chairs action, with support from the Lay Member with responsibility for EPRR, was agreed for the review and agreement to the action plan which needs to be submitted to NHS England by 12 January 2018.
Appendix 1 – Constitutional Standards Key Exceptions Graphs

Cancer 62 day standard
NHS Lewisham CCG (Performance)

4 hour standard LGT
Appendix 2 – Finance Report for Month 8, period to 30th November 2017

1. Summary

At Month 8 the CCG is forecast to deliver an in year break even position and a cumulative surplus of £9.38m for the year. There is significant contract over performance and QIPP delivery is below plan. Available mitigations have been fully deployed into the forecast outturn at Month 8 and there remains considerable net risk to the delivery of the CCG’s 2017/18 financial plans, i.e. risk is greater than available mitigations.

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<td>6</td>
</tr>
</tbody>
</table>

2. Revenue Resource Limit and Start Budget

2.1. At Month 8 the CCG’s combined Revenue Resource Limit totals £477.45m. This includes £6.65m for the running cost allowance as included in the budget.

2.2. Table 2 shows the confirmed opening and closing allocations for Month 8 categorised by Running and Programme Costs.
### Table 2: Revenue Resource Limit

<table>
<thead>
<tr>
<th></th>
<th>Admin £’m</th>
<th>Programme £’m</th>
<th>Co-Commissioning £’m</th>
<th>Total £’m</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Month 7 Closing position 31st October 2017</strong></td>
<td>6.65</td>
<td>423.14</td>
<td>43.12</td>
<td>472.91</td>
</tr>
<tr>
<td>CYP Crisis Acceleration Funding</td>
<td></td>
<td>0.42</td>
<td></td>
<td>0.42</td>
</tr>
<tr>
<td>Community Services Development Funds</td>
<td></td>
<td>0.90</td>
<td></td>
<td>0.90</td>
</tr>
<tr>
<td>Major Incident Funding</td>
<td></td>
<td>0.25</td>
<td></td>
<td>0.25</td>
</tr>
<tr>
<td>Charge Exempt Overseas Visitor (CEOV)</td>
<td></td>
<td>2.97</td>
<td></td>
<td>2.97</td>
</tr>
<tr>
<td><strong>Month 8 Closing position 30th November 2017</strong></td>
<td>6.65</td>
<td>427.68</td>
<td>43.12</td>
<td>477.45</td>
</tr>
</tbody>
</table>

3. **Month 8 Financial Performance**

At Month 8 the CCG forecasts to deliver a cumulative surplus of £9.38m for the year. The CCG is reporting a cumulative surplus of £6.25m at Month 8 which is on plan. Programme budgets were under-spent by £5.92m and Running Cost budgets were under-spent by £0.33m on a cumulative basis.

It should be noted that forecasts in some key budget areas show significant overspends; mainly on acute contracts and adult joint commissioning budgets of £6.69m and £2.57m respectively. Under delivery against QIPP savings targets is a contributory factor as is over performance on acute contracts.

These forecast overspends are being offset by full utilisation of the CCG’s allowable reserves to deliver an overall on plan forecast for the year.

3.1 **Acute Budgets**

- The reported financial position is based on SLAM activity data from acute providers and also reflects the agreed year end outturn with LGT. The Year to Date (YTD) and forecast year end position for the CCG’s acute budgets is an over spend of £3.65m and 6.69m respectively.

- In LGT, YTD is (£2.35m) overspent overall with overspends relating to Emergency (£2.21m), A&E (£0.81m) and net under spends in several other points of delivery totaling £0.67m, the main under spend being under performance in Elective.

3.2 **Other Budget Areas**

- Overall community service performance is within plan YTD and forecast year end position is marginally over plan. There are however emerging
pressures on termination of pregnancy and sexual health contracts of £0.2m. These will be reviewed each month to inform any changes in the forecast outturn.

- The Year to Date (YTD) position for the CCG’s Adult Joint Commissioning budget is an over spend £1.72m and year end forecast over spend £2.57m. This position reflects actual activity being greater than planned. Within the forecast over spend Continuing Care costs are £1.88m (including QIPP slippage), and mental health costs £0.15m.

- The Children’s Joint Commissioning contracts are overspent year to date by £0.33m and forecast to over spend by £0.5m for the year.

- The primary care delegated co-commissioning budget is marginally overspent YTD by £0.008m and forecast outturn is £0.03m underspent.

- The CCG is awaiting more up to date information from NHS Prescription Services. Based on the month 6 information available, the Month 8 YTD position is showing an over spend of £0.45m and the full year forecast is showing an over spend of £0.6m, driven by price behaviour and forecast QIPP under delivery.

- At Month 8 corporate expenditure is within budget year to date and for the full year expenditure is forecast to be under budget.

3.3 Other, Reserves and Financing

- The CCG’s opening budget includes reserves in line with NHS England national business rules, Better Care Fund transfers and budget equal to the CCG’s planned surplus. The CCG also holds a co-commissioning reserve of c £0.75m. Reserves are released against their specific purposes or applied to manage general risk within the CCG’s forecasted financial position.

- The CCG is not permitted to commit half of the 1% non-recurrent (set-aside) reserve. 0.5% of allocation or £2.077m in 2017/18 from this reserve is being treated as part of a national risk reserve pool. NHS England expects the CCG to achieve its forecast surplus of £9.38m without recourse to this national risk reserve contribution.

4. Quality, Innovation, Productivity and Prevention (QIPP) Savings Position

4.1. The CCG’s agreed budget includes targeted net savings totalling £14.012m (3.3% of RRL excluding Delegated Co-commissioning), from QIPP schemes.

4.2. The CCG is achieving QIPP of £7.189m against the YTD plan of £8.577m. The current most likely forecast outturn is £11.033m achievement against the £14m plan.
5. Financial Sustainability

5.1. Risks and Mitigation (In Year)

- The CCG’s general reserves and contingencies are less than 2016/17. In addition the CCG is not permitted to make expenditure commitments against half, i.e. £2.1m of the non recurrent set-aside reserve. Consequently the CCG’s capacity to mitigate financial risk through utilisation of reserves is lower than in previous years.

- As at Month 8 the CCG has crystalised several of its risks and all of its allowable mitigations (excluding the set aside reserve) into the forecast outturn. Net Risk at month 8 remains significant however at £3.78m mainly driven by acute contract pressures.

5.2. Underlying Position

- The CCG’s underlying financial position is 0.07% (previous month 0.07%) surplus against RRL; indicating that the CCG has recurring expenditure commitments that are less than it’s notified and estimated recurring income. However this is significantly worse than the planned position of 1.5%.

<table>
<thead>
<tr>
<th>Table 3: Underlying Financial Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>201718 Plan</td>
</tr>
<tr>
<td>Underlying Position – Surplus/ (Deficit) Cumulative</td>
</tr>
<tr>
<td>Underlying Position – Surplus/ (Deficit) Cumulative %</td>
</tr>
</tbody>
</table>

- This underlying position of 0.07% is mainly driven by forecast under achievement of QIPP. The CCG will need to significantly increase its delivery of QIPP to more than 3% of total RRL per annum in order to rectify the underlying surplus towards 1.5%.

6. Financial Control

6.1. Cash and Maximum Cash Drawdown

- The CCG’s advised maximum cash drawdown is £466.0m for the year. As at Month 8 the CCG has drawn down £298.7m (64%). This is in line with the CCG’s cash forecasts.

- At the end of each month the CCG expects to hold a cash balance that is not in excess of 1.25% of its monthly drawdown. The CCG’s cash balance at the end of November was £70k compared to a target of £462k maximum.
• The CCG expects to spend its annual maximum cash drawdown in total by 31st March 2018.

6.2. Creditors and Debtors

• Table 4 below shows the performance against the Better Practice Payments Code (BPPC) in terms of the total value of invoices and the number of invoices by count. This confirms that the CCG is compliant with the code target of 95%.

Table 4: Better Practice Payments Code

<table>
<thead>
<tr>
<th></th>
<th>November 2017</th>
<th>Cumulative</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NHS</td>
<td>Non-NHS</td>
</tr>
<tr>
<td>% of Invoices Paid within Target (Count)</td>
<td>95.7%</td>
<td>98.6%</td>
</tr>
<tr>
<td>% of Invoices Paid within Target (Value)</td>
<td>99.8%</td>
<td>98.9%</td>
</tr>
</tbody>
</table>

• The CCG’s total aged debt position is £2.822m. Of this £0.781m is overdue and the main individual elements of this overdue debt relate to two organisations. There are some relatively minor queries on these debts delaying payment and these are expected to be resolved soon. The total debt position is considered to be low risk.

6.3. Statement of Financial Position

• The Statement of Financial Position is presented in table 5 below. The CCG has a negative value of total assets deployed and therefore taxpayers’ equity. This is due to the CCG owning no fixed assets, holding a low cash position (as it draws down cash on a monthly basis), low debtors and a relatively high level of creditors at any one time.
Table 5: Statement of Financial Position

<table>
<thead>
<tr>
<th></th>
<th>30th November 2017 £000</th>
<th>31st March 2017 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Non Current Assets</strong></td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Current Assets</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade &amp; Other Receivables</td>
<td>6,537</td>
<td>4,453</td>
</tr>
<tr>
<td>Cash &amp; Cash Equivalents</td>
<td>(38)</td>
<td>397</td>
</tr>
<tr>
<td><strong>Total Current Assets</strong></td>
<td>6,499</td>
<td>4,850</td>
</tr>
<tr>
<td><strong>Total Assets</strong></td>
<td>6,499</td>
<td>4,850</td>
</tr>
<tr>
<td><strong>Current Liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade &amp; Other Payables</td>
<td>(42,027)</td>
<td>(28,309)</td>
</tr>
<tr>
<td>Provisions</td>
<td>(250)</td>
<td>(323)</td>
</tr>
<tr>
<td><strong>Total Current Liabilities</strong></td>
<td>(42,277)</td>
<td>(28,632)</td>
</tr>
<tr>
<td><strong>Total Assets Less Current Liabilities</strong></td>
<td>(35,778)</td>
<td>(23,782)</td>
</tr>
<tr>
<td><strong>Total Non Current Liabilities</strong></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total Assets Employed</strong></td>
<td>(35,778)</td>
<td>(23,782)</td>
</tr>
<tr>
<td><strong>Financed by Taxpayers Equity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Fund</td>
<td>35,778</td>
<td>23,782</td>
</tr>
<tr>
<td><strong>Total Taxpayers</strong></td>
<td>35,778</td>
<td>23,782</td>
</tr>
</tbody>
</table>

Michael Cunningham
Head of Finance
2nd January 2018
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South East London (SEL) Cancer Recovery Plan Update

11 December 2017
## Summary of commitments made to regulators on 20 October

<table>
<thead>
<tr>
<th></th>
<th>Performance</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>• SEL aggregate performance of 82.85% by March 2018</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• GSTT internal performance of 85% from January 2018</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• KCH &amp; LGT – overall compliance to be maintained</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Inter Trust Transfers (ITTs)</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>• LGT – 85% from October 2017</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• KCH – 85% from March 2018</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Overall Backlog</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>• GSTT - 85 by March 2018</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• KCH - 55 by March 2018</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• LGT - 43 by March 2018</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Diagnostic Capacity</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>• Each organisation to invest an additional £250k to fund additional ISOS</td>
<td></td>
</tr>
<tr>
<td></td>
<td>outsourcing capacity to be fully available from late November 2017. CT, MRI and Endoscopy highlighted as the highest priority.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• A long term diagnostic strategy to be delivered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tumour groups</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>• Weekly system task and finish groups, including providers, commissioners and the ACN are overseeing the delivery of agreed actions for high priority tumour groups and cross-cutting issues, and are reporting to the 62 Day Cancer Waits Leadership Group</td>
<td></td>
</tr>
</tbody>
</table>
Review of progress against commitments to date
Current performance against commitments

1. Performance
   - SEL aggregate performance of 82.85% by March 2018
   - GSTT internal performance of 85% from January 2018
   - KCH & LGT – overall compliance to be maintained

Current RAG

SEL Overall Performance versus Trajectory

<table>
<thead>
<tr>
<th></th>
<th>Oct trajectory</th>
<th>Oct performance*</th>
</tr>
</thead>
<tbody>
<tr>
<td>SEL</td>
<td>77.07%</td>
<td>77.10%</td>
</tr>
<tr>
<td>GSTT</td>
<td>66.67%</td>
<td>70%</td>
</tr>
<tr>
<td>KCH</td>
<td>85.19%</td>
<td>84.6%</td>
</tr>
<tr>
<td>LGT</td>
<td>83.12%</td>
<td>78.5%</td>
</tr>
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*unvalidated
Current performance against commitments

<table>
<thead>
<tr>
<th>ITTs</th>
<th>Current RAG</th>
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<tbody>
<tr>
<td>LGT – 85% from October 2017</td>
<td>40%</td>
</tr>
<tr>
<td>KCH – 85% from March 2018</td>
<td>45%</td>
</tr>
</tbody>
</table>

LGT ITT performance – actual* and trajectory

KCH ITT performance – actual* and trajectory

*This data is based on referrals received each month, rather than treatments, to provide a more real-time view of ITT performance.
## Current performance against commitments

<table>
<thead>
<tr>
<th>Overall Backlog</th>
</tr>
</thead>
<tbody>
<tr>
<td>• GSTT 85 by March 2018</td>
</tr>
<tr>
<td>• KCH 55 by March 2018</td>
</tr>
<tr>
<td>• LGT 43 by March 2018</td>
</tr>
</tbody>
</table>

### Current RAG

<table>
<thead>
<tr>
<th>LGT Backlog</th>
</tr>
</thead>
<tbody>
<tr>
<td>LGT trajectory</td>
</tr>
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<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>KCH trajectory</td>
</tr>
</tbody>
</table>

<table>
<thead>
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</tr>
</thead>
<tbody>
<tr>
<td>GSTT trajectory</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>GSTT Internal Backlog</th>
</tr>
</thead>
<tbody>
<tr>
<td>GSTT internal trajectory</td>
</tr>
</tbody>
</table>
Current performance against commitments

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<tr>
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</tr>
</thead>
<tbody>
<tr>
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<td></td>
</tr>
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<td></td>
</tr>
<tr>
<td>• A long term diagnostic strategy to be delivered</td>
<td></td>
</tr>
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</table>

**Current RAG**

**Short term IS outsourcing:**
- £1m secured with contributions from five partners- LGT, KCH, GSTT, Southwark, Lambeth,
- Endoscopy procurement discussions ongoing with providers. Ramsey Health care, BMI, HCA.
- CT and MRI outsourcing has begun.

**Long term diagnostic strategy:**
- Clinical lead and project support in post
- Baseline info request issued from KCH and LGT
Closing the gap: Shared Actions taken forward locally
Weekly Shared Pathway Task and Finish group

- Due to the need to focus on the ITT shared pathway improvement. A weekly task and finish group has been convened to deliver agreed actions for each tumour group – Chaired by Kate Haire (ACN)

- SEL had bi-lateral meetings with GSTT / KCH and GSTT / LGT in September 2017.

- In October a SEL Cancer Shared Pathway Task and Finish Group was set up with weekly meetings to review and progress actions to address shared pathway issues. The meetings jointly review patient level information on the shared pathways in the context of implementation.

- The Group reviews all agreed pathways however there will be a particular focus on pathways currently experience the most breaches these will differ for each Trust but include: Lower GI, Upper GI, Urology, Lung, Head and Neck.
1 Prostate pathway

• QEH:
  - Appoint 2WTE consultants with GSTT
  - Commence template biopsy service
  - Complete demand and capacity review and consider new pathway model if capacity not available
  - Pathway mapping indicates current arrangements at QEH cannot deliver on agreed timed pathway.
  - ACN is now working with both GSTT and LGT to produce first draft of system Pathway model expected by January 2018. Chief Executive support has been given from both Trusts to progress.

• KCH:
  - Introduce virtual imaging review and telephone clinics
  - Revise pathway to ensure biopsy slots and results are ring fenced
  - Introduce automated MRI report
  - Begin pooling template biopsy lists

2 Somerset across South East London

- Commitment to implementation of industry leading cancer management software (Somerset) across SEL. Somerset offers the ability for all Trusts to monitor the shared pathway of patients on a live PTL. It also offer the opportunity to share administrative workforce across trusts and joint automatic shared breach reports.
- Agreed as a priority and requested Tranche 2 Transformation Funding be prioritised for Somerset revenue costs
- South East London received 100% of the requested central revenue funding to support implementation, totalling £275,000 (£91,500 per trust)
- GSTT implementation underway – LGT internal business case being progress.
Key Shared Actions

3 Diagnostic capacity

- £1m committed (£250k from GSTT, KCH, LGT. £125k from Southwark, Lambeth) to fund IS capacity intended to support backlog clearance in the short term
- Anticipated costs for MRI / CT c£800k – LGT Live from 24th November, KCH 6/12
- Endoscopy capacity – go live date still tbc, discussions with Ramsey Health, HCA and BMI

4 NHS Improvement Programme Support to support transformational change

- 1 WTE programme support for GSTT extended until 31 March 2018
- Further 2.8 WTE programme support requested and verbally agreed at September regulatory meeting to provide:
  - Additional 1 WTE for LGT
  - Additional 1 WTE for KCH
  - Additional 0.8 WTE (of originally agreed in June) for South East London

5 Electronic Referral System roll out

- e-RS shown to reduce median 2 week wait times
- GSTT successfully moved to full e-RS utilisation for 2ww from September 2017
- PRUH has all services available for booking on e-RS
- LGT and Denmark Hill to move to full e-RS utilisation
A meeting of the Governing Body
11 January 2018

The Governing Body is asked:

- To agree the revised risk scores for specific risks (section 2)
- to agree that there are adequate controls in place to mitigate the risks to the Corporate Objectives and where existing controls have not reduced the current risk score to the target risk score there are credible action plans (Appendix B)

1. Introduction

At the Governing Body meeting held on 09 November 2017, the Board Assurance Framework (BAF) was presented. Given the information received and discussed, the Governing Body questioned whether the assessment of a number of the Target Scores were appropriate, or achievable, and as such asked for these to be reviewed again by the SMT via the Risk Management Group.

The proposed revisions were endorsed by the IGC, but with comments for further clarification and review.

Additionally, following discussions with one of the Lay Members, Risk Owners have endeavoured to more consistently explain acronyms and how actions, owners and timelines are summarised throughout the BAF.

2. Re-Assessment of Target risk scores

Following assessment from the Risk Management Group and endorsement by the IGC the following risk scores have been amended since the Governing Body:

- Risk ID 8: Cancer waiting times: Cancer 62 days: increased to target score 16 (4x4) from 12 (4x3), increasing the likelihood from ‘possible’ to ‘likely’.
- Risk ID 53: QIPP 2017/18: Securing in-year delivery: increased to target score of 12 (4x3) from 8 (4x2), increasing the likelihood from ‘unlikely’ to ‘possible’.
• Risk ID 83: QIPP – Planning for 2018/19 and 2019/20: Increased target score increased to 12 (4x3) from 8 (4x2) increasing the likelihood from ‘unlikely’ to ‘possible’.
• Risk ID 86: Financial Targets 2017/18 – current score increased to 16 (4x4) from 12 (4x3) increasing likelihood from ‘possible’ to ‘likely’.

The IGC accurately commented that some of these risks are now issues as they are already occurring. However, the CCG does not currently have a separate mechanism to report issues to the Governing Body and so these are included within the BAF. The CCG Risk Management Framework is being reviewed and this will be addressed to ensure that the Governing Body can be sighted on issues as well as risks.

3. Review of Assessment of Risks in Corporate Risk Register

Risk Owners have reviewed the risks contained within the Corporate Risk Register with updates reflected in a number of risks and addressed gaps identified in. This includes:

• OD risks (Employee, public and membership engagement) which have been reviewed to reflect the SEL Collaborative work, and assessing the impact on staff and future working practices.
• Emergency Preparedness, Resilience and Response current score has been reduced following a substantial assurance assessment with NHS England for 2017/18, and no further incidents involving Lewisham CCG since Malware (May 2017).

4. Changes in Risks and Assessment during 2017/18

The below heatmap table (figure 1) shows the distribution of the all risks identified through the Corporate Risk Register, with their current risk score, compared to the initial assessment of risk made in Quarter 1 (heatmap table, figure 2).

At this point of the year, risk movement would normally demonstrate a downward trend, with many risks decreasing in their current scores. However, given the environment that the CCG is working in relation to the performance of our main acute providers and the risks to the financial position, many risks have remained at a high level.

Additional new risks have been identified during the year, which are now included on the BAF which were not included at the start of the year are:

• Access into ‘evidence based’ mental health treatment for children and young people (Risk ID 93)
• CCG cannot endorse development of new Provider Alliance(s) (Risk ID 95)
• The key enablers of workforce, estates and IT do not support the establishment of an accountable care system and the delivery of community based care. (Risk ID 96)
• An accountable care system (ACS) is not established (Risk ID 97)
• Integrated Strategic Commissioning is not established as part of the ACS (Risk ID 98)
- The NHSE target for CHC Assessments completed in non-acute settings is not delivered and the CCG is not assured by the NHS E (Risk ID 99)

Figure 1: Current Assessment as at January 2018

Heat Map - January 2018 Current Ratings

<table>
<thead>
<tr>
<th>Likelihood</th>
<th>Almost Certain 5</th>
<th>Likely 4</th>
<th>Possible 3</th>
<th>Unlikely 2</th>
<th>Rare 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk Matrix</td>
<td>Negligible 1</td>
<td>Minor 2</td>
<td>Moderate 3</td>
<td>Major 4</td>
<td>Catastrophic 5</td>
</tr>
<tr>
<td>No of Risks</td>
<td>1 Risk ID: 99</td>
<td>No of Risks = 6 Risk ID: 8, 53, 80, 81, 83, 86</td>
<td>No of Risks = 3 Risk ID: 30, 84, 92</td>
<td>No of Risks = 6 Risk ID: 77, 78, 93, 95, 96, 97, 98</td>
<td>No of Risks = 1 Risk ID: 39</td>
</tr>
<tr>
<td>Impact</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total Number of Risks = 29

Figure 2: Assessment as first presented to Governing Body for 2017/18 (July 2017)

Heat Map - July 2017 Current Ratings

<table>
<thead>
<tr>
<th>Likelihood</th>
<th>Almost Certain 5</th>
<th>Likely 4</th>
<th>Possible 3</th>
<th>Unlikely 2</th>
<th>Rare 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk Matrix</td>
<td>Negligible 1</td>
<td>Minor 2</td>
<td>Moderate 3</td>
<td>Major 4</td>
<td>Catastrophic 5</td>
</tr>
<tr>
<td>No of Risks</td>
<td>1 Risk ID: 99</td>
<td>No of Risks = 4 Risk ID: 8, 78, 80, 81, 83</td>
<td>No of Risks = 4 Risk ID: 30, 84, 87</td>
<td>No of Risks = 6 Risk ID: 53, 77, 86</td>
<td>No of Risks = 2 Risk ID: 59, 88</td>
</tr>
<tr>
<td>Impact</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total Number of Risks = 22
Following this assessment, there are currently 14 risks on the CCG Risk Register that meet
the criteria for inclusion on the BAF (Current Risk Score of 12 or over) which are summarised
in the table below.

5. CCG’s Board Assurance Framework

The table (Figure 3) below provides a summary of the BAF with current and target scores
shown, as assessed at 02 January 2018 with the highest Current Risk Score, followed by
Target Risk Score (both high to low) at the top so that those assessed as the highest ‘threat’
are presented first. The Summary Risk Table is shown for each current risk score rated 12
or above (i.e. “High” or “Very High”).

As stated above, the RMG has undertaken a review of the current risks facing the CCG
which are associated with the delivery of the corporate objectives. These will continue to be
reviewed and monitored through the SMT, in line with the Risk Management Framework.

Figure 3: Summary of the BAF

<table>
<thead>
<tr>
<th>ID</th>
<th>Risk Title</th>
<th>Risk Owner/Team</th>
<th>Risk Response</th>
<th>Original</th>
<th>Current</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Risk Owner/Team</td>
<td>Risk Response</td>
<td>Rating</td>
<td>Score</td>
<td>Impact</td>
</tr>
<tr>
<td>1</td>
<td>Cancer waiting times; Cancer 62 days</td>
<td>Cottingham , Sarah</td>
<td>Mitigate</td>
<td>16</td>
<td>Very High Risk</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td>QIPP 2017/18: Securing in-year delivery</td>
<td>Braithwaite , Diana</td>
<td>Mitigate</td>
<td>16</td>
<td>Very High Risk</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>Supported Discharge Initiatives</td>
<td>Browne, Alison</td>
<td>Mitigate</td>
<td>16</td>
<td>Very High Risk</td>
<td>4</td>
</tr>
<tr>
<td>4</td>
<td>QIPP - Planning for 2018/19 and 2019/20</td>
<td>Braithwaite , Diana</td>
<td>Mitigate</td>
<td>16</td>
<td>Very High Risk</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td>Financial Targets 2017/18</td>
<td>Read, Tony</td>
<td>Mitigate</td>
<td>12</td>
<td>High Risk</td>
<td>5</td>
</tr>
<tr>
<td>6</td>
<td>Transformation of Urgent and Emergency Care Services</td>
<td>Browne, Alison</td>
<td>Mitigate</td>
<td>12</td>
<td>High Risk</td>
<td>5</td>
</tr>
<tr>
<td>30</td>
<td>The NHSE target for CHC Assessments completed in non-acute settings is not delivered and the CCG is not assured by NHSE</td>
<td>Hughes, Heather</td>
<td>Mitigate</td>
<td>12</td>
<td>High Risk</td>
<td>5</td>
</tr>
<tr>
<td>31</td>
<td>A&amp;E: System wide delivery</td>
<td>Wilkinson, Martin</td>
<td>Mitigate</td>
<td>12</td>
<td>High Risk</td>
<td>5</td>
</tr>
<tr>
<td>32</td>
<td>CCG cannot endorse development of new Provider Alliance(s)</td>
<td>Wilkinson, Martin</td>
<td>Mitigate</td>
<td>12</td>
<td>High Risk</td>
<td>5</td>
</tr>
<tr>
<td>33</td>
<td>Key enablers do not support establishment of an ACS &amp; delivery of accessible, sustainable and high quality community based care</td>
<td>Wilkinson, Martin</td>
<td>Mitigate</td>
<td>12</td>
<td>High Risk</td>
<td>5</td>
</tr>
<tr>
<td>34</td>
<td>An accountable care system is not established</td>
<td>Wilkinson, Martin</td>
<td>Mitigate</td>
<td>12</td>
<td>High Risk</td>
<td>5</td>
</tr>
<tr>
<td>35</td>
<td>Integrated Strategic Commissioning is not established as part of the ACS</td>
<td>Wilkinson, Martin</td>
<td>Mitigate</td>
<td>12</td>
<td>High Risk</td>
<td>5</td>
</tr>
<tr>
<td>36</td>
<td>Acute Providers – Delivering Quality Referral to Treatment (QRTT) standard</td>
<td>Cottingham , Sarah</td>
<td>Mitigate</td>
<td>12</td>
<td>High Risk</td>
<td>5</td>
</tr>
<tr>
<td>37</td>
<td>Access into ‘evidence based’ mental health treatment for children and young people</td>
<td>Hirst, Caroline</td>
<td>Mitigate</td>
<td>12</td>
<td>High Risk</td>
<td>5</td>
</tr>
</tbody>
</table>
More detail about the Current Risk Score of 12 or over is provided at Appendix A.

The Governing Body are asked to agree that there are adequate controls in place to mitigate the risks to the Corporate Objectives and where existing controls have not reduced the current risk score to the target risk score there are credible action plans.

Appendices
Appendix A – BAF – January 2018
Appendix B- Risk Appetite Matrix
Appendix C– Glossary of Terms

CORPORATE AND STRATEGIC OBJECTIVES
This paper outlines the Corporate Objectives and the risks associated with the achievement of these.

CONSULTATION HISTORY:
Integrated Governance Committee: 20 December 2017
Risk Management Group: 12 December 2017
Senior Management Team Meeting: 05 December 2017
Governing Body: 09 November 2017
Integrated Governance Committee: 26 October 2017

PUBLIC ENGAGEMENT
The Corporate Risk Register includes a risk for Public Engagement (Risk ID 38), which outline priority actions.

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

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

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

### RESPONSIBLE MANAGERIAL LEAD CONTACT:

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

### AUTHOR CONTACT:

Name: Victoria Medhurst  
E-Mail: Victoria.medhurst@nhs.net
<table>
<thead>
<tr>
<th>Corporate Objective:</th>
<th>Contract Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk</td>
<td>Cancer waiting times; Cancer 62 days (Risk ID 8)</td>
</tr>
<tr>
<td>Risk Description: (What is the risk?)</td>
<td>Local providers do not deliver health services that meet the NHS Constitutional commitments on waiting times for patients with cancer or suspected cancers</td>
</tr>
<tr>
<td>It is caused by:</td>
<td>Poor performance of commissioned services</td>
</tr>
<tr>
<td></td>
<td>Provider failure to meet contracted quality and performance standards</td>
</tr>
<tr>
<td></td>
<td>The capacity and capability of the provider workforce</td>
</tr>
<tr>
<td></td>
<td>The alignment of CCG and provider priorities</td>
</tr>
<tr>
<td>It could lead to:</td>
<td>Delays to appropriate treatment and potential harm to patients</td>
</tr>
<tr>
<td></td>
<td>Failure to meet NHS Constitutional Commitments in Lewisham</td>
</tr>
<tr>
<td></td>
<td>Loss of reputation</td>
</tr>
<tr>
<td>Risk Owner:</td>
<td>Cottingham, Sarah</td>
</tr>
<tr>
<td>Risk Manager:</td>
<td>Osborn, Sarah</td>
</tr>
<tr>
<td>Directorate:</td>
<td>Commissioning &amp; Primary Care Directorate</td>
</tr>
<tr>
<td>Risk Appetite:</td>
<td>Low</td>
</tr>
<tr>
<td>Risk Response:</td>
<td>Mitigate</td>
</tr>
<tr>
<td>Original Score:</td>
<td>Current Score:</td>
</tr>
<tr>
<td>Target Score:</td>
<td>Risk Movement:</td>
</tr>
<tr>
<td>Very High Risk</td>
<td>Very High Risk</td>
</tr>
<tr>
<td>Impact 4 x</td>
<td>Impact 4 x</td>
</tr>
<tr>
<td>Likelihood 4</td>
<td>Likelihood 4</td>
</tr>
<tr>
<td>Controls: (What are we doing to mitigate the risk?)</td>
<td>The CCG has an agreed contract with all providers.</td>
</tr>
<tr>
<td></td>
<td>The CCG has included appropriate penalty clauses in its major contracts in line with national mandated guidance.</td>
</tr>
<tr>
<td></td>
<td>The CCG has agreed a cancer recovery plan, which is monitored and performance managed by the ICDT with quality issues managed through the Clinical Quality Review Group (CQRG) and the Cancer 62 Day leadership group.</td>
</tr>
<tr>
<td></td>
<td>The CCG has employed an expert multi-disciplinary team from the CSU and the CCG has developed an internal contract management multi-disciplinary team to support.</td>
</tr>
<tr>
<td></td>
<td>Bexley, Lewisham &amp; Greenwich Cancer Locality Group</td>
</tr>
<tr>
<td></td>
<td>Delivery of the SEL Cancer Improvement Plan agreed</td>
</tr>
</tbody>
</table>
by all providers and received by system regulators.
• The CCG undertakes root cause analysis of cancer breaches including long waiters, with the Trust to support pathway development, improvements and review clinical risk and harm as part of the CCGs quality assurance framework.
• Additional senior oversight and scrutiny is achieved through the cancer 62 leadership group Chaired by the SRO for Cancer and supported by the Director of the ICDT. Providers are held to account through this group for delivery of the agreed SEL improvement plan and achievement of inter trust transfers.

<table>
<thead>
<tr>
<th>Assurance Sources:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contracts with LGT, GSTT and Kings.</td>
</tr>
<tr>
<td><strong>LGT Contract Management Board, monthly provider Performance meeting minutes held by the ICDT and shared with the CCG’s Director of Commissioning and Chief Finance Officer.</strong></td>
</tr>
<tr>
<td>CQRG Minutes.</td>
</tr>
<tr>
<td><strong>Cancer 62 leadership group with feedback from ICDT.</strong></td>
</tr>
<tr>
<td>Cancer Pathway Clinical Review Group Minutes</td>
</tr>
<tr>
<td>Integrated Performance Report to the Integrated Governance Committee.</td>
</tr>
<tr>
<td>Minutes reflect actions that are being taken to secure improvement and are a formal record of the Trust’s reporting to commissioners.</td>
</tr>
<tr>
<td><strong>Monthly teleconference calls between CCG and ICDT performance leads</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk Assurances: (What evidence do we have that the controls are working?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signed contracts.</td>
</tr>
<tr>
<td>Performance Reports to Integrated Governance Committee against the performance trajectory.</td>
</tr>
<tr>
<td><strong>In November 2017, NHSE/I agreed a revised plan and trajectory for cancer 62 days - termed Return to trajectory. This plan assume that SEL as a system will return to the planned trajectory by March 2018. For LGT, 62 day performance is expected to the national standard by November 2017.</strong></td>
</tr>
<tr>
<td>NHSE/I system oversight group – cancer.</td>
</tr>
<tr>
<td>Cancer Pathway Clinical Review Group Minutes</td>
</tr>
<tr>
<td>Integrated Performance Report to the Integrated Governance Committee.</td>
</tr>
<tr>
<td>Minutes reflect actions that are being taken to secure improvement and are a formal record of the Trust’s reporting to commissioners.</td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th>Gaps in Risk Controls:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lewisham CCG is dependent on the host commissioner for GSTT to assure delivery of improvement on contracts where the CCG is an Associate. Gaps in this control is limited</td>
</tr>
</tbody>
</table>
as ICDT acts on behalf of all hosted SEL contracts with autonomy and are driving performance improvement across all SEL

<table>
<thead>
<tr>
<th>Actions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The ICDT is actively managing cancer recovery plan as part of the SEL footprint Who: ICDT; When: monthly</td>
</tr>
<tr>
<td>• Trusts are working together through the Area Cancer Networks (ACN) to support delivery of performance through; Shared pathway analysis work across the SE London Sector moves organisations on from separate action plans covering a broad range of activities that affect all/some tumour groups to a focussed view of the shared pathways between Trusts. Who: ACN and 62 Day Leadership Group; When: review monthly and by exception</td>
</tr>
<tr>
<td>• Cancer long-waiters are being escalated to CQRG for review of clinical harm. Who: CQRG; When: As and when a breach of the standard occurs</td>
</tr>
</tbody>
</table>

<p>| Last updated: | Faizan Rana 17/11/2017 |</p>
<table>
<thead>
<tr>
<th><strong>Corporate Objective:</strong></th>
<th>Deliver the 2017/18 QIPP programme</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risk</strong></td>
<td>QIPP 2017/18: Securing in-year delivery (Risk ID 53)</td>
</tr>
<tr>
<td><strong>Risk Description: (What is the risk?)</strong></td>
<td>If the CCG does not deliver QIPP savings, this will jeopardise delivery of the financial control total, which would impact on the opportunity to improve quality and innovation</td>
</tr>
<tr>
<td>It is caused by:</td>
<td></td>
</tr>
<tr>
<td>• Insufficient QIPP programmes to deliver the £14m target</td>
<td></td>
</tr>
<tr>
<td>• Identified QIPP programmes are not robust</td>
<td></td>
</tr>
<tr>
<td>• Failure to develop pipeline schemes that deliver in year savings</td>
<td></td>
</tr>
<tr>
<td>• Lack of appropriate internal focus on QIPP</td>
<td></td>
</tr>
<tr>
<td>• Lack of engagement from provider staff to the change programme</td>
<td></td>
</tr>
<tr>
<td>• Collaborative QIPP programmes across SEL</td>
<td></td>
</tr>
<tr>
<td>It could lead to:</td>
<td></td>
</tr>
<tr>
<td>• Failing to meet planning expectations of IAF for 2017/18</td>
<td></td>
</tr>
<tr>
<td>• Contract mediation and/or arbitration</td>
<td></td>
</tr>
<tr>
<td>• Inability to deliver balanced budget on a planning basis</td>
<td></td>
</tr>
<tr>
<td>• Inability to commit to new investments</td>
<td></td>
</tr>
<tr>
<td>• Loss of reputation</td>
<td></td>
</tr>
<tr>
<td><strong>Risk Owner:</strong></td>
<td>Braithwaite, Diana</td>
</tr>
<tr>
<td><strong>Risk Manager:</strong></td>
<td>Braithwaite, Diana</td>
</tr>
<tr>
<td><strong>Directorate:</strong></td>
<td>Commissioning &amp; Primary Care Directorate</td>
</tr>
<tr>
<td><strong>Risk Appetite:</strong></td>
<td>Low</td>
</tr>
<tr>
<td><strong>Risk Response:</strong></td>
<td>Mitigate</td>
</tr>
<tr>
<td><strong>Original Score:</strong></td>
<td>Very High Risk</td>
</tr>
<tr>
<td><strong>Current Score:</strong></td>
<td>Very High Risk</td>
</tr>
<tr>
<td><strong>Target Score:</strong></td>
<td>Very High Risk</td>
</tr>
<tr>
<td><strong>Risk Movement:</strong></td>
<td>Increased</td>
</tr>
<tr>
<td>Impact 4 x</td>
<td>Impact 4 x</td>
</tr>
<tr>
<td>Likelihood 4</td>
<td>Likelihood 4</td>
</tr>
<tr>
<td><strong>Controls: (What are we doing to mitigate the risk?)</strong></td>
<td></td>
</tr>
<tr>
<td>• Monthly QIPP Clinics.</td>
<td></td>
</tr>
<tr>
<td>• QIPP Reporting Schedule to the Integrated Governance Committee: (i) QIPP 2017/18 Programme Overview (23rd February 2017); (ii) Lessons Learnt 2016/17 (23rd March 2017); Monthly exception reporting from June; and (iii) Quarterly full programme report.</td>
<td></td>
</tr>
<tr>
<td>• Intervention Project documentation in place; Project Initiation Documents (PID) and highlight reports completed.</td>
<td></td>
</tr>
<tr>
<td>• QIPP 2017/18 Programme Monthly reporting (including escalation) to the Integrated Governance Committee from June onwards.</td>
<td></td>
</tr>
</tbody>
</table>
| Assurance Sources: | • QIPP Clinic Documentation: Action Tracker, Highlight Reports and Project Initiation Documents (PIDs)  
• QIPP Monthly Programme Report to the Clinical Directors and Senior Management meeting and to the Integrated Governance Committee  
• Deloitte Review reported to the Integrated Governance Committee (27.04.2017)  
• Deloitte De-risk Programme reported to the Clinical Directors and Senior Management Team – key interventions for improvement, Continuing Healthcare (CHC), Respiratory and Medicines (15.06.2017)  
• Chief Executive and Chief Finance Officer Recovery Plan Challenge Sessions with Senior Responsible Officers |
| --- | --- |
| Risk Assurances: (What evidence do we have that the controls are working?) | • Monthly CSU QIPP activity assessment;  
• Key milestones against each of the interventions are met and assured by the Integrated Governance Committee;  
• Exception Reporting to the Integrated Governance Committee where interventions are off track (activity and finance);  
• NHS England QIPP submission;  
• BGL Outpatient Pathways rolled out to primary care;  
• Review of Continuing Healthcare (CHC) Pathway and recommendations;  
• Respiratory Audit completed; |
| Assurance Type: | Management |
| Assurance level: | Limited |
| Gaps in Risk Controls: | • Development of ‘Plan B’ schemes to support stretch in QIPP  
• Recovery Plans only support a partial recovery of the QIPP target (Continuing Healthcare, Emergency Discharge Team and Medicines Management) |
| Actions: | • Challenge Sessions: Implementation of Chief Officer and Chief Finance Officer ‘Challenge Sessions’ due to M4 position with accountable directors to provide greater assurance on deliverability in-year and stretch, reporting to the Finance & Investment Committee (Who: Tony Read/Martin Wilkinson When: December 2017)  
• Recovery Plan/s: Develop Recovery Plan for submission to the Finance & Investment Committee (WhoHO: Dee Carlin/Alison Browne/Diana Braithwaite; WhenHEN: January 2018) |
• Review of 2018/19 QIPP interventions from the ideas generation that can be brought forward (Who: Dee Carlin/Alison Browne/Tony Read/Diana Braithwaite; When: January 2018)

Last updated: Diana Braithwaite 06/12/2017
Corporate Objective: Contract Management

Risk

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

Risk Description: (What is the risk?)

The acute providers do not deliver against contract requirements including performance and/or quality standard for RTT

It is caused by:
• The contract requirements and specification are not appropriately defined and agreed with providers.
• The CCG does not utilise all available resources and processes to manage contract variations against performance and quality standards.
• Poor provider performance.
• The capacity and capability of the provider workforce
• The alignment of CCG and provider priorities

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

Risk Owner: Cottingham, Sarah
Risk Manager: Osborn, Sarah
Directorate: Commissioning & Primary Care Directorate
Risk Appetite: Moderate
Risk Response: Mitigate

Original Score: Moderate | Current Score: Moderate | Target Score: Moderate | Risk Movement: None

High Risk
Impact 4 x Likelihood 3
Impact 4 x Likelihood 3
Impact 4 x Likelihood 2

Controls: (What are we doing to mitigate the risk?)
• LGT has completed a revised RTT recovery plan and associated trajectory following non delivery of the original plan. The first draft of the plan was submitted to NHSE on 18th October and, following feedback, a further iteration was
Submitted on 7th November. Positive feedback was received from NHS particularly in relation to the 40 week review process set out in the plan.

- The plan includes appropriate recovery actions for each of the Trust's challenged specialities along with recovery trajectories.
- Progress against the recovery plan will be monitored at the monthly performance meetings.

### Assurance Sources:

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

### Risk Assurances:

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

- Signed contracts and register
- Integrated Performance Reports to the Integrated Governance Committee
- Bi-monthly performance reports to the Governing Body
- Quality indicator reports to Clinical Quality Review Group (CQRGs)
- Lewisham & Greenwich Trust Contract Management Board and Performance Reports
- Revised RTT Trajectory Plan has been agreed with LGT
- NHS England Stocktakes

### Assurance Type:

Management

### Assurance level:

Adequate

### Gaps in Risk Controls:

- A fully integrated recovery plan for RTT was submitted to NHSE on 7th November and the feedback received was positive.
- Increased focus on improvement with the expansion of the ICDT.

### Actions:

- The ICDT will monitor performance against the agreed RTT recovery plan through the monthly performance meetings with LGT, chaired by the Director of the ICDT (or deputy).
- Additional capacity has been provided at Kings (KCH) through insourcing with 18 Week Support. Insourcing for outpatient clinics and day cases for Ophthalmology, Dermatology, and General Surgery services commenced in August 2017.
- LGT recognise that to deliver the recovery plan theatre productivity is key to the admitted pathways and are undertaking a theatre transformation programme of work. Who: LGT; When by: End of Q4 2017-18.
- LGT were previously unsuccessful in securing all of the additional planned outsourcing capacity due to numerous problems with external providers to support backlog clearance, the Trust has subsequently reviewed capacity
required and has approached differing providers to provide this such as Homerton University Hospital Foundation Trust (HUH). Who: LGT; When: End of Q4 2017/18

| Last updated: | Faizan Rana 17/11/2017 |
**Corporate Objective:** Urgent and Emergency Care

<table>
<thead>
<tr>
<th>Risk</th>
<th>A&amp;E: System wide delivery (Risk ID 78)</th>
</tr>
</thead>
</table>

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

The improvement programme across Lewisham, Greenwich and Bexley local system does not deliver the anticipated outcomes for our patients and local populations at the pace required

It is caused by:

- Incorrect diagnosis of the issues leading to the wrong plan and therefore under performance
- Poor cross-organisational collaboration, leadership and ownership of the issues and/or plan and/or delivery of the actions agreed
- Capacity and capability within the EDs, hospitals and wider system to adopt improvements to pathways and processes at the pace identified in the plan
- Clinical leadership necessary to drive and lead the change is not in place
- Workforce constraints - both numbers and mindset
- Lack of holding partners to account for their aspect of delivery whether through contracts or partnership arrangements
- Misaligned focus or priorities such as between BGL, sites, LA areas, or competing agendas
- Delivery is not adequately tracked through data caused by poor systems, capacity or ineffective PMO

It could lead to:

- Improvement trajectory agreed through Operating plan for this key NHS Constitution Standards is not met.
- Potential harm or safeguarding incidents occur for patients
- Poor patient experience of care
- Inappropriate activity is undertaken in the wrong care setting, including admissions and re-admission
- Adverse financial impact to CCG and providers/failure to achieve financial recovery
- Improvement of urgent and emergency care services does not occur or is short lived
- Adverse impact on staff morale and retention
- Worsening inequalities caused by poor access
- Organisations being put into ‘special measures’
Risk Owner: Wilkinson, Martin
Risk Manager: McSharry, Monica
Directorate: Commissioning & Primary Care Directorate
Risk Appetite: Moderate
Risk Response: Mitigate

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

Controls: (What are we doing to mitigate the risk?)
- Diagnosis of issues and plan agreed locally and with regulators, including improvement trajectory
- System wide PMO agreed between Commissioners and LGT, and programme managers in place supporting workstream Senior Responsible Officers
- A&E Delivery Board in place with revised governance structures, and independent chair with oversight of improvement plan.
- Independent Chair completed Governance review with recommendations.
- External leadership and improvement support resources, including clinicians in place
- A&E Plans considered and being tracked by IGC
- Alignment of work with SEL STP and Urgent and Emergency Care Network, including delivery of high impact areas
- Better Care Fund (BCF) 17/18 plan in place.
- National capital funds (£1.6m) awarded locally for short term estate changes in UCCs at UHL and QEH and delivered on time.
- CCG placed under ‘Directions’ with additional senior management support being provided by Southwark CCG for acute commissioning.
- From 01 November 2017, Clinical streaming service operating GP Extended Access relocated from ACU to near UCC.
- Underpinning financial agreements in place to support 17/18 plan including winter.
- Following November budget system benefitted from non-recurrent resources to supplement local plans securing enhanced staffing and further additional escalation capacity. This included a separation allocation for mental health.

Assurance Sources:
- A&E Plans to IGC.
- A&E Delivery Board papers, progress reports and
- PMO workstreams reports and metrics
- BCF metrics
- STP delivery plan for urgent and emergency care
- *NHSE and NHSI escalation meeting*

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

- Jointly agreed A&E revised trajectory, and progress against delivery (see performance reports)
- PMO established
- Performance Reports to IGC
- Performance Reports to A&E Delivery Board and supporting structures (Programme Steering Group in place for SROs to support reporting to A&E Delivery Board)
- Feedback from monthly escalation meetings with regulators (NHSE/NHSI)
- Implementation against nationally defined areas of high impact changes addressed through Improvement Plan

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

**Gaps in Risk Controls:**

- Workforce levels/plans inadequate from LGT and across system to support agreed changes
- PMO staffing gaps in engagement, data analytics and project managers.
- Improvements unable to be tracked back to specific improvement plan interventions
- External support (clinical and managerial) resources to system leave before substantive arrangements are put in place
- Frontline clinical staff leadership and engagement not sufficiently robust to support changes required at pace needed
- *Demand and capacity model needs updating to reflect current position and support planning for 18/19.*

**Actions:**

- *Agreed phased development of 18/19 plan with regulators including stocktake of progress (18 December). Timetable phased to end February 2018.*
- System OD plan to be developed as part of the 18/19 plan to include investment in the capability of the system - skilled staff with access to training to support new ways of working, clinical leadership, strong collaborative leadership and adoption of an agreed system improvement method.
- *Programme structure refreshed to site based improvement teams and PMO resourced to support (January 2018) and proposals for system PMO support for 18/19 put forward.*
- *Extend transformation capacity (Transformation Nous) procured nationally to support local work (December). Work to integrated work within overall programme.*
<p>| | |</p>
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|   | (December/January).  
  - Further refine data tracking and analytic capacity and capability of programme (January) including refresh of demand and capacity model to support Q4 18/19.  
  - Confirmed work with ICDT to align 18/19 planning across programme and contracts (January). |
<p>| Last updated: | Martin Wilkinson 12/12/2017 |</p>
<table>
<thead>
<tr>
<th>Corporate Objective:</th>
<th>Urgent and Emergency Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk</td>
<td>Transformation of Urgent and Emergency Care Services (Risk ID 80)</td>
</tr>
<tr>
<td><strong>Risk Description: (What is the risk?)</strong></td>
<td>We fail to deliver the transformation required in redesigning the services to prevent people from becoming admitted into hospital</td>
</tr>
<tr>
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<td>It is caused by:</td>
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<tr>
<td></td>
<td>• Poor provider performance in both the engagement with the CCG to redesign and transform services</td>
</tr>
<tr>
<td></td>
<td>• Poor provider performance and failure to deliver the redesigned services</td>
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<tr>
<td></td>
<td>• Provider capacity and capability with workforce unable to deliver to the specified contract or transformational change</td>
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<tr>
<td></td>
<td>It could lead to:</td>
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<tr>
<td></td>
<td>• Emergency Re-admissions are not reduced</td>
</tr>
<tr>
<td></td>
<td>• QIPP is not delivered</td>
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<td></td>
<td>• Inability to serve improvement notices as part of the contract management process</td>
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<td></td>
<td>• Market testing does not happen which results in a procurement not being undertaken</td>
</tr>
<tr>
<td></td>
<td>• Transformation of urgent and emergency care services does not occur.</td>
</tr>
<tr>
<td>Risk Owner:</td>
<td>Browne, Alison</td>
</tr>
<tr>
<td>Risk Manager:</td>
<td>Browne, Alison</td>
</tr>
<tr>
<td>Directorate:</td>
<td>Nursing &amp; Quality Directorate</td>
</tr>
<tr>
<td>Risk Appetite:</td>
<td></td>
</tr>
<tr>
<td>Risk Response:</td>
<td>Mitigate</td>
</tr>
<tr>
<td><strong>Original Score:</strong></td>
<td><strong>Current Score:</strong></td>
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<tr>
<td>Very High Risk</td>
<td>Very High Risk</td>
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<tr>
<td>Impact 4 x</td>
<td>Impact 4 x</td>
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<tr>
<td>Likelihood 4</td>
<td>Likelihood 4</td>
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**Controls: (What are we doing to mitigate the risk?)**

- Contract management support from the CSU
- Clear service specifications for each service with KPIs monitored through performance and quality dashboards
- Community contract monitoring *now CMB part 2*
- *LBG* Integrated systems improvement programme
- Established Frailty pathway group with outcomes framework
- QIPP clinic for assurance
- *Interim Joint Commissioning Group*

**Assurance**

- Community contracts
Sources:
- Individual service specifications
- Community contract meeting papers
- IGC community quarterly report
- QIPP clinic data sets and papers
- Clinical Audits
- Reports for Interim Joint Commissioning Group
- Bed capacity and review audit completed and capacity is sufficient

Risk Assurances: (What evidence do we have that the controls are working?)
- Check point data
- Clinical audits
- Deep dive of the emergency discharge team (EDT) (July/August 2017) - recovery plan in place
- QIPP data, which links to recovery plan above

Assurance Type: Management
Assurance level: Limited

Gaps in Risk Controls:
- Failure to serve timely Contract Variations (CVs) to the provider leading to gaps in service or recruitment
  - Review of ACU pathways

Actions:
- Clarification of commissioners role in part 2 Contract Management Board (CMB) as CMB now chaired by ICDT (AB; Dec 2017)
  - Identify who is reviewing ACU pathways (TBC) (Links to actions undertaken in Risk ID 78 (A&E))

Last updated: Alison Browne 15/11/2017
**Corporate Objective:** Urgent and Emergency Care

<table>
<thead>
<tr>
<th>Risk</th>
<th>Supported Discharge Initiatives (Risk ID 81)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risk Description:</strong> (What is the risk?)</td>
<td><strong>Failure to manage the flow through of patients through the hospital who are fit for discharge</strong></td>
</tr>
<tr>
<td></td>
<td>It is caused by:</td>
</tr>
<tr>
<td></td>
<td>• Poor provider performance with lack of clinical leadership, senior management and executive accountability</td>
</tr>
<tr>
<td></td>
<td>• Sustainability - inability of the provider to sustain improved performance</td>
</tr>
<tr>
<td></td>
<td>• Provider capacity and capability with workforce unable to deliver to the specified contract or transformational change</td>
</tr>
<tr>
<td></td>
<td>It could lead to:</td>
</tr>
<tr>
<td></td>
<td>• Bed occupancy increases</td>
</tr>
<tr>
<td></td>
<td>• Ready For Discharge (RFD) list increases</td>
</tr>
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<td>• through put of patients through the hospital slows down</td>
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<td>• patients waiting for admission stay in A&amp;E resulting in ambulance delays and congestion along the whole pathway</td>
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<td>• Inability to appropriately manage the contract and share risk with LGT</td>
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<td></td>
<td>• Patients are readmitted through inconsistent management of LTCs</td>
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<tr>
<td></td>
<td>• System transformation does not occur which leads to inefficiencies and a reduction in safety for patients.</td>
</tr>
</tbody>
</table>

| Risk Owner: | Browne, Alison |
| Directorate: | Nursing & Quality Directorate |
| Risk Appetite: | Low |
| Risk Response: | Mitigate |

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

| Controls: (What are we doing to mitigate the risk?) | | |
|-----------------------------------------------------|--------------------------------------------------|
| • Lewisham, Bexley and Greenwich Integrated System improvement plan is an integrated system improvement programme with commissioner and provider representation. |
| • Safe and timely discharge work stream is part of this programme. |
| • Discharge to Assess (D2A) is being driven by LCCG across BGL, to ensure timely and safe discharge of patients to |
their own home. Weekly reports and action plan is generated from this.

- The (ECS) Emergency Care and Support sub group reports to the Lewisham Health and Care Partners Executive Board, which in turn reports Health & Wellbeing Board.
- The Section 75 partnership board is aligned to BCF
- We are working with Brymore house (LCCG community beds) to take more complex D2A patients

| Assurance Sources: | • ECS papers and reports
• BCF work stream papers
• QIPP data sets
• Ready for Discharge (RFD) list (one across Trust)
• Discharge to Assess (D2A) reporting template
• Papers from the work streams from the LBG integrated systems improvement programme |
| --- | --- |

| Risk Assurances: (What evidence do we have that the controls are working?) | • Data from Ready for Discharge list (<14 patients for LCCG per day, <less than 20 total)
• Discharge to Assess reporting template
• Ready for Discharge list
• Standard Operating Procedures for Sapphire beds |
| --- | --- |

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

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

| Gaps in Risk Controls: | • Fragmented ECS services which need review – Emergency Discharge Team (EDT), Discharge to Assess (D2A), Rapid Response Team (RRT) supported discharge which need redesigning as one single service in progress
• Improvement in numbers for Discharge to Assess against trajectory which is off target at the moment
• The need for a standardised approach to discharge across the trust on both sites |
| --- | --- |

| Actions: | • Complete the work for standardised approach across both LGT sites for Discharge to Assess *(DM; March 2018)*
• Improvement in numbers for Discharge to Assess against trajectory which is off target at the moment as we need to take more complex patients *(DM; March 2018)*
• Identify funding for more complex patients or we will not be able to achieve D2A trajectory *(DM; March 2018)* |
| --- | --- |

<p>| Last updated: | Alison Browne 15/11/2017 |</p>
<table>
<thead>
<tr>
<th>Corporate Objective:</th>
<th>Planning QIPP Programme for 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risk</strong></td>
<td>QIPP - Planning for 2018/19 and 2019/20 (Risk ID 83)</td>
</tr>
<tr>
<td><strong>Risk Description:</strong> (What is the risk?)</td>
<td>If the CCG does not deliver a credible two year QIPP Programme this will jeopardise delivery of the financial control total for future years</td>
</tr>
</tbody>
</table>
| It is caused by: | • Failure to develop Year 2 impact assessment of 2017/18 programmes  
• Lack of identified resource and expertise to develop early programmes |
| It could lead to: | • Failing to meet planning expectations of IAF for 2018/19  
• Contract mediation and/or arbitration  
• Inability to deliver balanced budget on a planning basis  
• Inability to commit to new investments  
• Loss of reputation |
| **Risk Owner:**     | Braithwaite, Diana |
| **Risk Manager:**   | Braithwaite, Diana |
| **Directorate:**    | Commissioning & Primary Care Directorate |
| **Risk Appetite:**  | Low |
| **Risk Response:**  | Mitigate |
| **Original Score:** | Very High Risk |
| **Current Score:**  | Very High Risk |
| **Target Score:**   | High Risk |
| **Risk Movement:**  | None |
| **Impact:** 4 x     | Impact 4 x |
| **Likelihood:** 4   | Likelihood 4 |

**Controls: (What are we doing to mitigate the risk?)**
- QIPP 2018/19 development will be directed by the Clinical Directors and Senior Management Meetings;
- Monthly QIPP Pipeline Clinics;
- ‘QIPP Ideas Generation Model’ agreed by Finance & Investment Committee;
- Continued collaboration across SEL CCGs;
- ICDT support in commissioning intentions and revised contract form;
- Right Care Opportunities;
- NHS England submissions;

**Assurance Sources:**
- Reports from the QIPP Clinic to the Clinical Directors and Senior Management Meeting
- DRAFT QIPP 2018/19 Programme Report to Integrated Governance Committee – November 2017 and January 2018
- SEL collaborative QIPPs on the Treatment Access Policy Review and other areas like continuing healthcare,
**medicines optimisation**

- QIPP 2018/19 Programme submitted to the Governing Body in February 2018

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

- Integrated Governance Committee review of 2018/19 Programme
- Project Initiation Documents (PIDs) and business developed
- Interventional programmes deliver reductions in acute activity from 1st April 2018
- High level acute QIPP submitted to acute providers in CCG Commissioning Intentions for 2018/19
- QIPP 2018/19 Programme will be reviewed by the ICDT
- Interventional programmes deliver reductions in acute activity from 1st April 2018
- *Deloitte recommendations to be reviewed by the Finance & Investment Committee (December 2017)*

**Assurance Type:** Management  
**Assurance level:** Limited

**Gaps in Risk Controls:**

- Interventional programmes do not deliver reductions in acute activity from 1st April 2018;
- Sustained QIPP/Right Care PMO to support the co-ordination of QIPP;
- Interfaces between QIPP as an outcome of integrated programmes as stipulated in the STP are not evident;
- Lack of appropriate resources to sufficiently interpret benchmarking information to develop large scale interventions to deliver the QIPP targets for 2018/19 and 2019/20;
- Lack of internal capacity to develop and deliver QIPP Programme;
- 2018/19 QIPP Target has increased to £18.3m due to expected under delivery on the 2017/18 target

**Actions:**

- Draft QIPP programme for review and testing (Who: Diana Braithwaite/Dee Carlin/Alison Browne); When: *December 2017*.
- Review the Integration Programme to support QIPP identification (Who: Sarah Wainer; When: *January 2018*).
- QIPP/Right Care PMO to support the co-ordination of QIPP recruitment (Who: Diana Braithwaite; When: *January 2018*).
- *ICDT review of QIPP programme to support contracting round; who: ICDT; When: November 2017*  
  - *Implementation of Deloitte recommendations; When: January 2018*

**Last updated:** Diana Braithwaite 06/12/2017
<table>
<thead>
<tr>
<th>Corporate Objective:</th>
<th>All Corporate Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risk</strong></td>
<td>Financial Targets 2017/18 (Risk ID 86)</td>
</tr>
<tr>
<td><strong>Risk Description: (What is the risk?)</strong></td>
<td><strong>The CCG fails to meet its statutory financial duties and fails to deliver NHS England's targeted surplus</strong></td>
</tr>
</tbody>
</table>
| It is caused by:    | - The CCG does not have effective arrangements to control expenditure  
                     - The CCG does not have effective cash management arrangements  
                     - The CCG does not have adequate management and reporting arrangements  
                     - The CCG does not fully deliver its QIPP savings plan  
                     - Unplanned and unavoidable cost pressures |
| It could lead to:   | - Failure to manage within Revenue Resource limit.  
                     - Failure to manage within combined resource limit.  
                     - Failure to manage within draw down limit.  
                     - Failure to manage within running cost allowance.  
                     - Failure to deliver targeted revenue surplus. |
| **Risk Owner:**     | Read, Tony |
| **Risk Manager:**   | Read, Tony |
| **Directorate:**    | Finance Directorate |
| **Risk Appetite:**  | Low |
| **Risk Response:**  | Mitigate |
| **Original Score:** | **High Risk** |
|                     | **Impact 4 x Likelihood 3** |
| **Current Score:**  | **Very High Risk** |
|                     | **Impact 4 x Likelihood 4** |
| **Target Score:**   | **High Risk** |
|                     | **Impact 4 x Likelihood 3** |
| **Risk Movement:**  | Increased |

**Controls: (What are we doing to mitigate the risk?)**
- Expenditure Controls  
- Standing Financial Instructions and Financial Policies  
- Reservation of Powers and Scheme of Delegation  
- Schedule of Matters Delegated to Officers  
- Detailed Budget Setting Procedures  
- Budget approved by Governing Body  
- Budgets delegated to authorised budget managers  
- Audit Committee  
- Finance and Investment Committee investment controls  
- Integrated Governance Committee scrutiny.
<table>
<thead>
<tr>
<th><strong>Assurance</strong></th>
<th><strong>Sources:</strong></th>
</tr>
</thead>
</table>
|               | • Prime Financial Policies and schemes of delegation approved by GB  
|               | • Budget approved by GB  
|               | • Financial reporting to Delivery Committee and Governing Body  
|               | • Audit Committee Scrutiny  
|               | • Finance and Investment Committee Scrutiny  
|               | • Internal Audits  
|               | • External Audit  
|               | • Service Auditor Report on CSU Controls  
|               | • Monthly Performance report to Delivery Committee  
|               | • Finance report to Governing Body  
|               | • Bank account reconciliations  
|               | • CFO review meetings with ARC team  
|               | • Audit Committee and IA review of financial control environment self assessment. |

<table>
<thead>
<tr>
<th><strong>Risk Assurances:</strong> (What evidence do we have that the controls are working?)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• External Audit of and opinion on 2016/17 Accounts EA+ (positive external assurance)</td>
<td></td>
</tr>
<tr>
<td>• Internal Audit report on Financial management (Significant Assurance) 2016/17 EA+</td>
<td></td>
</tr>
<tr>
<td>• Service Auditor Report on CSU Controls 2016/17EA+</td>
<td></td>
</tr>
<tr>
<td>• Block 2017/18 contract agreements with GSTT and Kings IA+</td>
<td></td>
</tr>
<tr>
<td>• Operating plan meets NHSE business rules. EA+</td>
<td></td>
</tr>
<tr>
<td>• Financial control environment self assessment 2016/17</td>
<td></td>
</tr>
<tr>
<td>Assurance Type:</td>
<td>Management, Independent</td>
</tr>
<tr>
<td>----------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Assurance level:</td>
<td>Adequate</td>
</tr>
</tbody>
</table>

| Gaps in Risk Controls: | • Minimal reserves. Negative net risk in financial position.  
                         • Insufficient reserves to meet all potential financial risks.  
                         • Uncertainty over LGT run rate support payment.  
                         • *Uncertainty over year end outturn of cost and volume contracts*.  
                         • *QIPP savings shortfall*. |

| Actions: | • Clarify LGT run rate payment (TR: end Jan 18)  
          • Seek agreement on year end contract values (TR: end Jan 18) |

<p>| Last updated: | Tony Read 02/01/2017 |</p>
<table>
<thead>
<tr>
<th>Corporate Objective:</th>
<th>Urgent and Emergency Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk Description: (What is the risk?)</td>
<td>That local non-NHS and NHS providers are not able to increase access to ‘evidence based’ mental health provision and non-NHS data cannot be flowed to the Mental Health Services Data Set (MHSDS)</td>
</tr>
</tbody>
</table>

It is caused by:
- New services which are not yet fully mobilised and therefore not up to full capacity
- Difficulties for non-NHS services when flowing data to MHSDS

It could lead to:
- Difficulties when meeting national access targets
- Escalation of need resulting in crisis presentations at UHL
- More lower level mental health cases being referred to CAMHS, as opposed to non-NHS mental health providers

<table>
<thead>
<tr>
<th>Risk Owner:</th>
<th>Hirst, Caroline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk Manager:</td>
<td>Tomsett, Warwick</td>
</tr>
<tr>
<td>Directorate:</td>
<td>Other</td>
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<td>Risk Appetite:</td>
<td>Low</td>
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<tr>
<td>Risk Response:</td>
<td>Mitigate</td>
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</table>

<table>
<thead>
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<th>Original Score:</th>
<th>Current Score:</th>
<th>Target Score:</th>
<th>Risk Movement:</th>
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<tbody>
<tr>
<td>High Risk</td>
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<td>Impact 4 x</td>
<td>Impact 3 x</td>
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</tr>
<tr>
<td>Likelihood 3</td>
<td>Likelihood 3</td>
<td>Likelihood 2</td>
<td></td>
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</tbody>
</table>

**Controls: (What are we doing to mitigate the risk?)**
- A review of the CAMHS performance framework, which will look in detail at any patterns and trends
- Significant involvement of commissioners in the role out and performance of new NHS and non-NHS mental health services (including the Young People’s Health and Wellbeing Service (Compass), Conduct Provision (PSLA), Crisis Care Service, Children’s Wellbeing Practitioner Programme)
- Commissioners are working with NHSE to develop processes to capture non-NHS mental health provision through MHSDS
- An evaluation is being undertaken of the CAMHS CAPA programme and waiting list initiative, which were created to improve access and demand management

**Assurance Sources:**
- Contract Monitoring Processes for SLaM, Compass and PSLA
- SLaM Core Contract Meetings
- CYP Mental Health and Emotional Wellbeing Programme
<table>
<thead>
<tr>
<th>Board</th>
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</thead>
<tbody>
<tr>
<td>• CYP Joint Commissioning Programme Board</td>
</tr>
<tr>
<td>• 7 Borough CAMHS Collaborative Commissioning Group</td>
</tr>
<tr>
<td>• New Models of Care CAMHS Commissioning Group</td>
</tr>
<tr>
<td>• STP Mental Health Steering Group</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk Assurances: (What evidence do we have that the controls are working?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Signed contracts with SLaM and VCS organisations</td>
</tr>
<tr>
<td>• Performance reports to Core Contract Meetings</td>
</tr>
<tr>
<td>• SEL STP trajectory plan, overseen by STP Mental Health Steering Group</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Gaps in Risk Controls:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Recovery plan with milestones and quantified / impact on delivering the required trajectory.</td>
</tr>
<tr>
<td>• All providers of NHS funded Mental Health treatment are required to flow data to the MHSDS (mental health services dataset) – non-NHS providers continue to experience challenges when doing so.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Actions:</th>
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</thead>
<tbody>
<tr>
<td>• The CCG is actively working with existing and new providers to monitor KPIs, which is supported through performance management processes</td>
</tr>
<tr>
<td><strong>March 2018</strong> CYP Joint Commissioning Team</td>
</tr>
<tr>
<td>• Monitor progress made through crisis care and CAPA implementation, specifically in terms of the waiting list initiative and capacity / demand management</td>
</tr>
<tr>
<td><strong>March 2018</strong> CYP Joint Commissioning Team</td>
</tr>
<tr>
<td>• Working with NHSE to improve dataflow to the mental health services dataset (MHSDS) to ensure access data is reported</td>
</tr>
<tr>
<td><strong>March 2018</strong> NHSE, Joint Commissioning Team and providers</td>
</tr>
<tr>
<td>• Monitor access rates to ‘evidence based’ mental health provision in the community through the Young Person’s Health and Wellbeing Service and the Children’s Wellbeing Practitioner programme.</td>
</tr>
<tr>
<td><strong>March 2018</strong> Joint Commissioning Team</td>
</tr>
<tr>
<td>• Working across the STP to share good practice and when identifying opportunities to co-commission regionally.</td>
</tr>
<tr>
<td><strong>Ongoing</strong> NHSE, Joint Commissioning Team, SEL commissioners and providers</td>
</tr>
<tr>
<td>• Extend co-commissioning opportunities across South London, specifically in relation to New Models of Care (partnership between SLaM, Oxleas, SWL and St Georges and NHSE specialised commissioning), which commenced delivery in 1st October 2017. SEL Commissioners to play an active role when identifying and monitoring KPIs</td>
</tr>
<tr>
<td><strong>March 2018</strong> NHSE, Joint Commissioning Team and providers</td>
</tr>
</tbody>
</table>

| Last updated: | Caroline Hirst 13/12/17 |
Corporate Objective: To take forward Accountable Care System

Risk

CCG cannot endorse development of new Provider Alliance(s)  
(Risk ID 95)

Risk Description: (What is the risk?)

The development of an alliance of providers collaboratively delivering CBC is a key element within the proposed ACS. Provider alliances will be accountable for quality and the delivery of community based care and agreed health and care outcomes. Failure to deliver this element would impact on the delivery of the ACS as a whole. However, the CCG will need confidence that the provider alliances which are formed are able to deliver the outcomes required, improve patient experience and be financially viable.

It is caused by:
• CCG does not state clearly its expectations of providers to participate in development of provider alliances
• Providers do not offer satisfactory evidence of viability and robustness of plans
• Lack of trust in ability of providers to deliver successful provider alliance
• Providers are unable to form alliances which include a sufficiently diverse membership to deliver holistic care

It could lead to:
• Inability of system to deliver co-ordinated and holistic care that meets commissioning intentions
• Potential increase in provider costs
• Quality remains variable and poor performance is not addressed collectively
• CCG continues to commission and issue contracts to a large number of individual providers
• Patients demand is inappropriately met
• Gaps in services lead to incomplete provision and lack of shift across the system
• Lack of investment in upstream activities/services

Risk Owner: Wilkinson, Martin  Risk Manager: Wainer, Sarah
Directorate: Corporate Directorate  Risk Appetite: High
Risk Response: Mitigate
Original Score:  Current Score:  Target Score:  Risk Movement:

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

- Endorsement of ACS to incorporate provider alliances has been, and will continue to be secured, regularly from:
  - The Health & Wellbeing Board
  - Lewisham Health and Care (LHC) Partners Executive Board
  - CCG Governing Body
  - CCG Strategy and Development
- Health and Wellbeing Board (HWB) supported and endorsed the intended direction of travel to strengthen the governance and partnership arrangements for the delivery of community based care as part of an accountable care system on 6 July.
- CCG Commissioners are involved in the discussions being held by local providers to explore a provider alliance for MH initially, and in the discussions to move to a wider CBC provider alliance in due course.
- Providers have been asked to develop and agree a shared provider workforce strategy and plan to support the development of provider alliances.

### Assurance Sources:

- Regular reports to LHC Exec Board and HWB Board on progress
- Reports to sovereign governing bodies as necessary
- Some contracts for 2018/19 are outcome based to test out provider response

### Risk Assurances:

- Providers have supported the development of an ACS in Lewisham and are engaging positively in the development of provider alliances

### Assurance Type:

- Management

### Assurance level:

- Limited

### Gaps in Risk Controls:

- LCCG is reliant on local providers to progress this element of the ACS and for local providers to form sustainable provider alliances

### Actions:

- LCCG is supporting the providers to form a provider alliance and CCG representatives attend the provider alliance development meetings
- Reports to sovereign governing bodies of both providers and commissioners before formal changes take place
- Analysis of learning from vanguards on provider alliance development elsewhere

### Last updated:

- Sarah Wainer 15/11/2017
<table>
<thead>
<tr>
<th>Corporate Objective:</th>
<th>To take forward Accountable Care System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk</td>
<td>Key enablers do not support establishment of an ACS &amp; delivery of accessible, sustainable and high quality community based care (Risk ID 96)</td>
</tr>
<tr>
<td><strong>Risk Description: (What is the risk?)</strong></td>
<td><strong>The strategies and plans across the system for workforce, IT and estates need to complement and support the development of an ACS in Lewisham. Failure in any of these areas will have a negative impact on the success of the ACS as a whole.</strong></td>
</tr>
<tr>
<td></td>
<td>It is caused by:</td>
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<tr>
<td></td>
<td>- The commitment to the development of an ACS has not been clearly articulated or communicated across CCG and elsewhere</td>
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<tr>
<td></td>
<td>- Those developing plans for workforce, IT and estates are not aware of requirements in relation to ACS</td>
</tr>
<tr>
<td></td>
<td>- Provider workforce:</td>
</tr>
<tr>
<td></td>
<td>Existing workforce do not have the capacity, skills or capability to deliver the agreed activity</td>
</tr>
<tr>
<td></td>
<td>Workforce development plans do not address training and development needs for ACS working</td>
</tr>
<tr>
<td></td>
<td>Workforce development plans across whole system do not align in relation to ACS requirements</td>
</tr>
<tr>
<td></td>
<td>- IT across the system:</td>
</tr>
<tr>
<td></td>
<td>Lack of integrated or interoperable information systems undermines the ability to integrate services and realise benefits</td>
</tr>
<tr>
<td></td>
<td>Lack of investment/capacity/commitment within individual organisations to IT developments</td>
</tr>
<tr>
<td></td>
<td>- Provider Estates:</td>
</tr>
<tr>
<td></td>
<td>Planning and development for estates does not align with new service requirements and new delivery models for CBC</td>
</tr>
<tr>
<td></td>
<td>It could lead to:</td>
</tr>
<tr>
<td></td>
<td>- Provider workforce:</td>
</tr>
<tr>
<td></td>
<td>Lack of workforce development leads to ineffective change and retention of current ways of working and behaviours</td>
</tr>
<tr>
<td></td>
<td>Staff continue to work in silos</td>
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<tr>
<td></td>
<td>Progress in the delivery of holistic and co-ordinated care is slow</td>
</tr>
<tr>
<td></td>
<td>Workforce remains focused on single organisational issues</td>
</tr>
<tr>
<td></td>
<td>Workforce unable to identify areas where improvement and transformation can be made across system</td>
</tr>
<tr>
<td></td>
<td>Workforce unable to promote benefits of ACS to wider</td>
</tr>
</tbody>
</table>

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stakeholders
• IT across the system:
  Duplication across system incurs avoidable costs
  Stifle innovation by failing to maximise the potential
  transformative effects of IT
  Lack of information sharing leads to poorer patient
  experience
  Lack of system wide financial and activity data means
  partners area unable to model proposed changes
effectively or agree shared benefits and risks
• Provider Estates:
  Underutilisation of buildings
  Estates do not accommodate service requirements
  Lack of value for money

<table>
<thead>
<tr>
<th>Risk Owner:</th>
<th>Wilkinson, Martin</th>
<th>Risk Manager:</th>
<th>Wainer, Sarah</th>
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<tbody>
<tr>
<td>Directorate:</td>
<td>Corporate Directorate</td>
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<tr>
<td>Risk Appetite:</td>
<td>High</td>
<td>Risk Response:</td>
<td>Mitigate</td>
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<thead>
<tr>
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<th>Current Score:</th>
<th>Target Score:</th>
<th>Risk Movement:</th>
</tr>
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<tbody>
<tr>
<td>High Risk</td>
<td>High Risk</td>
<td>High Risk</td>
<td>None</td>
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<tr>
<td>Impact 4 x</td>
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<tr>
<td>Likelihood 3</td>
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</table>

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

- HWB supported and endorsed the intended direction of travel to strengthen the governance and partnership arrangements for the delivery of community based care as part of an accountable care system on 6 July.
- Workforce, IT and Estates are recognised as being key enablers to the successful delivery of an ACS. IT and Estates Steering groups report to the LHCP Executive Board on progress in these areas. CCG is represented on both steering groups.
- LHCP agreed that the workforce development should be taken forward in two strands. One for commissioners and one for providers.
- In addition, a new communication role has been agree by LHCP to improve and develop communication and engagement on LHCP activity, in particular the direction of travel towards an ACS.

**Assurance Sources:**

- Regular reports to LHC Exec Board and HWB Board on progress.
- Reports to sovereign governing bodies as necessary.

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

- Workforce:
  Agreement to review and align OD and workforce plans for providers
  Positive feedback from staff within NCT pilots on benefits of
### Integrated Working

- **IT:**
  - IT Steering Group meeting regularly. CCG represented. Programme Plan developed. Quarterly updates to LHCP scheduled. Approval of population health system.
- **Estates:**
  - Estates Steering Group meeting regularly. CCG represented. Estates plan being developed to reflect CBC requirements. Quarterly updates to LHCP scheduled.

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

**Gaps in Risk Controls:**

LCCG can ensure workforce development within this organisation but is reliant on other local providers and commissioners to follow up on a commitment to develop an ACS and implement strategies and plans to support demonstrate cultural and behavioural change.

**Actions:**

- CBC vision to be finalised and agreed.
- Vision to be communicated regularly at all levels of organisation.
  - **Provider Workforce:**
    - Workshop to explore the potential to develop new, flexible, hybrid roles that bridge organisational boundaries on 12.09.17.
    - LCCG workforce development plan produced.
    - Providers implement workforce plans, and identify leads for key activity.
    - Individual staff development plans to identify training needs in relation to ACS.
  - **IT:**
    - Project Board for population health system to be established to ensure systems underpin improvements in quality of care and supports financial and activity modelling across the system.
  - **Estates:**
    - The CBC vision to inform the development of estates across the system, in particular the development of the neighbourhood care hubs.

**Last updated:** Sarah Wainer 15/11/2017
**Corporate Objective:** To take forward Accountable Care System

<table>
<thead>
<tr>
<th>Risk</th>
<th>An accountable care system is not established (Risk ID 97)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risk Description: (What is the risk?)</strong></td>
<td>An accountable care system in Lewisham is not established by 2020 as CCG members do not agree to proposals and do not contribute to its development.</td>
</tr>
<tr>
<td></td>
<td>It is caused by:</td>
</tr>
<tr>
<td></td>
<td>• No CCG mandate for direction of travel is given</td>
</tr>
<tr>
<td></td>
<td>• Focus remains on short term developments rather than long term aims</td>
</tr>
<tr>
<td></td>
<td>• Decisions support organisational benefit, address risks or do not establish value to system as a whole</td>
</tr>
<tr>
<td></td>
<td>• Implications for future CCG role are unclear and unacceptable, including any delegated responsibility to the ACS</td>
</tr>
<tr>
<td></td>
<td>• Insufficient system wide leadership and commitment to drive forward the transformed change at pace and scale</td>
</tr>
<tr>
<td></td>
<td>It could lead to:</td>
</tr>
<tr>
<td></td>
<td>• Accountability for delivery of ACS not shared</td>
</tr>
<tr>
<td></td>
<td>• Diminution of CCG influence across system</td>
</tr>
<tr>
<td></td>
<td>• Potential increase in costs across the system which are not financially sustainable in the long term</td>
</tr>
<tr>
<td></td>
<td>• Risks are not shared jointly across the system</td>
</tr>
<tr>
<td></td>
<td>• No change in culture and lack of trust across partnership</td>
</tr>
<tr>
<td></td>
<td>• Improvements in outcomes are not achieved</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk Owner:</th>
<th>Wilkinson, Martin</th>
<th>Risk Manager:</th>
<th>Wainer, Sarah</th>
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<tbody>
<tr>
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<th>Mitigate</th>
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<tbody>
<tr>
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<tr>
<td>Impact 4 x Likelihood 3</td>
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<td>Impact 3 x Likelihood 3</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Controls: (What are we doing to mitigate the risk?)</th>
<th>Endorsement on the direction of travel and associated activity in the development of the ACS has been, and will continue to be secured, regularly from:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• The Health and Wellbeing Board</td>
</tr>
<tr>
<td></td>
<td>• Lewisham Health and Care Partners (LHCP) Executive Board</td>
</tr>
<tr>
<td></td>
<td>• CCG Governing Body</td>
</tr>
</tbody>
</table>
| Assurance Sources: | • Reports on progress and planned actions submitted to LHC Exec Board and HWB Board for approval – membership includes CCG.
• Reports on progress and planned actions submitted to sovereign governing bodies for approval – including CCG Governing Body and Strategy and Development
• Development of ACS follows guidance on best practice and information from New Models of Care team in NHSE
• All formal changes fall within legal framework
• Better Care Fund Plan 2017-19 |

| Risk Assurances: (What evidence do we have that the controls are working?) | • HWB supported and endorsed the intended direction of travel to strengthen the governance and partnership arrangements for the delivery of community based care as part of an accountable care system on 6 July 2017.
• CCG Governing Body supported and endorsed the intended direction of travel to strengthen the governance and partnership arrangements for the delivery of community based care as part of an accountable care system on 11 July 2017. |

| Assurance Type: | Management |
| Assurance level: | Limited |
| Gaps in Risk Controls: | LCCG is dependent on other local providers and commissioners to mirror CCG’s commitment who work on a wider geographical footprint, e.g. LGT and SLaM, given their wider remit. |

| Actions: | • Benefits of ACS articulated and communicated
• Roadmap for ACS delivery produced and CCG commit to delivery plan
• Business case produced to include longer term system wide benefits including financial and risks
• Proposals scrutinised by the appropriate governance route to review system wide impact |
• Accountable leads identified for key activity
• LHCP Executive Board drive forward delivery
**Corporate Objective:** To take forward Accountable Care System

**Risk**
Integrated Strategic Commissioning is not established as part of the ACS (Risk ID 98)

**Risk Description:** (What is the risk?)
An integrated commissioning, accountable for delivering public value, is a key element within the proposed ACS. Strategic commissioning will agree joint commissioning intentions for community based care and collectively agree health and care ambition, outcomes and priorities. Failure to deliver this element would impact on the delivery of the ACS as a whole

It is caused by:
- Commissioners are not committed to the direction of travel because the ‘case for change’ is unclear and unconvincing
- *Examples of good practice are not disseminated or replicated across the system*
- Commissioning staff continue to work in silos both within the CCG and elsewhere
- Commissioners have insufficient capacity and/or capability to take forward strategic commissioning
- Benefits of strategic commissioning role within ACS cannot be demonstrated
- No change in working practices and behaviours
- Lack of trust between commissioners across CCG and LBL

It could lead to:
- Existing mixed approach to commission across Lewisham is retained
- Commissioners continue to work in silos
- Duplication across system not reduce and no improvement in value for money
- Information and data sharing is limited
- *Lack of ability to respond collectively to meet local need and address inequalities*
- Lack of investment in upstream activities/services

| Risk Owner: | Wilkinson, Martin |
| Directorate: | Corporate Directorate |
| Risk Appetite: | High |
| Risk Response: | Mitigate |
| Original Score: | High Risk |
| Current Score: | High Risk |
| Target Score: | High Risk |
| Risk Movement: | None |

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<table>
<thead>
<tr>
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### Controls: (What are we doing to mitigate the risk?)
- Endorsement on the direction of travel to establish integrated strategic commissioning as part of the ACS has been, and will continue to be secured, regularly from:
  - The Health and Wellbeing Board
  - Lewisham Health and Care Partners Executive Board
  - CCG Governing Body
  - CCG Strategy and Development
- LCCG has agreed with Lewisham Council to review the current commissioning arrangements for adults and children and to take forward discussions on developing integrated strategic commissioning within ACS. *Interim arrangements in place*
- Lewisham Health and Care Partners (LHCP) has asked commissioners to identify next steps to develop integrated strategic commissioning and to feedback to LHCP on proposals for any changes required to function, form, governance, skills and competences. An initial workshop was held on 17 August for all commissioners (CCG/LBL) to share understanding of the context and to progress this work.
- A further workshop for commissioners is planned.
- The new ways of working will be modelled within existing commissioning arrangements.
- Integrated commissioning intentions are being refreshed and will include specific areas to model different commissioning relationship with providers.

### Assurance Sources:
- Regular reports to LHC Exec Board and HWB Board on progress.
- Regular involvement of all commissioners and regular reports to sovereign governing bodies as necessary

### Risk Assurances: (What evidence do we have that the controls are working?)
- Commissioners have accepted case for change and identified next steps to take this work forward.
- Agreement on partnership commissioning outcomes and ambition
- Key conclusions from workshop will be presented to the next meeting of the Adult Joint Commissioning Group on 12th September

### Assurance Type: Management
### Assurance level: Limited

### Gaps in Risk Controls:
LCCG is dependent on LBL supporting the development of integrated strategic commissioning and progressing work at a similar pace

### Actions:
- Agree and formalise interim governance arrangements for strategic commissioning across adults and CYP by
January 2018 – WT/DC
- Agree outcomes framework for strategic commissioning by March 2018 – WT/DC/CMS
- Agree proposed functions required to be undertaken by strategic commissioning, within the context of the south east London CCG Review by Dec 2017. To be considered by CCG Governing Body and M&C by March 2018 – WT/DC
- Agree refreshed integrated commissioning intentions across adults and CYP by March 2018 for 18/19 and September 2018 for 19/20, including specific areas to model different commissioning relationship with providers – partially completed, frailty and transitions agreed for modelling new approach – WT/DC
- Negotiate outcome based contracts in specific areas for 2018/19 and 19/20 based on integrated commissioning intentions – WT (Transitions) AB (Frailty).
- Develop commissioning workforce strategy to ensure that the appropriate level of capacity and capability for commissioners is available to deliver strategic commissioning at a Borough level by March 2018 (CMS)

Last updated: Sarah Wainer 15/11/2017
Corporate Objective: 

Urgent and Emergency Care

<table>
<thead>
<tr>
<th>Risk</th>
<th>The NHSE target for CHC Assessments completed in non-acute settings is not delivered and the CCG is not assured by NHSE (Risk ID 99)</th>
</tr>
</thead>
</table>

**Risk Description: (What is the risk?)**  
The DH is requiring <15% of CHC assessments to be undertaken in acute hospitals by March 2018. The Sept 17 figure was 48% and the overall figure for Q2 was 54%.

This is caused by:
- The DH setting the 15% target as a requirement in year
- Significant variation in numbers referred across months not reflected in the overall % measure making it difficult to track
- Late inclusion of complex patient presentation in the Discharge to assess (D2A) programme (thus interdependence with Risk 81)
- Existing pathways promote high levels of CHC checklists (assessment start point)
- Development of discharge pathway that promotes acute hospital assessment to minimise RfD delays

It could lead to:
- Unsafe discharges to get people home
- Increased pressure on A&E/ inpatient beds through readmissions
- General capacity issues for CHC Team to manage assessments currently undertaken by hospital staff on the wards exacerbated by people being placed in dispersed community settings, including out of borough residential and nursing homes
- Increase in referral to decision breaches (>28days)
- Increased delayed discharges

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

<table>
<thead>
<tr>
<th>Original Score: Impact 3 x Likelihood 4</th>
<th>Current Score: Impact 3 x Likelihood 5</th>
<th>Target Score: Impact 4 x Likelihood 3</th>
<th>Risk Movement: New</th>
</tr>
</thead>
<tbody>
<tr>
<td>Controls: (What) Project Plan in place</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| **are we doing to mitigate the risk?** | • Exploring options to reshape the pathway to/ use of community beds at Brymore and Sapphire including Brymore contact extension  
  • Monthly reporting to NHSE, monthly review at CHC Exec and 6 weekly review at the STP CHC Review Board  
  • Weekly scrutiny of the assessment list to identify discharges home  
  • Extending D2A to complex presentations  
  • Dates in place for training staff on use of enhanced checklist  
  • Working with LBL to manage pathway for agreeing ‘funding without prejudice’ |
|---|---|
| **Assurance Sources:** | • A&E Delivery Board Reports  
  • LGT Assessment list  
  • CHC Team assessment list  
  • Checklist to assessment timescale  
  • NHSE reporting Framework |
| **Risk Assurances: (What evidence do we have that the controls are working?)** | • Limited assurance. Most development work remains informal.  
  • There is evidence of Q1 and Q2 reduction in acute assessments but this now plateau’d. London NHS Continuing Healthcare Q2 Activity Report highlights non delivery to target |
| **Assurance Type:** | Management |
| **Assurance level:** | Limited |
| **Gaps in Risk Controls:** | • Discharge to assess (D2A) and pathway reshaping remains fragmented for complex patients  
  • No financial agreement to proceed with D2A service work (Night Owl pilot or Brymore additional staffing) but agreement reached with London Borough of Lewisham (LBL) Legal to call down from the Domcare Framework  
  • Implementation of Enhanced Checklist  
  • Delayed sign up from LBL re revised decision pathway  
  • Lack of clarity about ongoing project management support |
| **Actions:** | • Escalate approval for funding for D2A services for complex patients – Debbie Marsh/ Dee Carlin 16 11 17  
  • Deliver Enhanced Checklist Training to hospital and community staff – Perfect Mawaka/ Debbie Marsh by 30 November 2017  
  • Agree and implement RC pathway with escalation processes – Heather Hughes/ Mary Farinha by end Nov 17  
  • Embed revised brokerage pathway to support Enhanced Checklist take up – Heather Hughes/ Tom Bird by end Dec 17  
  • Establish new pathway for community check listing – Debbie Marsh by end Dec 17 |
• Prepare Night Owl Specification for call down – Heather Hughes by end of Nov 17
• Revise specification for Sapphire bed use – Debbie Marsh by end Nov 17

Last updated: Heather Hughes 16/11/2017
Appendix C: Risk Appetite

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

<table>
<thead>
<tr>
<th>Good Governance Institute v2.2</th>
<th>Appendix 4 Risk Appetite for NHS Organisations - A maturity matrix to support better use of risk in decision taking</th>
<th>Developed with Southwark BSU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk levels ①</td>
<td>Key elements ②</td>
<td></td>
</tr>
<tr>
<td>0 Avoid</td>
<td>Avoidance of risk and uncertainty is a Key Organisational objective</td>
<td></td>
</tr>
<tr>
<td>1 Minimal (MIARIP)</td>
<td>Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward</td>
<td></td>
</tr>
<tr>
<td>2 Cautious</td>
<td>Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward</td>
<td></td>
</tr>
<tr>
<td>3 Open - Willing to consider all potential delivery options and choose those that provide an acceptable level of reward (and VFM)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Seek - Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Mature - Consistent focus on the best possible return for stakeholders; resources allocated in ‘social capital’ with confidence that process is a return in itself</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Appendix C: Risk Appetite

#### Financial / VFM
- Avoidance of financial loss is a key objective.
- Only prepared to accept the possibility of very limited financial loss if essential.
- Prepared to accept the possibility of some limited financial loss if essential.
- Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level.
- Consistently focused on the best possible return for stakeholders.
- Resources allocated without firm guarantees of return - investment capital type approach.

#### Compliance / Regulatory
- Avoid anything which could be challenged, even unsuccessfully. Play safe.
- Limited tolerance for sticking our neck out. Want to be reasonably sure we won’t have any challenge.
- Consistently pushing back on regulatory burden. Front foot approach informs better regulation.

#### Innovation / Quality / Outcomes
- Defensive approach to objectives - aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision-taking authority.
- General avoidance of systems / technology developments.
- Innovations always avoided unless essential or commonplace elsewhere.
- Tendency to stick to the status quo and demonstrate Commissioner’s improvements in management control. Sustained technological developments limited to improvements in protection of current operations.
- Innovation supported, with demonstration of significant improvements in management control. Systematic technology development to address evolving operational delivery responsibilities for non-critical decisions may be devolved.
- Innovation pursued - desire to break the mould and challenge current working practices. New technologies viewed as a way of delivering operational delivery. High levels of devolved authority - management by trust rather than tight control.
- Track record and investment in communications has built confidence in public, press and patients that organisation will take the difficult decisions for the right reasons with benefits outweighing the risks.

### APPETITE

<table>
<thead>
<tr>
<th>APPETITE</th>
<th>NONE</th>
<th>LOW</th>
<th>MODERATE</th>
<th>HIGH</th>
<th>SIGNIFICANT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Status</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Description</td>
<td></td>
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</table>
Appendix D – Glossary of Terms

Glossary of terms: Risk

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

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

<table>
<thead>
<tr>
<th>A</th>
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</table>
| **Action Required**  
Work that is required to close assurance gaps |
| **Action Target Date**  
The date that the actions are due to be completed |
| **Assurance Gaps**  
Where the CCG has no evidence of whether or not its controls are effective |
| **Assurance Given**  
The evidence that controls are effective or not |
| **Assurance Level**  
The strength of the evidence; None, Limited, Adequate, Significant |
| **Assurance Source**  
Where the CCG finds evidence that its controls are effective |
| **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) |

---

<table>
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</table>
| **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 |
| **Current Score**  
The Current (‘residual’) risk score which is the most recent risk assessment |
<table>
<thead>
<tr>
<th>Risk Appetite</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘The amount and type of risk that an organisation is willing to take in order to meet their strategic objectives.” (Institute of Risk Management)</td>
</tr>
<tr>
<td>Risk appetite is normally smaller or less than risk tolerance.</td>
</tr>
<tr>
<td>“The amount and type of risk than an organisation is prepared to seek, accept or tolerate.” (BS 31100:2008)</td>
</tr>
<tr>
<td>“The amount of risk, on a broad level, that an organisation is willing to take on in pursuit of value.” (KPMG)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Risk Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk Scoring Matrix</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Likelihood</th>
<th>Almost certain 5</th>
<th>Likely 4</th>
<th>Possible 3</th>
<th>Unlikely 2</th>
<th>Rare 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impact</td>
<td>Moderate</td>
<td>High</td>
<td>Very High</td>
<td>Very High</td>
<td>Very High</td>
</tr>
<tr>
<td></td>
<td>Moderate</td>
<td>High</td>
<td>High</td>
<td>Very High</td>
<td>Very High</td>
</tr>
<tr>
<td></td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
<td>High</td>
<td>Very High</td>
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<tr>
<td></td>
<td>Low</td>
<td>Moderate</td>
<td>Moderate</td>
<td>High</td>
<td>High</td>
</tr>
<tr>
<td></td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
<td>Moderate</td>
<td>Moderate</td>
</tr>
</tbody>
</table>

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>Target Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Target risk score is the level of risk which the CCG Board has deemed acceptable level, reflecting the CCG’s risk appetite and which the CCG plans to achieve once all the controls are fully applied and proved to be effective.</td>
</tr>
</tbody>
</table>
A meeting of the Governing Body  
11th January 2018

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>Tony Read</td>
<td>Post Chief Finance Officer</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 2017/18 Annual Report and Accounts.
2. Delegate authority to approve the 2017/18 Annual Report and Accounts to the Audit Committee
3. Note the management arrangements in place prepare the content of the 2017/18 Annual Report and Accounts

Summary:

- The 2017/18 NHS Lewisham CCG unaudited Annual Report and Accounts are due to be submitted to NHS England in draft form on the 24th April 2017 and as a final audited version by the 29th May 2017.
- The Governing Body is asked to delegate authority to the Audit Committee to approve the 2016/17 Annual Report and Accounts prior to submission to NHS England.

Key Issues:

The management team has reported to the Audit Committee on the review and lessons learnt from 2016/17 annual report and accounts and is implementing the recommendations accordingly. This includes the management arrangements for the oversight and coordination of the annual report are unchanged, that is led by the CCG’s Deputy Director (Strategy & OD) working with the Head of Finance reporting to the Chief Officer and management team, and that where possible the members of the Audit Committee receive the draft content of the annual report in advance of the other papers for its meeting to allow full and more detailed consideration.

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

2017/18 Annual Report and Accounts Key Dates

The dates as currently set by NHS England are:

<table>
<thead>
<tr>
<th>When</th>
<th>What</th>
</tr>
</thead>
<tbody>
<tr>
<td>16(^{th}) March</td>
<td>CCGs submit draft final head of internal audit opinion</td>
</tr>
<tr>
<td>20th April</td>
<td>CCGs submit draft annual report, full copy of the draft final head of internal audit opinion statement as issued by the CCG internal auditors.</td>
</tr>
<tr>
<td>24(^{th}) April</td>
<td>Unaudited draft accounts including the annual governance statement, as approved by the Accountable Officer and Chief Financial Officer (and passed to appointed auditors for audit).</td>
</tr>
<tr>
<td>29th May</td>
<td>CCGs to submit full audited and signed 2017/18 Annual Report and Accounts, as approved in accordance with the CCG scheme of delegation and signed and dated by the Accountable Officer and appointed auditors.</td>
</tr>
<tr>
<td>30(^{th}) September</td>
<td>CCGs should hold a public meeting at which the audited Annual Report and Accounts should be presented.</td>
</tr>
</tbody>
</table>

The Audit Committee is also planning to review the impact on the year end Annual Report and Accounts production arising from the transition to new collaborative working arrangements between the CCGs in south east London.

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 2017/18 Annual Report
- The annual report will include a summary of the CCG’s progress in meeting its responsibilities for public engagement during 2017/18

HEALTH INEQUALITY DUTY & PUBLIC SECTOR EQUALITY DUTY
The Annual Report will report the CCG’s progress in meeting these duties during the 2017/18
financial year.

<table>
<thead>
<tr>
<th>RESPONSIBLE MANAGERIAL LEAD CONTACT:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name: Tony Read</td>
</tr>
<tr>
<td>E-Mail: <a href="mailto:tonyread@nhs.net">tonyread@nhs.net</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>AUTHOR CONTACT:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name: Charles Malcolm-Smith</td>
</tr>
<tr>
<td>E-Mail: <a href="mailto:charles.malcolm-smith@nhs.net">charles.malcolm-smith@nhs.net</a></td>
</tr>
</tbody>
</table>
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CCG Safeguarding Children Annual Report 2016-2017

<table>
<thead>
<tr>
<th>CLINICAL LEAD: Dr Faruk Majid</th>
<th>Post Clinical Director Executive Lead Safeguarding</th>
</tr>
</thead>
<tbody>
<tr>
<td>MANAGERIAL LEAD: Alison Browne</td>
<td>Post Director of Nursing and Quality</td>
</tr>
<tr>
<td>Author: Maureen Gabriel</td>
<td>Designated Nurse Safeguarding and Looked After Children</td>
</tr>
<tr>
<td>Author: Dr Bola Adeyemi</td>
<td>Consultant Community Paediatrician Designated Doctor Safeguarding /Child Protection</td>
</tr>
</tbody>
</table>

**RECOMMENDATIONS:**

The Governing Body is asked to approve the NHS Lewisham Safeguarding Children Annual Report 2016/17 as providing sufficient assurance that there are effective safeguarding systems and processes in place for Lewisham to ensure that the CCG is fulfilling statutory duties to safeguard children.

**SUMMARY:**

- The report outlines the CCG responsibilities in respect of safeguarding children and the actions taken by the CCG to meet these responsibilities. The report outlines the areas for development during 201/18.

- The report sets the context for safeguarding children in Lewisham and provides an overview of the arrangements in place to safeguard and protect children across health services in Lewisham.

- Reports on governance and accountability arrangements within the CCG and the provider health organisations including representation to and involvement in the Lewisham Safeguarding Children Board.

- Reports on the Serious Case Reviews (SCRs) for Lewisham.
Achievements:

- A new CCG Health Safeguarding Operational Group will receive and scrutinize safeguarding performance information and data. Information received could be evidence discussed at provider organisation respective safeguarding committees, those shared by health with Lewisham Safeguarding Boards, NHS England and other statutory or mandatory returns. Bespoke reports to the CCG would only be sought from providers where other reporting arrangements do not provide sufficient assurance.

- To ensure continued sharing of safeguarding learning and improve safeguarding effectiveness across the local health economy; the CCG Safeguarding Leads organised a health safeguarding conference held on Monday 30th January 2017. The aim was to bring together health providers and commissioners from all sectors of the Lewisham health economy to share best practice on identifying and protecting people who are at risk of experiencing domestic violence.

- The CCG Child Safeguarding Leads collaborated with the CCG Adult Safeguarding Leads to develop a bespoke Safeguarding training package for the CCG Governing Body.

- Contributing to the London Borough of Lewisham Children Services Ofsted Improvement plan; the CCG, Local Health Providers and General Practice Primary Care contributed to working Groups to develop the “Early Help “Package and review of the Multi-Agency Safeguarding Hub (MASH).

- New Joint Targeted Area Inspections of services for vulnerable children and young people (JTAI) were launched in 2016. Inspectorates Ofsted, Care Quality Commission (CQC), Her Majesty’s Inspectorate of Constabulary (HMIC) and Her Majesty’s Inspectorate of Probation (HMIP) are working together. The new short inspections would allow inspectorates to be more responsive, targeting specific areas of interest and concern. During 2016, the theme was Child Sexual Exploitation and missing children. London Borough of Lewisham set up a JTAI group which included representation from LGT (Named Safeguarding Professional) and the CCG Designated Professionals, to examine the processes and arrangements to safeguard children at risk of exploitation in Lewisham. The theme for 2017 will be Neglect.
CORPORATE AND STRATEGIC OBJECTIVES

- Safety of Children and Young People
- Statutory functions of the CCG

CONSULTATION HISTORY INCLUDING MEMBERS ENGAGEMENT:

- This document can be shared for accountability and assurance.

PUBLIC ENGAGEMENT

- This document can be shared for accountability and assurance.

HEALTH INEQUALITY DUTY

- Safeguarding children is for the total child population of Lewisham
- 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

- 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

RESPONSIBLE MANAGERIAL LEAD CONTACT:

Name: Alison Browne       Director of Nursing and Quality

AUTHOR CONTACT:

Maureen.gabriel@nhs.net
Abimbola.adeyemi@nhs.net
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NHS LEWISHAM

SAFEGUARDING CHILDREN

ANNUAL REPORT

April 2016- March 2017

Authors

Maureen Gabriel - Designated Nurse Safeguarding and Looked After Children

Dr Abimbola Adeyemi – Consultant Community Paediatrician & Designated Doctor for Child Protection / Safeguarding Children
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<td></td>
<td>Appendices</td>
<td>21</td>
</tr>
</tbody>
</table>
1. The Purpose of the Report

1.1. The purpose of this Annual Safeguarding Children Report is to assure NHS Lewisham Clinical Commissioning Group Governing Body that the CCG is fulfilling statutory duties to safeguard children.

1.2. To demonstrate how the health contribution to safeguarding and promoting the welfare of children is discharged across the whole Lewisham health economy through Lewisham Clinical Commissioning Group’s commissioning arrangements.

1.3. The report will inform the Governing Body of the progress made on the key priorities of the year and identify the main issues, risks, and key priorities relating to safeguarding children within Lewisham for the year pending.

1.4. The report also provides information about national changes which influence, local developments and activity, including safeguarding inspections.

1.5. The report is compiled with contributions from papers submitted by NHS England, South London and Maudsley (SlaM), NHS Lewisham and Greenwich Trust (LGT), The Named General Practitioner (GP) for Safeguarding Children, The Local Authority and the Looked After Children Health Team (LAC).

2. Local Context

2.1. NHS Lewisham CCG commissions health services for approximately 70,000 children and young people in Lewisham. Children and young people under the age of 20 represent 25% of the total population in Lewisham. 76.5% of school aged children are from a minority ethnic group. Children in Lewisham have worse than national averages of child poverty, family homelessness, obesity rates and GSCE achievement. Teenage conception rates and teenage birth rates are higher than national averages.

2.2. The Joint Commissioning unit based in the Council manage the commissioning of community child health services and safeguarding on behalf of the CCG and Public Health. During 2016-2017 procurement and retendering of Health Visiting (including the Family Nurse Partnership) and School Nursing took place. New contracts to begin in 2017.

2.3. Lewisham is described in the 2015 Lewisham Public health report as a young borough it is also one of the most ethnically diverse local authorities in England. The report relates that although this creates a richness there are challenges associated
with this. Lewisham is a London Borough where a significant number of children live in circumstances where they are at risk of significant harm from abuse and neglect. There were approximately 380 children subject to a Child Protection plan (CP) at the end of March 2017. This demonstrates a small increase from 360 at end of March 2016. The number of children subject to a CP Plan in Lewisham remains higher than statistical neighbours.

2.4. Ofsted Inspection

The London Borough of Lewisham Children’s Services had an inspection in October 2015 under the revised framework known as the SIF inspection. These inspections are conducted under section 136 of the Education and Inspections Act 2006. They focus on the effectiveness of local authority services and arrangements to help and protect children, the experiences and progress of children looked after, including adoption, fostering, the use of residential care, and children who return home.

Following the publication of the Ofsted findings for Lewisham in January 2016, an improvement plan was in place. The improvement plan included revising the MASH (Multi-Agency Safeguarding Hub), refreshing the threshold document, developing an Early Help Strategy and a redesign of the early help services. This has involved collaboration, multi-agency workshops and a vast amount of dissemination of the revised procedure to health organisations including General Practice Primary Care.

On 31st January 2017 referrals to the revised MASH for safeguarding children concerns became via an electronic online procedure. There were inevitable initial problems with the online referral. The Partnership have acknowledged feedback and examined solutions to address the problems. A feature of the revised referral system is that reports can be generated to identify the actual sources of referrals. This is especially helpful for individual health organisations which were often previously described as “Health Other” in data reports.

2.5. Lewisham LSCB

A new Independent Chair of the Lewisham LSCB was recruited in September 2016. The Chair is also the Independent Chair of the Greenwich LSCB, this may prove to be beneficial as there is an opportunity for sharing learning and best practice across the two Boroughs.

3. Safeguarding Obligations and Responsibilities

3.1. This annual report is set within the context of safeguarding responsibilities as defined in the revised “Working Together to Safeguard Children” (2015):

- Protecting children from maltreatment
Preventing impairment of children’s health or development
- Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care
- Taking action to enable all children to have the best outcomes

3.2 Effective safeguarding arrangements must be underpinned by two key principles:
- Safeguarding is everyone’s responsibility therefore, for services to be effective each professional and organisation should play their full part
- A child-centred approach, therefore for services to be effective they should be based on a clear understanding of the needs and views of children

3.3 In addition, Section 11 (s11) of the Children Act (2004) places a duty on organisations including the CCG to ensure their functions and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children.

This means organisations should have in place arrangements required to safeguard and promote the welfare of children which reflects the importance of safeguarding and promoting the welfare of children. At an organisational or strategic level, key features are ensuring:
- Senior management commitment to the importance of safeguarding and promoting children’s welfare
- A clear statement of the agency’s responsibilities towards children; available for all staff
- Service development that takes account of the need to safeguard and promote welfare, and is informed, where appropriate, by the views of children and families.
- Staff training on safeguarding and promoting the welfare of children for all staff
- Safe recruitment procedures in place


- The Wood report was published on the 26th May 2016. The report reviewed the role and functions of Local Safeguarding Children Boards (LSCBs) within the context of local strategic multi-agency working. This included the child death review process, and consideration of the serious case review (SCR) process.
- The main recommendation was to replace the existing statutory framework for LSCBs with a new statutory framework for multi-agency arrangements for
child protection; to require all areas to move towards new multi-agency arrangements; to require three key agencies (health, police and local authorities to design multi-agency arrangements for protecting children, and to work together on key strategic issues.

- These changes required legislation. Therefore, these proposals were included, in The Children and Social Work Bill which went through Parliament during 2016-2017.

3.5 **NHS England** is responsible for ensuring that the commissioning system in London is working effectively to safeguard children and adults at risk of abuse or neglect.

The CCG has a duty to support NHS England with the quality of Primary Care Services. This role includes commissioning assurance as well as strategic leadership and influencing. Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework (NHS England, 2015a) clearly sets out the safeguarding responsibilities of NHS England.

NHS England ensures that the health commissioning system as a whole is working effectively to safeguard children at risk of abuse or neglect. NHS England is the policy lead for NHS safeguarding, working across health and social care, including leading and defining improvement in safeguarding practice and outcomes. Key roles include:

- Providing leadership support to safeguarding professionals
- Ensuring the implementation of effective safeguarding assurance arrangements and peer review processes
- Providing specialist safeguarding advice to the NHS
- Leading a system where there is a culture that supports staff in raising concerns regarding safeguarding issues
- Ensuring that robust processes are in place to learn lessons from cases where children or adults die or are seriously harmed and abuse or neglect is suspected
- Ensuring that locally NHS England teams are appropriately engaged in the Local Safeguarding Boards and any local arrangements for safeguarding both adults and children
Over the past year, the London region Safeguarding Programme has delivered on several key pieces of work that reflect these commitments as listed in the Accountability and Assurance Framework.

Key pieces of work that the NHSE programme continued to strengthen across the region included:

- Female Genital Mutilation (FGM)
- Child Sexual Abuse (CSA), including Child Sexual Exploitation (CSE)
- Prevent
- Looked After Children (LAC), including Unaccompanied Asylum-Seeking Children (UASC)
- Child Protection Information Sharing (CP-IS)

3.5.1 Lewisham CCG Designated Professionals are represented at the NHS England forums.

4. CCG Safeguarding Children Governance & Accountability Arrangements

4.1. The current safeguarding governance arrangements for Lewisham CCG meet the statutory duty to safeguard and promote the welfare of children and young people. There have been no vacancies in the safeguarding team.

4.2. Current CCG Responsibilities:

- **The Accountable Officer**: Martin Wilkinson, The Chief Officer ensures that the responsibility to safeguard and prevention of harm to children, young people and vulnerable adults is discharged effectively across the whole health economy through Lewisham CCGs commissioning arrangements.
- **The Governing Body Lead** and Senior Clinical Director Lead for Safeguarding- Dr Faruk Majid is the board executive for safeguarding and is accountable to NHS Lewisham CCG Governing Body for providing assurance that the range of safeguarding statutory duties are discharged and all responsibilities met.
- **Nurse Director**: Alison Browne is responsible for the management of the safeguarding team and supports the Governing Body Lead to undertake his role.
- **Designated Professionals**: Lewisham CCG has secured the expertise of the following Designated Professionals:
  - Designated Doctor Child Protection/Safeguarding Children
Designated Nurse Safeguarding and Looked After Children
Designated Paediatrician for Child Deaths
Designated Doctor for Looked After Children

The role of the designated safeguarding children professional is to provide the clinical expertise and strategic lead for the local health community and is a vital source of advice to the CCG, NHS England, the local authority and the LSCB. They also advice and support to other health professionals.

5. CCG Safeguarding Children Priorities and Achievements in 2016-2017

5.1. Develop and deliver a safeguarding training package for the CCG Governing Body

*Update: The CCG Child Safeguarding Leads collaborated with the CCG Adult Safeguarding Leads to develop a bespoke Safeguarding training package for the CCG Governing Body.*

5.2. Multi-agency working with partners contributing to Children’s Services Ofsted Improvement Plan, which includes implementation of a revised Early Help and MASH service; to ensure improved outcomes for children and young people

*Update: The CCG, Local Health Providers and General Practice Primary Care contributed to the working Groups to develop the “Early Help “Package and to review the MASH.*

5.3. Develop & deliver safeguarding training package incorporating learning from local SCR’s, national reviews and research for GP ‘s and Practice Nurses.

*Update: The GP Child Safeguarding Training Package was revised and delivered. It will run from April 2016 until March 2018.*

5.4. Work with partner agencies to ensure an FGM joint protocol is in place across the Borough

*Update: The Lewisham Partnership have developed a Female Genital Mutilation (FGM) Protocol which will be ratified by the LSCB.*

5.5. Work in partnership with the LSCB and health providers to focus on ensuring that there are adequate arrangements in place in cases of Child Sexual Exploitation.

*Update: The partnership agreed a revised multi-agency forum (MET meeting) for safeguarding children being sexually exploited. Children who are missing or may be trafficked are also reviewed at this forum.*

*There is representation from the local acute and community health Trust, SlaM and the CCG.*
5.6. Maintain current high standard of Safeguarding work in CCG and provider organisations through assurance processes. The CCG will monitor through the Safeguarding Assurance template

Update: this is discussed in the introduction of item 6 of this report.

6. Safeguarding Monitoring and Assurance from Provider Organisations

During 2016-2017 the CCG arrangements for seeking safeguarding assurance were reviewed. It was noted that there was a duplication of reporting for safeguarding. For example, the same safeguarding reports were presented at the provider safeguarding committees and then again at the CCG safeguarding Assurance meetings. It was usually the same participants attending these meetings. The CCG therefore decided to seek safeguarding assurance in two ways:

1. A new CCG Health Safeguarding Operational Group will receive and scrutinise safeguarding performance information and data. Information received could be those provider organisation discussed at their respective safeguarding committees, those shared by health with Lewisham Safeguarding Boards, NHS England and other statutory or mandatory returns. Bespoke reports to the CCG would only be sought from providers where other reporting arrangements do not provide sufficient assurance.

2. To ensure continued sharing of safeguarding learning and improve safeguarding effectiveness across the local health economy; the CCG Safeguarding Leads would organise safeguarding conferences two or three times a year, focussing on relevant topics and invite all local healthcare providers to attend. The first NHS Lewisham CCG Health Safeguarding Conference was held on Monday 30th January 2017 which aimed to bring together health providers and commissioners from all sectors of the Lewisham health economy to share best practice on identifying and protecting people who are at risk of experiencing domestic violence. 60 people attended, with representation from general practice, LGT, SLaM, LBL, private providers, the LSCB, the LSAB, NHS England, and nursing homes. The attendees broke into groups to discuss two case studies adapted from Domestic Homicide Reviews that had occurred in Lewisham (DHRs). Feedback from respondents indicated that the conference was very good and interesting. Suggested changes have been acted upon, for example information on the local referral pathways for domestic abuse were widely disseminated.

6.1. Lewisham and Greenwich NHS Trust (LGT)

6.1.1. Lewisham and Greenwich NHS Trust have robust accountability arrangements and an established Safeguarding Committee for safeguarding
children & young people. The Trust’s safeguarding committee has oversight of the trust safeguarding arrangements and identifies areas for improvement. The CCG Designated Professionals attend this meeting. The LGT annual report is located in the appendix. Highlights from the report include the following:

6.1.2. During 2016-2017 procurement processes were in progress led by the Local Authority Public Health and Children’s Joint Commissioning for Health Visiting, School Health and the Family Nurse Partnership. The LGT Child Safeguarding Team were active in ensuring that child safeguarding arrangements were considered in the procurement decisions.

6.1.3. The governance structure of the LGT children’s safeguarding team has been revised. The safeguarding team were previously part of the Children’s Community Team and are now part of the Corporate Division from October 2016. This revision is advantageous as it raises the profile of child safeguarding in the Trust.

6.1.4. **LGT Maternity Safeguarding Meetings.**

This is a multi-agency meeting held weekly on both hospital sites and fortnightly to plan for and monitor women booking for antenatal care where safeguarding concerns have been identified. Actions taken are reviewed in a multi-agency setting; onward care and liaison is planned. This ensures timely information sharing and cohesive action planning to improve outcomes for unborn children and their families. The Maternity Safeguarding Pathway has been adapted to strengthen and standardise safeguarding practice cross site. A review of the governance and information sharing processes for the maternity safeguarding meeting is underway at the time of report. Serious Case reviews have identified that the maternity safeguarding pathway is essential but needs to be more robust.

6.1.5. **Family Nurse Partnership**

LGT is commissioned to deliver the Family Nurse Partnership (FNP) programme to first time mothers aged 19 and below. This was extended within London Borough of Lewisham to mothers up to the age of 22 years. It was recognised that there was a fall in the teenage pregnancy rate and many first time parents over 19 years had significant needs. LGT is in its tenth year of delivering the FNP in Lewisham and its third year in Greenwich. FNP is an evidence-based preventive programme for vulnerable young first time parents. It offers intensive and structured home visiting, delivered by specially trained nurses, from early pregnancy until the child is aged two.
Family Nurses build trusting and supportive therapeutic relationships with families, guiding first-time young parents, using behaviour change methods to help them adopt healthier lifestyles for themselves and their babies, enabling them to provide warm and nurturing parenting, and develop an aspirational plan for them and their babies’ futures. As part of the programme the FNP team receive safeguarding supervision from the Named Nurse Professionals.

6.1.6 Safeguarding Emergency Department (ED)

A multi-agency meeting is held weekly on both hospital sites to review ED attendances and admissions to the children’s ward that have been raised as presenting a safeguarding concern. Actions taken are reviewed in a multi-disciplinary setting and onward care and liaison are planned. This ensures timely information sharing and cohesive action planning to improve outcomes for children.

6.1.6. Again, this year there was a persistent emphasis to improve the Trust's Safeguarding Training data. There was a concerted drive throughout the year targeting the Divisions and Directorates who were experiencing difficulty in improving safeguarding training rates. The LGT safeguarding Committee requested that any Directorates who were less than 60% compliant in any Safeguarding Children & Young People mandatory training category be required to complete an exception report, to include any action plans for how the Directorate plans to improve compliance and meet the Trust target of 85%. Directorate General Managers, or their nominated representative, were invited to attend the meeting to deliver/discuss their exception report. The table below demonstrates safeguarding children training rates has improved in Lewisham.

6.1.7. Table LGT Safeguarding Training at 30/04/2017

<table>
<thead>
<tr>
<th>Safeguarding Children &amp; Young People Level</th>
<th>Non-Compliant</th>
<th>Compliant</th>
<th>Eligible</th>
<th>Overall Compliance 30/04/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>0</td>
<td>628</td>
<td>628</td>
<td>100%</td>
</tr>
<tr>
<td>Level 2</td>
<td>212</td>
<td>1405</td>
<td>1617</td>
<td>87%</td>
</tr>
<tr>
<td>Level 3 - Core</td>
<td>49</td>
<td>258</td>
<td>307</td>
<td>84%</td>
</tr>
<tr>
<td>Level 3 - Specialist</td>
<td>105</td>
<td>428</td>
<td>533</td>
<td>80%</td>
</tr>
<tr>
<td>Level 4</td>
<td>0</td>
<td>4</td>
<td>4</td>
<td>100%</td>
</tr>
</tbody>
</table>

(data extracted from LGT report pertaining to Lewisham only)

6.1.9 CP-IS Child Protection Information Sharing

LGT is one of the London NHS Trusts that are using smartcards to access the national system of safeguarding alerts on the NHS Spine. Currently there are
120,000 children with CP plans in England. At least 34,000 children on a CP Plan have been uploaded onto the NHS Spine. For CPIS to be fully functioning all local Authorities also need to upload children on a CP Plan or Looked After onto the NHS Spine. The London Borough of Lewisham is yet to go live.

6.1.10. LGT Trust was inspected by the CQC in March 2017. The inspection includes the category “Is the Service Safe?” Safeguarding is part of this dimension. The report will be published later in 2017.

6.2. South London and Maudsley NHS Foundation Trust (SLaM)

6.2.1. SLaM covers the CCG areas of Lambeth, Southwark, Lewisham and Croydon. The Director of Nursing is the Board lead for Safeguarding. The Trust is represented at Executive level by the Director of Nursing at the Local Safeguarding Children Board. The Trust Named Safeguarding Professional is proactive on local Safeguarding Boards and subgroups including Lewisham; to ensure the Trust is linked in at all levels to multiagency developments and assurance.

6.2.2. The CCG received regular safeguarding assurance reports from Lewisham CAMHS safeguarding lead during 2016.

6.2.3. A new, specific team, the Crisis Team was set up in May 2016. The Crisis team assess young people with serious and enduring mental health problems presenting at Lewisham Hospital ED. Previously, this work was carried out across the service by clinicians on a rota basis. With a dedicated team, a more coherent and continuous service can be offered, professional relationships developed and practices and protocols established, which enhance safeguarding processes through experienced clinicians and collaborative working. The funding for this service was supported by “Futures in Mind”.

6.2.4. SLaM Safeguarding training is in line with the intercollegiate guidance; all members of staff are required to undertake safeguarding children training. SLaM deliver training using the following strategy:

- Level 1 and 2 training is completed as part of the Trust Corporate Induction Programme for all new staff – completed once only.
- Level 1 updates - online for non-clinical staff
- Level 3 corporate training via face-to-face
In addition, Staff also access team based training and are encouraged to access LSCB multi-agency training.

6.2.5. The quarterly report presented to the CCG Safeguarding meeting indicated that, 100% of CAMHS staff are trained at level 1, 2 and 3. The training includes updated information on national and Trust arrangements and expectations. Key issues such as Female Genital Mutilation, Child Sexual Exploitation and lessons learned from Serious Case Reviews were also included in training.

6.2.6. SLaM Inter-agency working:

- GP’s are routinely copied into correspondence letters regarding service users of SLaM service.
- CAMHS staff routinely join TAC/TAF (Team around the Child/Family) meetings and other multi agency meetings
- CAMHS Symbol and ARTS team frequently work closely with Children’s Social Care carrying out joint assessments and consulting.

6.2.7. A concern that was highlighted for SLaM was the increase in the number of children on the waiting lists. In particular the generic service waiting times were high due to staffing and complexity of the cases. In 2017 the service will take part in a service transformation initiative called Choice and Partnership Approach (CAPA). As part of this transformation resources will be secured to tackle the unsustainable high waiting list. CAPA will streamline resources to offer a more collaborative, timely, effective and efficient service to children, young people and families. Through this change, safeguarding processes will be enhanced.

6.3. GP Services

6.3.1. Safeguarding arrangements in Primary Care remain strong. All General Practices in Lewisham have a Safeguarding Lead General Practitioner, who takes the lead for safeguarding in the practice. They receive supervision, training & support via a bi-monthly GP Safeguarding Leads meeting. The named General Practitioner receives regular supervision from the Designated Doctor for safeguarding.

6.3.2. Training:

The CCG provides Level 3 Safeguarding Children training for GPs and Practice Nurses. The training is facilitated by the Named GP supported by the Designated Doctor and Designated Nurse. Six sessions were delivered with an
average of 23 attendees at each session. The training package incorporated learning from local and national Serious Case Reviews. The feedback from practitioners were positive and indicated a request for more scenario based learning. This feedback has been incorporated into the revised 2016-2018 Level 3 GP Child safeguarding programme.

The training programme contents are revised two yearly. For 2016-2018 the GP level 3 safeguarding training includes scenarios to address learning on self-harm in children, a reflection of current SCRs, forced marriage, FGM, Prevent and physical abuse.

7. **Looked After Children (LAC)**

7.1. The term ‘Looked after Children’ (LAC) includes all children being looked after by a Local Authority, including those subject to a care order under Section 31 of the Children Act 1989 and those looked after on a voluntary basis through an agreement with their parents under Section 20 of that Act.

7.2. The CCG responsibility for the provision of LAC health assessments is set out in the statutory guidance “Promoting the Health and Well-Being of Looked After Children” (DH 2015) as well as the NICE guidance “Promoting the Quality of Life of Looked After Children and Young People” (2010).

7.3. As of 31/03/17 there were 438 children and young people looked after by Lewisham local authority, this is a slight decrease from 465 the previous year. In total 60.5% of this population was placed out of the borough. This is an increase in the numbers placed out of borough, as last year the ratio was 55.5% placed out of the borough. The increase is not in keeping with the Government recommendation to reduce the number of children placed out of borough nationally.

7.4. However, the table below demonstrates that the majority of the young people are placed less than 20 miles from the local Borough. For LAC placed over 20 miles away a Specialist Nurse LAC will assess them, if they are placed at a distance of approximately 2 hours travel. For LAC placed at a greater distance a commissioned service level agreement (SLA) between Lewisham and the area where the LAC is placed enables the receiving LAC health team to conduct the RHA. The CCG works with Children Joint Commissioning to facilitate this. Similarly, the LGT LAC health team may be asked by other Authorities/CCGs to conduct health assessments for children placed in Lewisham from other Boroughs or Counties. An invoice or payment is made.

<table>
<thead>
<tr>
<th>Placement Distance from Home (miles)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Placement Distance from Home (miles)</td>
<td></td>
</tr>
</tbody>
</table>
7.5. The reasons for admission into care when the child was classified as a child in need (CIN) have been tabled below:

<table>
<thead>
<tr>
<th>CIN when became LAC-1.4.16-31.3.17</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABSENT PARENTING</td>
<td>7</td>
</tr>
<tr>
<td>ABUSE OR NEGLECT</td>
<td>182</td>
</tr>
<tr>
<td>DISABILITY</td>
<td>8</td>
</tr>
<tr>
<td>FAMILY DYSFUNCTION</td>
<td>8</td>
</tr>
<tr>
<td>FAMILY IN ACUTE DISTRESS</td>
<td>8</td>
</tr>
<tr>
<td>SOCIALLY UNACCEPTABLE BEHAVIOUR</td>
<td>26</td>
</tr>
<tr>
<td>UNACCOMPANIED ASYLUM SEEKING CHILD</td>
<td>12</td>
</tr>
<tr>
<td>CH CASE NOT CIN</td>
<td>1</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>252</strong></td>
</tr>
</tbody>
</table>

7.6. Delivery of LAC health assessments remain under scrutiny and is reported monthly with narrative for each assessment not carried out within timescales. There is considerable fluctuation in the figures. Often the numbers of missed health assessments are small but have a significant impact on the percentage uptake for that month. This is why the narrative is important in explaining the exceptions. During 2016-2017 the Joint Commissioning team arranged regular meetings to discuss any issues which may be impacting on performance. The Designated Nurse for Looked After Children attends and contributes to these meetings.

7.7. Currently the provider Trust is monitored on their obligation to arrange and deliver health assessments (bi-annually for children under the age of five years and annually for children over the age of five years) which result in the development and implementation of a health action plan along with attendance at statutory review meetings. Initial Health Assessments (IHA) were not achieved within the timescales for a variety of reasons such as young person refusing to attend the health assessments, a delay in LAC health administrators receiving notification that the child had become looked after from social care and reduced capacity of health administrators.

7.8. The LAC Nurses held monthly drop-in session for Social Workers (SWs) since March 2016. The nurses offer the meetings to all SWs who hold LAC cases. The aim is to build on the established good working relationships, offer advice and health-related support and enable early intervention to be applied to any LAC. Over the year there is evidence of an improvement in a number of LAC health through the implementation of this service. On
average, approximately 30 LAC were discussed at each drop-in session and many SWs reported the benefits of this innovation.

### Summary of reporting

<table>
<thead>
<tr>
<th></th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
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<tr>
<td>2015-2016</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% LAC who have had IHA within 20 days of BLA</td>
<td>50%</td>
<td>82%</td>
<td>100%</td>
<td>80%</td>
<td>85%</td>
<td>57%</td>
<td>64%</td>
<td>77%</td>
<td>78%</td>
<td>44%</td>
<td>100%</td>
<td>58%</td>
</tr>
<tr>
<td>No. LAC who have had IHA within 20 days of BLA</td>
<td>8</td>
<td>9</td>
<td>8</td>
<td>11</td>
<td>10</td>
<td>6</td>
<td>11</td>
<td>16</td>
<td>21</td>
<td>0</td>
<td>4</td>
<td>15</td>
</tr>
<tr>
<td>No of IHA due in the month</td>
<td>9</td>
<td>12</td>
<td>11</td>
<td>12</td>
<td>11</td>
<td>13</td>
<td>20</td>
<td>23</td>
<td>1</td>
<td>7</td>
<td>20</td>
<td></td>
</tr>
</tbody>
</table>

### Key
- **BLA (Being Looked After)**
  - **Target 95%**
  - 7.9. From 1st July 2016, Unaccompanied Asylum-Seeking Children and Young People (UASC) arriving in Kent began to be dispersed to the on-going care of other Local Authorities, as advised by the UK Government. A National UASC Transfer Protocol has been devised by the DfES, Home Office, Association of Directors for Children’s Services ADCS and Local Government Association which sets out the agreed roles and responsibilities for Local Authorities, Central and Regional Admin teams. Lewisham borough expected to receive 28 UASC. It is still unknown when these young people are likely to arrive in the borough, or whether they will immediately require an Initial Health Assessment (IHA). The LGT LAC health team are awaiting an update from Kent as to the plans for dispersal.

### 8. Partnership

Partnership working remains a strong ethos for agencies in Lewisham. Following the Ofsted Single Inspection of Lewisham Children Services (Local Authority) a revision of the Multi-Agency Safeguarding Hub (MASH) was progressed as an action from the Improvement plan. CCG and Lewisham health providers contributes to the strategic MASH and Early Help forums. LGT safeguarding children advisors regularly contribute to the MASH process.

#### 8.1 LSCB

Lewisham LSCB executive meeting is attended by the Accountable Officer from the CCG and Chief Executives of provider health organisations. The main LSCB Board has robust representation from Safeguarding leads, senior management and Designated Professionals from Health organisations.

There is continued full representation from health on the various task groups of the LSCB
- Monitoring, Evaluation, and Service Improvement (MESI)
- Policies, Procedures and Training (PPT)
- Serious Case Review (SCR) and Case Review Panel (CRP)
- Child Death Review Panel
- Missing, Exploited and Trafficked (MET)

8.2 Joint Targeted inspections:
New Joint Targeted Area Inspections of services for vulnerable children and young people (JTAI) were launched in 2016. Inspectorates Ofsted, Care Quality Commission (CQC), Her Majesty's Inspectorate of Constabulary (HMIC) and Her Majesty’s Inspectorate of Probation (HMIP) are working together. The new short inspections would allow inspectorates to be more responsive, targeting specific areas of interest and concern. They will also identify areas for improvement and highlight good practice from which others can learn. Each inspection will include a ‘deep dive’ element.

During 2016, the theme was Child Sexual Exploitation and missing children. London Borough of Lewisham set up a JTAI group which included representation from LGT (Named Safeguarding Professional) and the CCG Designated Professionals, to examine the processes and arrangements to safeguard children at risk of exploitation in Lewisham. The theme for 2017 will be Neglect.

8.3 Serious Case Reviews/ Multi-Agency Reviews
8.3.1 The Croydon SCR R, S and W was published in January 2017. The SCR was jointly commissioned with Lewisham LSCB following serious injury to a young baby in 2015. The family had moved between several local authorities and had three children under the age of five. The family were living in Croydon at the time of the incident but were on a CP plan in Lewisham. Learning from the case relates to the assessment of neglect, role of early help in neglect and young parents.

8.3.2 SCR Child G. The SCR was commissioned following the suicide of a 13 year old girl in 2015. Learning from the SCR is in progress for LGT, GPs and SlaM. The final report has yet to be published, however early indicators highlight the need to recognise self-harm as a safeguarding issue.

8.3.3 SCR Child Z. The SCR was commissioned following the death of a young person with complex needs who was subject to Lewisham child protection processes. The final LSCB report is soon to be published.

8.3.4 NHS LGT links with three LSCBs including Lewisham. There has been an increase in the number of SCRs they contribute to. It was necessary to involve more practitioners in the process of writing the individual agency management reports (IMRs). In order to skill
practitioners up the CCG Designated Professionals developed an IMR report writing workshop for LGT.

8.4 Lewisham Child Death Overview Panel (CDOP) 5

The “Child Death Overview Panel” (CDOP) is a multi-agency sub-committee of the LSCB and is responsible for reviewing information on all child deaths. The CDOP report describes cases where there were modifiable factors and the actions taken to reduce risks for children.

The numbers of child deaths notified to the panel in 2016/17 was 21, the lowest annual number since reviews began in 2008. 28 child deaths were reviewed by the panel during the year. This is attributed to the number of child deaths for review carried over from the previous year.

As in previous years, the most common cause of death was extreme prematurity. Deaths of children with complex long-term conditions seemed to account for a significant proportion of deaths, and a small number of themes were discussed in the review of these deaths:

It would appear that these children are more vulnerable in the transition period from paediatric to adult services.

In some cases, parents and possibly practitioners may have difficulty in being able to recognise serious acute illness in children with very complex needs.
However, the panel have also reviewed deaths in which the parents were clearly experts in their child’s condition and their views were not always been appropriately considered by the teams caring for their child.

8.3.4 During 2016-2017 The CDOP Panel made three referrals to the Serious Case Review panel of the LSCB. Following consideration by the LSCB two of the cases progressed to SCR.

9. Summary

- The report demonstrates that Lewisham CCG continues to meet statutory obligations to safeguard Lewis ham’s children and young people.
- It further shows that governance arrangements are robust in health organisations across Lewisham, with Board accountability and a continued investment in improving services that support the safeguarding of children and young people.
- It is envisaged that there may be challenges in view of the changes to partnership working as outlined in the proposed Children and Social Work Bill.

10. Priorities for 2017-2018

i. CCG to work in partnership with the emerging Tri partnership for local safeguarding arrangements as proposed in the Children and Social Work Bill.

ii. Development of a joint adult and child level 3 safeguarding training package for General Practice Primary Care, for delivery from April 2018.

ii. Continue to work with partnership to prepare for thematic Joint Targeted safeguarding children inspections.

iii. Maintaining and improving safeguarding scrutiny and oversight to ensure robust safeguarding children arrangements are in place across the Lewisham health economy.

11. Recommendations

The Governing Body is asked to receive the safeguarding children report for information and assurance that effective safeguarding systems and processes are in place for Lewisham.

Maureen Gabriel  Designated Nurse Safeguarding and Looked After Children

Dr Abimbola Adeyemi – Consultant Community Paediatrician & Designated Doctor for Child Protection / Safeguarding Children
References


e. Working Together to Safeguard Children & Young People: A guide to inter-agency working to safeguard and promote the welfare of children 2015 HM Government


g. Promoting the health and well-being of Looked-after Children Statutory guidance for local authorities, clinical commissioning groups and NHS England Department for Education and Department of Health March 2015


k. Multi-Agency Practice Guidelines: Female Genital Mutilation
Appendix

Annual Reports informing Lewisham CCG Annual Safeguarding Children Report


   LGT 2016-17.pdf


   Ag 9 - CAMHS Safeguarding Children


   LAC ANNUAL REPORT 2016-17 (3)


   CDOP Annual Report 20162017 Final
A meeting of the Governing Body  
11 January 2018

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<td>CLINICAL LEAD: Fiona Mitchell</td>
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<tr>
<td>MANAGERIAL LEAD: Alison Browne</td>
</tr>
<tr>
<td>AUTHOR: Fiona Mitchell</td>
</tr>
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RECOMMENDATIONS:
The Governing Body are asked to approve the policy.

SUMMARY:
Safeguarding Supervision is an essential requirement to ensure that NHS Lewisham and Commissioned and Non-commissioned services fully understand and underpin the need to keep Adults and Children at risk safe and free from harm.

KEY ISSUES:
The purpose of this policy is to set out the arrangements for and the approach to the provision of effective Safeguarding supervision for both the Clinical Commissioning Group and commissioned services. Safeguarding Supervision is focused on and concerned with issues in relation to supporting individuals to ensure that they are competent to safeguard and promote the welfare of vulnerable adults and or children.

Function:
- Education: Professional development of staff
- Supportive: Helping staff to deal with the difficulties of safeguarding situations
- Management: Accountability and adherence to policies, practices and services
- Mediatory: Negotiating inside and outside of the organisation for resources and services

CORPORATE AND STRATEGIC OBJECTIVES
To ensure Quality is at the heart of service delivery.

CONSULTATION HISTORY INCLUDING MEMBERS ENGAGEMENT:
- NHS Lewisham CCG Safeguarding Team Adults and Children.
- NHS Lewisham CCG Integrated Governance Committee

PUBLIC ENGAGEMENT
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<tr>
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<td>Name: Fiona Mitchell  <a href="mailto:fiona.mitchell19@nhs.net">fiona.mitchell19@nhs.net</a></td>
</tr>
<tr>
<td>AUTHOR CONTACT:</td>
<td>Name: Alison Browne  <a href="mailto:alison.browne@nhs.net">alison.browne@nhs.net</a></td>
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Policy for Safeguarding
Supervision with commissioned and non-commissioned services
including NHS Lewisham Clinical Commissioning Group
(Relates to Safeguarding Adults at Risk and Children)

<table>
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</tr>
<tr>
<td>Reviewed by:</td>
<td>Integrated Governance Committee</td>
</tr>
<tr>
<td>Date:</td>
<td>23rd November 2017</td>
</tr>
<tr>
<td>Name of originator/author:</td>
<td>Karen Bates</td>
</tr>
<tr>
<td>Name of reviewers</td>
<td>Fiona Mitchell</td>
</tr>
<tr>
<td></td>
<td>Maureen Gabriel</td>
</tr>
<tr>
<td>Name of responsible committee/ individual</td>
<td>CCG Safeguarding Assurance</td>
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<td>Effective from:</td>
<td></td>
</tr>
<tr>
<td>Review date:</td>
<td>2018</td>
</tr>
<tr>
<td>Target audience:</td>
<td>CCG employees and All CCG Commissioned and non-commissioned Health Services</td>
</tr>
</tbody>
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Public Sector Equality Duty

The general equality duty requires public sector bodies, in the exercise of their functions, to have due regard to the need 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

Staff should be alerted to the increased likelihood of harm being suffered by disabled children, young people and vulnerable adults, along with those living in special circumstances, whose needs may not be recognised by staff employed in providing services.

Equality Statement –

Lewisham Clinical Commissioning Group aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. It is recognised that some people can suffer disadvantage as a result of discrimination and this can increase vulnerability.

Safeguarding Adult and Children’s procedures support all Adults and Children at Risk who may be or are abused and is also aimed at preventing abuse occurring.

It is every person’s right to live a life free from abuse and neglect. Adults and Children at Risk will be treated in a way that respects and promotes the human rights of all citizens under the Human Rights Act 1998.

Actions taken within the policy aim to protect an individual’s interests and to respect their dignity, privacy and beliefs, whatever their race, religion, language, gender, disability, age or sexual orientation.

However, we do recognise that certain population groups may be more vulnerable than others; most pertinently those persons who are unable (by virtue of physical and / or mental disability) to express their choice directly and those who do not possess the Mental Capacity to make informed choice over significant decisions in their life. This CCG positively embraces the needs of such persons as being of a paramount consideration in the development of this policy.

Any individual’s communication needs will be considered at all times.

Equality Act 2010 - The Equality Act provides protection from direct or indirect discrimination; harassment and victimisation for people with a ‘protected characteristic’ that relate to: disability, gender reassignment, pregnancy and maternity, race, religion belief or non-belief, sex, sexual orientation and age.
Executive Summary

Safeguarding supervision is an essential requirement to ensuring that commissioned and
non-commissioned services fully understand and underpin the need to keep Adults and
Children at Risk safe and protected them from harm. The NHS Lewisham Clinical
Commissioning Group will encourage and support safeguarding supervision. The planning
and delivery of supervision sessions for staff must be resourced and the supervisor allocated
time in order to meet the identified supervision needs of the safeguarding team. The NHS
Lewisham CCG considers that supervision is intrinsically linked to quality. Refusing
safeguarding supervision may have an impact on quality and safety and will be escalated to
the Executive lead for safeguarding in the CCG and relevant Designated Professionals.

1. Policy Statement

NHS Lewisham Clinical Commissioning Group recognises the importance of the provision of
safeguarding supervision and guidance. Safeguarding supervision is an essential
requirement to ensuring that staff within commissioned and non commissioned services fully
understand and underpin the need to keep vulnerable adults and children and protect them
from harm. Provider Health organisations should have an organisational Safeguarding
Supervision policy as described in the CCG Safeguarding Through Commissioning policy.

2. Purpose

The purpose of this policy is to set out the arrangements for and approach to the provision of
effective Safeguarding supervision for both the Clinical Commissioning Group and
commissioned services and non-commissioned services. Safeguarding supervision is
focused on and concerned with issues in relation to supporting individuals to ensure that
they are competent to safeguard and promote the welfare of vulnerable adults and or
children.

2.1 Functions of Supervision

Education: Professional development of staff
Supportive: Helping staff to deal with the difficulties of safeguarding situations
Management: Accountability and adherence to policies, practices and services
Mediatory: Negotiating inside and outside of the organisation for resources and services

3. Scope

This policy applies to all nominated safeguarding leads within commissioned services and
non-commissioned services and the NHS Lewisham CCG and those staff who have been
advised by their organisations to participate when appropriate. The content of this policy
does not preclude any practitioner from seeking advice at any time from the Designated
Professionals for Safeguarding Adults and Children at NHS Lewisham Clinical
Commissioning Group.

4. Definitions

4.1 Individual Supervision

Individual supervision is provided for any member of staff as a booked session. This form of
tailored supervision is for staff where they have concerns about a vulnerable adult and
needs direct communication. Individual supervision is arranged by the supervisee when s/he
feels able to address how a case has impacted on them. Although the supervisor will be
aware of on-going cases and the impact these have on individual staff, the supervisor cannot initiate safeguarding supervision. However the supervisor can initiate ‘checking-in’ with the relevant supervisee. The supervisor will continue to offer individual safeguarding supervision whilst difficult cases are being progressed until the time of closure of the concern.

In reference to individual cases, safeguarding supervision helps practitioners to keep a focus on the vulnerable person, to avoid any delay in action, to maintain objectivity and to feel supported and understood with regard to the emotional impact of the work on the employee.

4.2 Group Supervision

Group supervision (peer supervision) can be based on a specific topic or a “case”. group safeguarding supervision is defined as “A negotiated process whereby members come together in an agreed format to reflect on their work by pooling their skills, experience and knowledge in order to improve both individual and group capacities” (Morrison 2001).

Benefits of group supervision include:

- It promotes a culture of team/peer support and accountability.
- It expands the skills pool and knowledge base.
- The diversity of the group widens perspectives.
- It enables a focus on a process as well as a task.
- It is a source of emotional support from peers.
- It increases options, ideas and innovations.
- It fosters a sense of group or team cohesion.

All staff involved in safeguarding children and adult at risk will have access to advice and support from designated persons, managers and from named and Designated Safeguarding Adult and Children professionals. Successful supervision is important in promoting good standards of practice and to supporting individual staff members in protecting adults and children at risk from harm.

4.3 Safeguarding Supervision for Named and Safeguarding Lead Professionals

4.3.1 In addition to any internal supervision the Safeguarding Lead/ Designated Professionals will offer supervision sessions for the Named Nurses/Doctors for Safeguarding within provider Trusts. In the event that the Named Professionals choose not to access supervision from the Designated/Lead Professionals assurances must be provided of the arrangements in place to ensure the Named Professionals receive this valuable support.

4.3.2 Providers commissioned by LCCG are expected to have relevant supervision policies in place which recognise the need for relevant staff in their employment e.g. Accident and Emergency departments, Health Visitors, Paediatric Nurses, School Nurses, Family Nurse Partnership, Mental Health Practitioners to name a few to receive the required levels of child/adult safeguarding supervision. (Safeguarding through Commissioning Policy LCCG vs6 2016)

4.3.4 These arrangements will be over seen by the Designated Adult and Children Professionals in conjunction with Director of Nursing and Quality. Audits of compliance should form part of the safeguarding dashboard.

4.3.5 Local arrangements for Child Safeguarding
The Designated Doctor and Nurse for Safeguarding Children will deliver safeguarding supervision to safeguarding specialists within provider organisations.

As important as it is for those health professionals involved in child protection work to receive support for their work and have an opportunity to develop their work, it is doubly so for the Named and Designated Professionals. The casework load is often more complex and challenging and there are issues relating to the extended safeguarding role implicit in the job description which need to be discussed and addressed. There are also issues which may be confidential to these particular roles which cannot be discussed in a peer review setting.

The Designated Nurse for safeguarding undertakes to provide supervision to the Named Nurse and Named Midwife on at least a 2 monthly basis.

The Designated Doctor for safeguarding undertakes to provide supervision sessions on a three monthly basis for the Named Doctor.

The Named GP will receive safeguarding supervision from the Designated Doctor.

There are two aspects to this supervision:

- The majority of clinical discussion of cases is best facilitated in the Peer Review setting, but the difficult, complex or politically sensitive cases could be discussed here.

- Secondly there is supervision of the wider roles for a Named Doctor, Nurse and Midwife, including working relationships within and between agencies, interagency issues and management issues within the context of the roles and responsibilities of the Named Professionals.

A supervision agreement should be completed by the professionals concerned (Named and Designated Doctors, Nurses and Midwife) and records kept as a summary of those meetings.

It would be advantageous for Directors to occasionally access these sessions, the Trust Boards can be further assured of the close and efficient working of the leads for Safeguarding within the organisations.

4.3.6 **Designated Adult Safeguarding Professional**

- Provides advice on adult safeguarding case-focused support and supervision for health staff at all levels within organisations across the health community that deliver health services.

- Provide supervision for Named Professionals across the health community, or ensure they are receiving appropriate supervision from elsewhere.

- To provide mentoring as required to the Named Doctors and Executive Leads as required.

- Receives supervision on a regular basis either internally or ensures they are receiving appropriate supervision from elsewhere.

4.3.7 **Primary Care**

- GPs, Practice Nurses, Dentists, Dental Nurses, Pharmacists and Optometrists should seek safeguarding supervision/advice as required to discuss individual cases. These professionals should have access to their GP Safeguarding Leads, Named
GPs, Designated Professionals or Safeguarding Advisors, depending on local arrangements.

**Supervision may take the form of:**

- Contracted and planned safeguarding supervision which is recorded with clear action planning,
- Supervision and professional support within established professional meetings
- 1:1 face to face and/or telephone contact mentorship
- Shadowing – within peer groups and/or with external bodies e.g. Department of Health, Care Quality Commission

**4.4 Confidentiality**

**Supervision is a confidential process, with the following exceptions:**

Information shared through the supervision process may need to be disclosed to other professionals or agencies in order to protect the Adult or Child at Risk from significant harm.

- If there are issues regarding professional competence, unsafe of poor practice, which cannot be resolved within the supervisory relationship this will be discussed with the Supervisee and a decision, taken as to how this issue will be resolved. This may involve consultation outside of the supervision with the supervisee’s line manager.

- If a serious concern is highlighted in regard of a professional working with vulnerable person this must be discussed with the local Authority designate officer (LADO, Head of Safeguarding).

**To be a good supervisor/supervisee you need to:**

- Plan a joint agenda (e.g. review previous supervision notes before meeting and make a note of issues you wish to raise)
- Openly discuss real issues
- Attend regular sessions at agreed dates and times and be on time
- Raise problems and issues before they get serious, e.g. in relation to potentially violent service users
- Do what you say you will do
- Keep up to date with related reading around legislative changes, policy and procedures
- Keep up to date with related reading around research and theory related to service user’s needs
- Use supervision to reflect on your understanding and application of knowledge, theory and your skills, and how this has an impact on outcomes for the service user
- Use supervision to reflect on how you promote the values of anti-oppressive behaviour
Note: Line Managers

It is the responsibility of the line managers to address any managerial issues arising from supervision.

CCG Responsibilities

The CCG will ensure that staff are allowed appropriate time and support to fulfil the requirements of the supervision process and to ensure that staff who provide (and receive) safeguarding children and adult supervision are appropriately qualified, in receipt of appropriate continual professional development and arrange their own regular supervision.

Monitoring Compliance

Monitoring Compliance The Designated Professionals will keep records to confirm that supervision has taken place.

The CCG will request information on provider supervision compliance and audit data.

5. Duties and Responsibilities of NHS Lewisham Clinical Commissioning group

5.1 The Accountable Officer

Ensures that the responsibility to safeguard and prevention of harm to Adults and Children at Risk is discharged effectively across the whole health economy through Lewisham CCGs commissioning arrangements.

Within the Lewisham CCG ultimate accountability for safeguarding resides with the Accountable Officer who will delegate the discharge of his responsibility for safeguarding to the Governing Body Lead (Clinical Director).

5.2 The Governing Body Lead Clinical Director Lead for Safeguarding

The Governing Body Lead (Clinical Director) will be the board executive for safeguarding and will be accountable to NHS Lewisham CCG Governing Body for providing assurance that the range of safeguarding statutory duties are discharged and all responsibilities met.

The Governing body lead will be responsible for ensuring that the organisation from which the CCG contracts or commissions services, provide a safe system that safeguards Adults and Children at Risk. This includes the CCG’s having an 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.

5.3 Nurse Director

The Nurse Director will be responsible for the management of the Designate Safeguarding Adults and Children's team support the Governing Body Lead (Clinical Director) to undertake his role.

5.4 Designated Safeguarding Adult and Children Professionals

- It is the role of the Designated Professionals to take the professional lead for Safeguarding supervision and to provide relevant advice and expertise to individuals.
Produce a Supervision policy for the health community which provides direction and options for supervision models, as appropriate to need.

Co-ordinating safeguarding supervision compliance measures and reporting these as required to both the CCG and external organisations as requested.

To ensure the effectiveness of arrangements for supervision and to demonstrate evidence of this including agreed audits on a regular basis.

The review this policy and the production of any supplementary practice guidance.

5.5 Supervision for the CCG Designated Safeguarding Professionals

Should receive regular safeguarding adult/child protection supervision/peer review and undertake reflective practice from outside the employing organisation (this should be funded by the employing organisation and be provided by someone with safeguarding/child protection expertise).

The Designated Professionals should also receive supervision at a strategic level. This is achieved through regular meetings with the Safeguarding lead from the Commissioning body and peer support from the Health Safeguarding Operational monthly meeting.

6. Support and Guidance to Staff

Safeguarding supervision will:

- Provide the opportunity for discussion of personal experience and the testing of ideas incorporating reflective practice.
- Enable the practitioner to express both positive and negative feelings that they may have towards cases. Consideration should be given to the effect of fear or anxiety on current work and perceptions.
- Discussion and sharing of responsibility will help to reduce stress and anxiety in practitioners.
- Allow the discussion of inter-professional relationships with team members and professional colleagues.

6.1 Ad-hoc supervision

It is recognised that staff will often require advice or support in relation to safeguarding outside of formal supervision sessions. In the first instance they should approach the safeguarding organisational lead, who will record the information discussed and the actions agreed. All staff should have access to ad hoc supervision for urgent and routine work, which should be recorded by the supervisor for quality assurance purposes and by the supervisee in the relevant documents. This type of supervision will not involve a contract of supervision.

7. The Process/ Safeguarding Supervision Agreements Specialist 1:1/Group Supervision

All staff who receives regular supervision will complete a written agreement with their Safeguarding supervisor. This agreement will identify the roles and responsibilities of both the supervisor and supervisee (Appendix 1 or 2). The agreement:

- Reflects the seriousness of the activity.
- Represents a positive modelling of behaviour.
ensures the supervisee is aware of his/her responsibilities and roles within supervision.

- Provides a basis for renewing and developing the supervisory relationship.
- Promotes the interests of the Vulnerable individual, children and young people and staff accessing Safeguarding supervision.
- Ensures that the standard of supervision afforded to the staff by the provider is of an appropriate quality.
- Places a duty of staff to demonstrate continuing development (Adapted from Morrison 2001)

8. Documentation/Record Keeping

A group (Appendix 2) or individual (Appendix 1) supervision agreement will be signed by the supervisor and all supervisees at the start of the supervision session. The supervisor should keep a copy. All supervisee’s should keep a copy and a copy should be available to line managers on request. Supervision must be recorded using supervision tools identified.

The safeguarding supervision form (Appendix 3) will be completed by the supervisor when giving telephone advice or direct face to face supervision to the supervisee. The supervisor should keep a copy and forward a copy to the supervisee. A copy should be made available to the supervisee’s Line Manager on request.

The supervisor must complete the supervision monitoring form (Appendix 4) upon completion of the supervision. The supervisor should keep a copy, the supervisee should keep a copy and a copy should be made available to the supervisee’s Line Manager on request.

Supervision Matrix

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<th>Supervision Type</th>
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<td>Named GP</td>
<td>Designated Doctor</td>
<td>Individual</td>
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<td>Designated Professionals CCG</td>
<td>Individual</td>
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<td>Specialists</td>
<td>case advice</td>
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</table>

Page 150
This policy is underpinned by the findings and recommendations from legislation, guidance and reports including:

- Royal College of Paediatrics and Child Health: Safeguarding children and young people:
  - Roles and competences for health care staff - Intercollegiate document, March 2014
- Health Care Act 2014
- No Secrets (2000)
- Department of Health & Department Education and Skills (2004)
Appendix 1 Example:
Individual Supervisory Agreement
Safeguarding supervision is a supportive and enabling means of encouraging professionals to reflect on their practice. It takes place in a safe environment and optimises the learning for practitioners to be confident within their practice in relation to safeguarding Adults at Risk and Children. It involves:
• A discussion combined with analysis of perceived safeguarding concerns.
• A discussion to share and analyse concerns where issues of vulnerability/need are causing concern for the practitioner.

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<td>Frequency</td>
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<td>Length</td>
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<td>Venue</td>
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<tr>
<td>Specific needs</td>
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<tr>
<td>Confidentiality</td>
<td>For example: Confidentiality is respected unless a risk to practice or an adult at risk is identified and accountability issues are raised. In this instance the issue will be raised directly with the supervisee prior to contacting the relevant manager/team leader.</td>
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<tr>
<td>Professional Responsibility</td>
<td>For example: The identification of cases to bring to supervision lies with the practitioner.</td>
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<td>Commitment</td>
<td>For example: To be given priority to enable safe practice.</td>
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<tr>
<td>Documentation</td>
<td>For example: A copy of supervision monitoring form should be kept by both the supervisor and the supervisee.</td>
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Proposed venue(s) and Agreement Date........................................................................................................
Agreement Review Date ........................................................................................................................................
Frequency ..............................................................................................................................................................
Duration ....................................................................................................................................................................
Supervisee ...............................................................................................................................................................
Supervisor .................................................................................................................................................................
Appendix 2 Example:

**Group Supervisory Agreement**

Safeguarding Supervision is a supportive and enabling means of encouraging professionals to reflect on their practice. It takes place in a safe environment and optimises the learning for practitioners to be confident within their practice in relation to safeguarding Adults at Risk. It involves:

- A discussion to share and analyse concerns where there are perceived safeguarding concerns.
- A discussion to share and analyse concerns in relation to Adults at Risk and Children where issues of vulnerability/need are causing concern for the practitioner.

<table>
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<tr>
<th>Practicalities</th>
<th>For example: Are the sessions meeting your needs?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Review as required</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Frequency</strong></td>
<td>For example: 3 monthly.</td>
</tr>
<tr>
<td><strong>Supervision can be sought between sessions.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Length and specific needs</strong></td>
<td>For example: 1 – 1 ½ Hours</td>
</tr>
<tr>
<td><strong>Venue</strong></td>
<td>For example: To suit practitioner and supervisor</td>
</tr>
<tr>
<td><strong>Confidentiality</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Professional Responsibility</strong></td>
<td>For example: The identification of cases to bring to supervision lies with the practitioners</td>
</tr>
<tr>
<td><strong>Commitment</strong></td>
<td>For example: To be given priority to enable safe practice.</td>
</tr>
<tr>
<td><strong>Documentation</strong></td>
<td>For example: A copy of supervision monitoring form should be kept by both the supervisor and the supervisee.</td>
</tr>
</tbody>
</table>

Proposed venue(s) and Agreement Date…………………………………………………………………………………………

Agreement Review Date ……………………………………………………………………………………………

Frequency ……………………………………………………………………………………………………………………………

Duration ………………………………………………………………………………………………………………………………

Supervisee ……………………………………………………………………………………………………………………………

Supervisor…………………………………………………………………………………………………………………………
Appendix 3 Example Supervision Record

<table>
<thead>
<tr>
<th>Safeguarding supervision record</th>
<th>Supervisor signature</th>
<th>Supervisee signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>Designation and contact details</td>
<td>Background concern and summary</td>
</tr>
</tbody>
</table>

A record of the supervision will be kept as a record of the supervision and discussed at the stage of agreement. This is for summary and background only and in agreement with the supervisee. Records will be maintained for both parties. The importance of appropriate storage of confidential material will be highlighted.
## Appendix 4 Example Monitoring of Supervision

<table>
<thead>
<tr>
<th>Name of Supervisee(s) and location</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Name of Supervisor and location</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of Supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Length of Supervision (in minutes)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Safeguarding Supervision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group □ Individual □</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date of last Mandatory Safeguarding Training Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name(s)</td>
</tr>
<tr>
<td>Date:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature of Supervisee(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature of Supervisor</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>
To be a good supervisor/supervisee you need to:

- Plan a joint agenda (e.g. review previous supervision notes before meeting and make a note of issues you wish to raise)
- Openly discuss real issues
- Attend regular sessions at agreed dates and times and be on time
- Raise problems and issues before they get serious, e.g. in relation to potentially violent service users
- Do what you say you will do
- Keep up to date with related reading around legislative changes, policy and procedures
- Keep up to date with related reading around research and theory related to service user’s needs.
- Use supervision to reflect on your understanding and application of knowledge, theory and your skills, and how this has an impact on outcomes for the service user.
- Use supervision to reflect on how you promote the values of anti-oppressive behaviour

Note: Line Managers
It is the responsibility of the line managers to address any managerial issues arising from supervision.
Report from the Chair of the Strategy & Development Workshop
Date of Meeting(s) reported: 7\textsuperscript{th} December 2017
Author: Dr David Abraham

Main Issues discussed

The primary aims of the workshop were to review current evidence and outcomes for the CCG’s assessment against the NHS Equality Delivery Systems (EDS2) four goals, how the CCG is meeting the Public Sector Equality Duty (PSED), and to review updates to the CCG Equality & Diversity Strategy and Equalities Objectives. The workshop also reflected on the recent board-to-board meeting with South London and the Maudsley NHS Foundation Trust (SLaM).

- **SLaM Board to Board Reflections**

  The draft notes and actions from the meeting held on 1\textsuperscript{st} November were reviewed, and CCG leads for each of the actions and commitments were identified.

- **EDS Goals 1 & 2**

  These goals are concerned with health outcomes, and with access to services and patient experience. The committee reviewed the conclusions from the stakeholder grading session that looked at the Ambulatory Care Unit, Hospital at Home for Children, Mindcare Dementia and Information Service. Stakeholders included representatives from Healthwatch, the CCG Public Reference Group, as well services users, providers and commissioners.

- **EDS Goal 3**

  This goal covers the representativeness of and support to the CCG workforce. The workshop looked at the provisional gradings for the goals covering fair recruitment and selection processes and equal pay, and all of the gradings will be finalised when the outcomes of the latest staff survey are available.

- **EDS Goal 4**

  This is concerned with the inclusive leadership. The committee looked at evidence of how members of the Governing Body are demonstrating inclusive leadership, and agreed the process for collecting further examples to support the independent assessment of the Goal 4 standards.

- **CCG Equality & Diversity Strategy & Equalities Objectives**

  The workshop received the draft updated Equality & Diversity strategy for the CCG which includes revised equalities objectives. The workshop discussed the alignment of revised objectives with the EDS goals, the outline areas, and their timeframes.
• Public Sector Equality Duty

The committee reviewed the three general duties for the CCG as commissioners, and the case studies that would be included in the CCG’s annual equality report, as well as identifying further examples.

Achievements

There were many instances where the CCG is demonstrating that it is fulfilling its equalities responsibilities to eliminate discrimination, advance equality of opportunity, and foster good relations. The CCG has established sound processes through which the EDS and other standards used to manage and monitor its responsibilities.

Challenges

Particularly through the review of EDS Goals 1 and 2 and draft equalities objectives, the committee identified the need for the CCG to have access to and to use more detailed data regarding protected characteristics. This would help to ensure that services are commissioned, procured, designed and delivered to meet the health needs of local communities.

Inequality & Fairness

All aspects of the workshop were concerned with how the CCG is addressing inequalities and fairness.
A meeting of the Governing Body  
11th January 2018

EQUALITY AND DIVERSITY UPDATE REPORT  
ANNUAL EQUALITY REPORT 2017

<table>
<thead>
<tr>
<th>CLINICAL LEAD:</th>
<th>Dr David Abraham</th>
<th>Senior Clinical Director</th>
</tr>
</thead>
<tbody>
<tr>
<td>MANAGERIAL LEAD:</td>
<td>Charles Malcolm-Smith</td>
<td>Deputy Director (Strategy &amp; Organisational Development)</td>
</tr>
</tbody>
</table>

| AUTHOR: | Valerie Richards | Equality & Diversity Lead, NEL Commissioning Support Unit |

RECOMMENDATIONS:

The Governing Body is asked to:

- To approve the Lewisham CCG Annual Equality report to be published by 31 January 2018.
- Note progress updates in the following areas:
  - Equality Delivery System2 (EDS) process for 2017
  - NHS Workforce Race Equality Standard (WRES) – CCG responsibility internally and externally (Providers)

SUMMARY:

Under schedule 1 of the Equality Act all public bodies including CCGs must:

- Publish equality objectives every four years from October 2013.
- Publish information as to how they are meeting the general duties (Public Sector Equality Duty - PSED) for 31 January every year.

It is also good practice to have an Equalities and Diversity Strategy in place.
KEY ISSUES:

1. Background and purpose

1.1 In March 2017, the Governing Body received a report on the completion of the EDS2 2016/17 process and approved Lewisham EDS2 Summary Report.

1.2 This report provides an update on the following:

- Lewisham CCG 2017 Annual Equality Report (requesting approval)
- Equality Delivery System2 (EDS) process for 2017
- NHS Workforce Race Equality Standard (WRES)


2.1 In compliance with the Public Sector Equality Duty (PSED), all CCGs must publish relevant, proportionate information that demonstrates how the organisation has used the Equality Duty as part of the process of decision making in the following areas:

- Service delivery - evidence of equality impact analysis that has been undertaken
- Information - details of information taken into account when assessing impact
- Consultation - details of engagement activity that has taken place

2.2 The Annual Equality (PSED) report (Appendix 1) is Lewisham CCG’s fifth and covers the period January 2017 – January 2018.

The report focuses on how the CCG has met the three aims of the General Duties of the Equality Act 2010, to eliminate discrimination, advance equality of opportunity and foster good relations between those people who share a protected characteristic and those people who do not. The report also covers how equality is embedded into the CCG commissioning cycle, Equality Delivery System Implementation, Partnership working and commissioning, Patient and Public Engagement.

2.3 The report gives the results of the EDS2 2017 up to December 2017. As described in point 3 below, all four Goals of the EDS are to be completed before the end of the financial year (March 2018) and published in the 2017 EDS2 Summary Report.

2.4 The report is presented to the Governing Body as a draft because there are a number of items highlighted to be added and to give members an opportunity to comment or make suggestions about its content. Case study authors have been asked to provide additional content on how the service or project is meeting the three aims of the PSED. After the Governing Body meeting a final version of the report will incorporate all items and comments.

2.5 It is proposed that the report is approved by Chair’s Action and published on the Lewisham CCG website by 31 January 2018.
3. Lewisham Equality Delivery System Process in 2017

3.1 Equality Delivery System2 (EDS2)

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

3.2 Goals 1 and 2 (EDS2) progress

Goal 1: Better Health Outcomes
Goal 2: Improved Patient Access and Experience

The CCG chose the following three areas upon which to focus the EDS (Goals 1 and 2),

- Ambulatory Care Service
- Lewisham MindCare – Dementia and Information Service
- Hospital at Home for Children

The NELCSU ED Lead worked with CCG Case Study commissioners to gather evidence to be assessed by an invited panel of external stakeholders. The CCG Public Reference Group and local people were invited to join the EDS2 External Stakeholder Panel because they had a connection to one of the services or represented local communities.

3.3 Lewisham CCG EDS2 Grading External Stakeholder Panel – 27 September 2017

The EDS2 Grading External Stakeholder Panel reviewed the above mentioned services.

All services were robustly critiqued during the event and areas of good practice, excellent patient experience and good outcomes were revealed. However, there were also other areas regarding lack of evidence of accessing the services and patient experience that require attention. The results of the Panel event were presented to and discussed by the Strategy and Development Committee as its meeting on 7 December 2017. It was proposed at this meeting that the CCG develops an Equality Objective regarding Providers collection and analysis of patient access and experience data.

3.4 EDS2 Goal 3 – Next Steps to complete the process

Goal 3: A Representative and Supported Workforce

The CCG takes part in NHS National staff survey that includes four of Goal 3 Outcomes and was carried out in November/December 2017. The results of the Staff Survey will be reviewed in February 2018.

3.5 EDS2 Goal 4 – Next Steps to complete the process

Goal 4: Inclusive Leadership
3.6 EDS2 2017 Summary Report – NHS England EDS2 Dashboard

An EDS2 Summary report with details of the process and evidence reviewed will be submitted to the CCG Governing Body for approval, and then published on the CCG website with the link to the report put on the NHS England EDS2 Dashboard by 31 March 2018.

4. NHS Workforce Race Equality Standard (WRES) – CCG responsibility

4.1 This initiative, launched in 2015, requires NHS organisations to demonstrate their work towards reducing differences between the experiences and treatment of white staff and black and minority ethnic (BME) staff. The Workforce Race Equality Standard is a response to research that shows there is a strong link between having a diverse NHS workforce, in which all staff members’ contributions are valued, and good patient care.

4.2 CCGs need to demonstrate that they are giving due regard to using the indicators (metrics) contained in the Workforce Race Equality Standard to help improve workplace experiences, and representation at all levels within their workforce, for Black and Minority Ethnic staff.

4.3 Lewisham CCG has gathered data against the nine WRES metrics for 2017. The data does not have to be published due to the small numbers reported and to protect staff identity under the Data Protection Act. However, the CCG has agreed to publish in its annual equality report the metric regarding BME staff in bands 8-9 and VSM (Very Senior Management) and Governing Body membership compared to the workforce overall.

4.4 Analysis

The report shows that percentages of BME staff in bands 8-9 and VSM and of Governing Body members are less than in 2016 and less than the CCG representation of BME employees in the CCG’s workforce.

The CCG has noted that both BME figures also do not reflect the percentage of BME people in the Lewisham population. A WRES action plan is being delivered to improve the percentages/representation of BME staff at senior levels and Board membership.

4.5 Workforce Race Equality Standard in Lewisham CCG’s Providers

Since 2015-2016, all CCGs need to demonstrate that they are giving “due regard” to using the WRES indicators, and assurance that their Providers are implementing the WRES.
An analysis of performance across the CCG’s Providers in 2015 has been reviewed by the CCG Equality and Diversity Steering Group.

In 2017, the CCG’s Clinical Quality Review Group will receive reports from Providers who are expected to:

- Carry out a comparison of baseline data from April 2015 with April 2016 including steps underway to address key shortcomings in data, or significant gaps between the treatment and experience of white and BME staff.
- Publish WRES data for March 31st 2018 on Trust web site and share with Board and staff.

4.6 WRES Guidance states that Boards will want to consider:

**Taking appropriate note of Indicator 9:** Boards are expected to be broadly representative of the population they serve when considering renewing non executive members terms of office or appointing new members.

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**CORPORATE AND STRATEGIC OBJECTIVES**

The report relates to the statutory duties of the CCG.

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**CONSULTATION HISTORY**

- CCG management team; Strategy & Development Workshop

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**PUBLIC ENGAGEMENT**

- Key stakeholders and partners, including Lewisham Healthwatch, Lewisham CCG Public Reference Group and Public Health were involved in the development of the draft equalities objectives and EDS gradings.

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**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 report summarises how the CCG is meeting its Public Sector Equality duties.

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This report was commissioned by NHS Lewisham Clinical Commissioning Group and produced by the Equality, Diversity & Inclusion Manager for the NEL Commissioning Support Unit. If you would like more details on any of the contents, or extra copies of this document, please contact the CCG Lead or CSU Lead.

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Acknowledgement: Thanks go to all colleagues from Lewisham Clinical Commissioning Group and NEL Commissioning Support Unit who contributed to this report.
1. Foreword

During 2017 Lewisham CCG has continued to work in and across the borough and South East London with our partners to develop integrated services for the population of Lewisham to improve health and care outcomes and reduce inequalities.

Throughout the year we have monitored our performance against the NHS Constitutional Standards and the areas covered in the Improvement and Assessment Framework for CCGs. Disappointingly, like many other CCGs, we have continued to experience particular challenges to meet the recovery plans for the national standards for accident and emergency 4 hour target, cancer waiting times, and referral to treatment times.

We recognise that these areas must be our highest priorities for improvement for 2018, particularly for urgent and emergency care. Compared with these challenges, there have been successes in a number of key health areas including improvements in the care of diabetes related leg ulcers; improvements to the District Nursing service; and the opening of a new Ambulatory Care Centre at University Hospital Lewisham.

It has been necessary for the CCG to change the way in which some health services have been available or delivered in Lewisham. Before any decisions are made about changes to services the CCG has ensured that Lewisham’s population has had an opportunity to give their views to inform the planning and redesign. In this report we set out how consultations have taken place ensuring Lewisham’s communities have taken part, as we continue to value comments from and debates with local people to help shape and improve local services as we take steps to make them more personalised.

We are fortunate to have a history of strong partnerships with Lewisham Council, NHS providers, the voluntary and community sector and others and we will continue to work together to deliver the changes and improvements that are required.

This report brings together evidence, activities and recommendations that demonstrate how Lewisham CCG has continued to maintain its equalities performance in 2017.

Highlights of achievements in 2017 include:

- Ambulatory Care Service, Lewisham MindCare – Dementia and Information Service and the Hospital at Home for Children all were assessed using Goals 1 and 2 of the NHS Equality Delivery System (EDS), an equality assessment tool-kit that helps NHS organisations to identity good practice and identify gaps or areas that require improvement.
- Equality Analyses have been completed to improve decision making in changing the prescribing of over the counter medicines, the future of the NHS New Cross Walk-in Centre and the revision of South East London Integrated Urgent Care Service.
- The CCG has continued to widen its engagement reaching more communities in the Borough facilitating many diverse groups to have their say on Lewisham and south-east London developments.

Many thanks to our member practices and all of Lewisham’s NHS and care staff, for the excellent hard work they do to treat, care for and support local people and to all the clinicians and staff who continue to be at the heart of clinical commissioning in Lewisham and who are committed to getting it right for our diverse population.
2. Introduction

The Equality Act 2010 provides a legal framework to strengthen and advance equality and human rights. The Act consists of general and specific duties:

The general duty requires public bodies to show due regard to:

- Eliminating unlawful discrimination or any other conduct prohibited by or under the Act
- Advancing equality of opportunity between persons who share a protected characteristic and persons who do not share it.
- Fostering good relations between people who share a relevant protected characteristic and people who do not share it.

There are nine ‘protected characteristics’ covered by the Equality Act: Age, Disability, Gender re-assignment, Marriage and civil partnership, Pregnancy and maternity, Race including nationality and ethnic origin, Religion or belief, Sex (male/female), Sexual orientation.

The specific duties require public bodies to publish relevant, proportionate information showing how they meet the Equality Duty by 31 January each year, and to set specific measurable equality objectives by 6 April every four years starting in 2012.

Both general and specific duties are known as the Public Sector Equality Duties (PSED). As a statutory public body, the NHS Lewisham Clinical Commissioning Group must ensure it meets these legal obligations and intends to do so by publishing information demonstrating how the organisation has used the Equality Duty as part of the process of decision making.

3. Organisational Context

NHS Lewisham Clinical Commissioning Group (LCCG) assumed statutory responsibilities from 1 April 2013.

The CCG is a membership organisation made up of all the GP practices in Lewisham. Our aim is to secure the best possible health and care services for everybody in Lewisham, to reduce health inequalities and improve health outcomes in a cost effective way that provides good value for money.

We use what we know about the health needs of our residents to plan how and where to provide care and support which we commission from hospitals, community services and other providers of care.

The CCG purchases a range of services from the NEL Commissioning Support Unit (NELCSU), which supports the CCG to discharge its statutory responsibilities, including those within the Equality Act 2010.

All Governing Body members have a collective and individual responsibility to ensure compliance with the public sector equality duty, which will in turn secure the delivery of successful equality outcomes for us, both as a commissioner and an employer.
A Lay Member has been appointed to the CCG’s Governing Body to lead on patient and public involvement. The Lay Member has oversight responsibility for ensuring that:

- the governance arrangements for promoting equality are effective
- opportunities are created and protected for patient and public involvement and engagement.

The Lay Member chairs the CCG’s Public Engagement and Equalities Forum. This is a committee of the Governing Body and was established in 2016 following a CCG governance review. Its role includes providing feedback and assurance to the CCG Governing Body that equalities responsibilities are being carried out in the best way and meet the legal duties placed on the CCG.

All Governing Body members share the responsibility in seeking assurance that the voice of the local population is heard in all aspects of the CCG’s business. The Governing Body took the lead in defining the organisational values for the CCG that are:

- Everyone Counts – we will work and behave in a way that ensures that everyone counts and feels valued.
- Openness & Transparency - we will strive to be open and transparent in the way we work and make decisions
- Learn & Improve - we are a learning organisation that is self-aware of the impact that we can make to improve health for the people of Lewisham.

At its strategy and development workshop in December 2017, members of the Governing Body reviewed their understanding and implementation of the Public Sector Equality Duty, including progress with the Equality Delivery System and draft revisions to the CCG Equality & Diversity Strategy and equalities objectives.

The Chief Officer has responsibility for ensuring that the necessary resources are available to progress the equality and diversity agenda within the organisation and for ensuring that the requirements of this framework are consistently applied, co-ordinated and monitored.

The Deputy Director (Strategy & Organisational Development) has operational responsibility for:

- Developing and monitoring the implementation of robust working practices that ensure that equality and diversity requirements form an integral part of the commissioning cycle
- Working with the (NELCSU to ensure that equality and diversity considerations are embedded within the CCG’s working practices
- Ensuring that the Governing Body, staff and member practices remain up to date with the latest thinking around diversity management and have access to appropriate resources, advice, and informal and formal training opportunities

All line managers have responsibility for:

- Ensuring that employees have equal access to relevant and appropriate promotion and training opportunities.
- Highlighting any staff training needs arising from the requirements of this framework and associated policies and procedures.
- Supporting their staff to work in culturally competent ways within a work environment free from discrimination
Lewisham CCG Equality and Diversity Steering Group

The CCG convened an Equality and Diversity Steering Group in April 2015 that has a remit to enhance the focus, support and monitor the implementation of the Equality Delivery System to ensure compliance with Equality Duties under the Equality Act 2010. The Group is a management group, chaired by the Chief Officer with membership including representatives from the directorates and teams in the CCG.

4. Our Communities

Health Needs of Lewisham Population

The information we use to understand the health and wellbeing and the diverse characteristics and needs of the people of Lewisham, is obtained from the Lewisham’s Joint Strategic Needs Assessment (JSNA).
Source - http://www.lewishamjsna.org.uk/

4.1 Population Growth

Lewisham has a growing population, projected to increase from 292,000 (Mid-year estimate, ONS, 2014) to 318,000 by 2021. Also Lewisham has a young population with 25% of the population being under the age of twenty.

There has been a sustained rise in the birth rate in Lewisham for several years, reflecting a similar rise in London and the country as a whole, although the trend in birth rate in Lewisham is expected to level off in future years.

Around 27,600 residents are above 65 years of age and over 3,700 are aged over 85 years. This latter group is often the most complex and therefore bears a very high proportion of care costs.

4.2 Deprivation

The Index of Multiple Deprivation 2015 ranks Lewisham 48th of 326 districts in England and 10th out of 33 London boroughs. People living in the most deprived areas have poorer health outcomes and lower life expectancy compared to the England average.

4.3 Disability

According to the Census 2011, the prevalence of disability in Lewisham is as follows:
- Day-to-day activities limited a lot – 7.1%
- Day-to-day activities limited a little – 7.3%

Source: 2011 Census: Long-term health problem or disability, local authorities in England and Wales
4.4 Ethnicity

Lewisham is the 14th most ethnically diverse local authority in England - 46.5% of the population are from Black and Minority Groups (BME) compared to 40.2% London and 12.5% in England. In 2011 the two largest BME groups were Black African (12%) and Black Caribbean (11%). In the school population the proportion from BME groups is 77% and over 170 different languages are spoken.

4.5 Gender

Males comprise 49% of Lewisham’s population, females 51%. Life expectancy is 6.1 years lower for men and 5.1 years lower for women in the most deprived areas of Lewisham than in the least deprived areas.

Source: Lewisham Health Profile, Public Health England, July 2017

4.6 Significant health inequalities in Lewisham

- People living in the most deprived wards in Lewisham have poorer health outcomes and lower life expectancy compared to England’s average. Life expectancy for men is five years longer in Crofton Park, than in New Cross. For women the gap is even bigger between both Perry Vale and Crofton Park wards (joint highest life expectancy) and New Cross (the lowest), the difference is 8.5 years.

- Health inequalities are considered by ethnic group too. Lewisham is one of the most ethnically diverse areas of the country. Mental ill health is more prevalent in some black and minority ethnic groups. Black residents are disproportionately over-represented in mental health admissions.

- Lesbian, gay, bisexual, transgender or transsexual people and those who are divorced/widowed/separated also have poorer health outcomes than the general population.

Source: http://www.lewishamjsna.org.uk/

4.7 Lesbian, Gay, Bisexual

Of the total Lewisham population, 3.2% or 9,344 people are estimated to be lesbian, gay or bisexual.

Source: Office of National Statistics 2013 (percentage in London)

4.8 Mortality

The main causes of death in Lewisham are cancer, circulatory disease and respiratory diseases. Over the last couple of years cancer has overtaken cardiovascular disease as the main cause of death, and cancer deaths are now 28% of all deaths.
Overall the death rates have been falling in Lewisham, and although Lewisham Central does have higher death rates than the average, it is New Cross that has consistently had the highest death rates.

4.9 Religion

According to the Census 2011, religion in Lewisham is categorised as follows:

<table>
<thead>
<tr>
<th>Religion</th>
<th>Percentage</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Christians</td>
<td>83%</td>
<td>145,588 people</td>
</tr>
<tr>
<td>Muslim (Islam)</td>
<td>10%</td>
<td>17,759 people</td>
</tr>
<tr>
<td>Hindu</td>
<td>4%</td>
<td>6,562 people</td>
</tr>
<tr>
<td>Buddhist</td>
<td>2%</td>
<td>3,664 people</td>
</tr>
<tr>
<td>Jewish</td>
<td>0.1%</td>
<td>643 people</td>
</tr>
<tr>
<td>Sikh</td>
<td>0.1%</td>
<td>531 people</td>
</tr>
<tr>
<td>Other religions</td>
<td>1%</td>
<td>1,478 people</td>
</tr>
</tbody>
</table>

Source: 2011 Census: Religion (Detailed), local authorities in England and Wales

4.10 Voluntary and Community Sector

Lewisham has over 800 active voluntary and community sector organisations and more than 200 individual faith groups. All these groups and many others help to strengthen our communities by galvanising our citizens, addressing local concerns and advocating on behalf of some of the most vulnerable in society.

More information is available about Lewisham’s population at www.lewishamjsna.org.uk

4.11 Child health

In Year 6, 24.8% (730) of children are classified as obese, worse than the average for England.

Source: Lewisham Health Profile, Public Health England, July 2017

4.12 Adult health

The rate of alcohol-related harm hospital stays is 601*, better than the average for England. This represents 1,418 stays per year. The rate of self-harm hospital stays is 91*, better than the average for England. This represents 283 stays per year. The rate of smoking related deaths is 338*, worse than the average for England. This represents 310 deaths per year. Estimated levels of adult smoking are worse than the England average. Estimated levels of adult excess weight are better than the England average. Rates of sexually transmitted infections and TB are worse than average. Rates of hip fractures and people killed and seriously injured on roads are better than average.

* rate per 100,000 population

Source: Lewisham Health Profile, Public Health England, July 2017

Adult Mental Health

Rates of mental illness are higher in Lewisham than England and London.
Within Lewisham there is variable need, with the southern wards of the borough (Downham, Bellingham and Whitefoot) estimated to have a 25 – 40% higher need for services, in contrast to more affluent wards such as Forest Hill and Catford South that have lower need than the national average.

Mental ill health is more prevalent in some black and minority ethnic groups. Black residents are disproportionately over-represented in mental health admissions.

There is considerable evidence that incidence of schizophrenia and other psychoses varies across ethnic groups in the UK, with particularly high rates for people of African-Caribbean origin.

5. Embedding Equality within the Commissioning Cycle

Lewisham CCG is committed in ensuring that the Public Sector Equality Duty is embedded in all aspects of commissioning activities throughout the commissioning cycle:

5.1 Strategic Planning

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<th>Strategic Planning</th>
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<td>Assessing needs</td>
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<td>Reviewing service provisions</td>
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5.1.1 Strategic Outcomes Framework

Good commissioning starts with a thorough understanding of local needs, based on the Joint Strategic Needs Assessment (JSNA). The purpose of JSNAs is to help commissioners to determine the priorities and actions to improve the health and wellbeing of the local community and reduce inequalities for all ages.

The CCG’s strategic priorities are based on an analysis of Lewisham’s JSNA’s identified health needs of the local population. This includes disease prevalence amongst different ethnic groups, the health needs of different age groups, and the impact of deprivation and other factors which affect health equality and inequalities.

The CCG’s ambitions include improving life expectancy, reducing premature mortality from the main causes of death, decreasing infant mortality, and a number of measures of high quality care including emergency admissions, end of life care, and patient experience; further development is being undertaken of equalities considerations for cancer rates, mental health, and diabetes.

5.1.2 South East London’s Suitability and Transformation Plan Partnership

The organisations and agencies within the south east London health and care system, including NHS commissioners and providers and local authorities, have developed a strategy for implementing the Five year Forward View, for the period up to March 2021, known as Sustainability and Transformation Plans. Lewisham CCG has been working as part of the Sustainability and Transformation Partnership to develop plans that meet the needs of Lewisham’s diverse population, whilst ensuring that we engage and listen to our local communities. Integral to the programme is an equalities steering group that ensures that the programme meets the requirements of the Equality Act 2010 and the Public Sector Equality Duty, including overseeing independent equalities analyses of the strategy and plans and which informed the approach to pre-consultation on proposals for changes to elective orthopaedic services. (more details on the south east London STP can be found under Section 10. Our Partnerships).

5.1.3 Community Based Care Vision

Lewisham’s vision and expectations for the future development and delivery of community based care is that we want community based care to be:

**Proactive and Preventative** – By creating an environment which promotes health and wellbeing, making it easy for people to find the information and advice they need on the support, activities, opportunities available to maintain their own health and wellbeing and to manage their health and care more effectively;

**Accessible** – By improving delivery and timely access when needed to planned and urgent health and care services in the right setting in the community, which meet the needs of our diverse population and address inequalities. This includes raising awareness of the range of health and care services available and increasing children’s access to community health services and early intervention support.
Co-ordinated – So that people receive personalised health and care services which are coordinated around them, delivered closer to home, and which integrate physical and mental health and care services, helping them to live independently for as long as possible.

As commissioners and providers, we will ensure that our vision for the transformation of community based care is shared with the public, patients and staff. We will engage, involve and collaborate with them to shape and deliver the care and support that is provided in the community.

Achievement of our vision will require people to take responsibility when appropriate for their own health and care, and will require changes to how, when and where services are currently delivered. As we seek to deliver our vision, some services will need to change and some services will move out of hospital settings into more appropriate community settings. Where changes are needed we will work with the public and other stakeholders to develop more detailed proposals and plans, welcoming challenge and debate, whilst remaining focused on improving health and care outcomes within a sustainable and accessible health and care system.

5.1.4 Lewisham’s Partnership Commissioning Intentions 2017-2019

In Lewisham we have developed the Partnership Commissioning Intentions to cover all local health and care services which are commissioned by the CCG, Adult Social Care, Public Health and Children’s’ and Young People. It is a single plan for the two year period 2017/18 and 2018/19, with one set of priorities for all commissioned services.

The Partnership Commissioning Intentions is in two parts - for Adults and for Children and Young People. The Children and Young People Plan 2015-18 – ‘It’s Everybody’s Business’ - was considered by the Health and Wellbeing Board in September 2015 and approved by the Council in November 2015. The Adults Partnership Commissioning Intentions was approved by the CCG’s Governing Body in November 2016.

The Partnership Commissioning Intentions has been informed by the feedback received from the public during 2015/16, the work of the Health and Care Partners, the Children and Young People’s Strategic Partnership Board and the South East London work on Sustainability and Transformation Plan.

The titled of our Commissioning Intentions is ‘Partnership Commissioning Intentions’ to emphasise our on-going commitment to strengthen local partnership work with the public and our partners. The commissioning focus will continue to be on how we will work differently and more effectively with the public and our providers to implement a stepped change in the way health and care is provided in Lewisham.

The key commissioning aim is to deliver community case that is preventable, high quality and efficient where:

- the majority of health and care services is accessed outside the hospital at a neighbourhood level
- health and care services is coordinated around the person and there is a parity of esteem between physical and mental health
• individuals, their family and carers have a stronger network of support within their local communities to help them proactively maintain their health, wellbeing and independence

From a commissioning and provider perspective, we are working to deliver services in four neighbourhood areas in Lewisham - North Lewisham, Central Lewisham, south east Lewisham and south west Lewisham. In these neighbourhood areas Neighbourhood Care Networks are being created which will support connections and links being made and strengthen the relationships between those providing community based care, particularly between statutory and voluntary providers.

For 2018/19 the commissioning priority areas are ‘Frail and Vulnerable people and ‘Transition from children’s to adults’ services for young people’, where we will be modelling, in practice, different ways of partnership working to deliver proactive upstream interventions in community care and to improve health and care outcomes, to transform the delivery of Community Based care, to address the above challenges.

An Equality Analysis has been undertaken of the Partnership Commissioning Intentions and has identified any potential or actual impact these Commissioning Intentions may have on differing groups of people. The impact could be positive, neutral or negative, has informed the service redesign and planning as outlined in section 5.2.

The Adults Partnership Commissioning Intentions can be found at:  

The Executive Summary of the Equality Analysis of Adults Partnership Commissioning Intentions can be found at:  

5.2 Procurement

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<tbody>
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<td>Shaping structure of supply</td>
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The key local commissioning priorities are Prevention and Early Action, Planned Care and Urgent and Emergency Care. In these commissioning areas the CCG has been working with service users to co-design and co-produce services which are more responsive to individual needs. Equality Analyses have been undertaken in many commissioning areas to
demonstrate that due regard has been taken of the general duty under the Equality Act 2010 to eliminate discrimination, advance equality of opportunity and foster good relations between people from different groups, as summarised in section ‘Meeting the Public Sector Equality Duties in 2017’.

An Example of this is the procurement of Community Specialist Palliative Care service (see Section 9). The objectives of the new service include:

- Ensure coordinated care for patients with a single point of contact;
- Address inequalities;
- Find unidentified patients needing Community Specialist Palliative Care;
- Ensure seamless care as patients are discharged from hospital into the community;

Expected outcomes of the service include:

- Increase in patients achieving their preferred place of care and preferred place of death;
- Reduced emergency admissions from patients in the last weeks and days of life as a result of greater access to specialist care in the community on evenings and weekends;
- Improved equity of access to Community Specialist Palliative Care;
- Increase access to 24/7 Community Specialist Palliative Care;
- Reduction is LAS conveyance rates;
- Increase in delivery of EOLC education;
- Reduction in gaps between the prevalence and the predicted prevalence of people requiring Specialist palliative care by finding unidentified need;

5.2.1 Prevention and Early Action

Our strategic aim is to promote and facilitate health and wellbeing and prevent illness and dependence. This will require changes in the way prevention is commissioned and delivered, given the level of public sector resources available. It will require also whole system transformation across all sectors, not just health and care. The CCG aims to embed prevention in all our commissioned services to promote health and wellbeing (primary prevention) and to prevent the need for treatment and care (secondary prevention), that is evidence based or based on best practice, cost effective and sustainable

Our local focus for our commissioning work in ‘Prevention and Early Action’ is:

- making it easier to access the right information and services to live a healthier lifestyle by commissioning; an example is the online Wellbeing Questionnaire was developed to help improve the triage of cases and to provide an opportunity to personalise advice, signposting, activities and promote healthy lifestyles by providing information on the website. An example is Lewisham’s Sugar Smart campaign (see Section 6.1). The public can use the forms to help gather information to help resolve problems for themselves without the need for help from others.
- commissioning and supporting a range of holistic and whole system actions to make it easier to choose to live a healthier lifestyle, an example is the consultation on Over the Counter Medicines (see Section 6.2)
- supporting people to live in their own homes safely and independently working with a range of voluntary and community sector organisations, for examples Lewisham Sail
Connections (see Section 6.1), the Community Falls Team (see Section 9) and the Children’s Hospital at home (see Section 9)

- commissioning a range of information, advice and care to support people with long term conditions to make it easier to self-manage their health, including self-management for diabetes, better psychological therapies and Dementia and Information Service (see Section 9).

5.2.2 Planned Care

Our aim is to commission services so that all people who need planned care have appropriate, timely access to high quality of care and excellent patient outcomes. Our local focus for our commissioning work in ‘Planned Care’ is:

- improving the quality of hospital referrals and also patient experience of the appointment booking process through the Referral Support Service.
- Cancer, with a specific focus on Bowel cancer, Lung cancer, the 2 Week Wait pathway, living with and beyond cancer and inequalities
- Through the Lewisham, Greenwich and Bexley “Clinical Cabinet”, developing and implementing new clinical pathways including gastroenterology, cardiology, neurology & clinical haematology
- developing services closer to home, supported by specialists, to enable the management of people with more complex health and care needs out of hospital for example HIV Care and Support (see Section 6.1)
- Testing a model of care (“caseloading”), which combines pre-term birth surveillance with a continuity of care pathway from pregnancy through to postpartum period. The POPPIE (Pilot study of midwifery practice and preterm birth including women’s experiences) is a joint research conducted by Lewisham & Greenwich NHS Trust (LGT), Lewisham CCG and other partners. (see Section 6.1)

5.2.3 Urgent and Emergency Care

Our aim is to commission urgent and emergency services across the whole system which are coordinated, consistent, clear and affordable, helping people to get the right advice and care in the right place first time, particularly for those with urgent or emergency physical and/or mental health needs.

Our local focus for our commissioning work in ‘Urgent and Emergency Care’ is:

- Implementing a range of community based services which may help to avoid or reduce the need for emergency admissions including the Ambulatory Care Service (see Section 9), Integrated Primary and Urgent Care service, the Rapid response teams and a GP Extended Access Pilot.
- The work on Primary Care access for homeless people as part of the consideration of the review of the NHS Walk in Centre and improving the provision and access to primary care.(see Section 6.1)
- working with partners to improve the Emergency Care provided in Lewisham, including improving the emergency care pathway and the interface with mental health services, developing further Supported Discharge Services so that discharge planning is consistent and begins as early as possible to facilitate early discharge from hospital and reduce avoidable admissions into hospital.
• On a south east London basis, a service which is being re-procured jointly by commissioning is the **South East London Integrated Urgent Care Services NHS 111** (formerly known as NHS 111), as summarised in a case study in (see Section 9).

### 5.3 Contract Monitoring

#### Contract Monitoring

- Supporting patient choice
- Managing Performance
- Seeking Public and Patient Views

A key aspect of commissioning is to monitor the contract and services the CCG has commissioned to ensure that these services deliver high quality care for all. One of the key challenges Commissioners are addressing is the availability of robust data to monitor and evaluate whether commissioned services are being accessed and provided appropriately for the nine specific areas (or protected characteristics) which are covered by equality and diversity guidelines and legislation. Generally monitoring data is available for age, sex and partially race. The CCG is working with the local Public Health department to identify the priority areas where more comprehensive JSNA data is required to find out the actual impact of current services on differing groups of people.

In Lewisham CCG, the Integrated Governance Committee, a subcommittee of the Governing Body, is responsible to provide assurances that current contracted services are monitored appropriately and to ensure that the Equality Act 2010 general duties are being met:

Recent examples of where information has been provided to the Integrated Governance Committee to assess whether the Equality Act 2010 general duties are being met include **safeguarding in commissioning** (see Section 12), complaints (see Section 13) and the development and implementation of QIPP schemes (see Section 6)
6. Meeting the Public Sector Equality Duties in 2017

The Equality Act 2010 requires the CCG to pay due regard to the three aims of the general duty of the Act. The three aims are to:

- Eliminate unlawful discrimination or any other conduct prohibited by or under the Act
- Advance equality of opportunity between persons who share a protected characteristic and persons who do not share it.
- Foster good relations between people who share a relevant protected characteristic and people who do not share it.

The CCG carries out Equality Analysis to highlight positive and negative impacts on protected characteristics and other local disadvantage groups, giving an opportunity to mitigate any negative impacts. Also Equality Analyses are used to inform decision making.

Below are examples of full Equality Analyses carried out in 2017:

- Proposal to no longer support the availability on prescription of medicines for the chemoprophylaxis of malaria and selected travel vaccines
- Discontinuation of the NHS prescribing of over the counter medicines
- The future of the NHS New Cross Walk-in Centre and improving provision and access to primary care.
- South East London Integrated Urgent Care Service - Revised service (building on the 111 pilot)

Equality Analysis of QIPP Schemes

The following schemes have carried out Equality Analysis Screening to assess if any negative impacts of proposals. No negative impacts were identified.

- **Discharge to assess (D2A)**

D2A model through 2018/19 is planned to deliver pathways 0-3 and ensure that people in an acute setting who are agreed by a Multi – Disciplinary Team (MDT) as medically fit (optimised) for discharge (MFFD)), leave that setting with support home on the day of discharge.

- **Referral Management - primary care**

*Awaiting EA Screening and description*

Equality Analysis of small changes

A ranges of smaller changes have taken place in 2017 regarding GP practices/services and Urgent Care Services. All the changes were developed to improve services, delivery of and access to the services. Equality Analysis screening was carried out for each proposal to identify both positive and negative impacts, the table below highlights some of them:
<table>
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<tr>
<th>Summary of proposed change</th>
<th>Identified impacts</th>
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| **UCC Primary Care Assessment Pilot**  
Lewisham CCG proposed to extend the Primary Care Assessment pilot for a further 12 months commencing the 1st April 2017. | • Positive impacts included: The service is delivered by a team of GP assessors and Health Care Assistants at the front end of Lewisham UCC. The pilot is an adult only service that operates 10am – 10pm 7 days a week. |
| **GP Practice mergers**  
To seek to reduce any variation in current outcomes between two practices. | • Some patients may have to travel further, but in each case the change would lead to a location fully fit for purpose and easily accessible for patients.  
• There are car parking facilities and bus stops in close proximity to the merged GP Practice site. |
| **GP Practice relocation**  
Many other community services provided at the new location which should improve convenience for patients and support integrated working. |  
| **GP Practice estate consolidation**  
Consolidation of ICO Health Group practice sites from 4 to 2. | • A larger number of services will be provided at the consolidated practice sites which should improve convenience for patients. |
| **Alternative Provider Medical Services (APMS) Contract – Strategic Review: Hurley Group, GP Registered List (Waldron Centre)**  
On the 20th October 2016, the NHS England and Lewisham Primary Care Joint Committee approved the recommendation to disperse the list of the Hurley Group APMS contract, located at the Waldron Health Centre. | • Patients would have the choice of registering with one of the 3 existing GP practices located in the same premises  
• There was confirmed capacity for 20,500 patients to be registered with 14 local practices located within 1 mile of the Centre.  
• A full engagement programme would take place with the registered patients to ascertain what they would like from their new practice and support them in the registration process. |
| **Clinical Streaming and Redirection Pilot**  
Lewisham CCG proposes to operate a Clinical Streaming and Redirection Pilot for 12 months commencing on the 1st of October 2017. The service will be delivered by a team of GP assessors and Health Care Assistants at the front end of University Hospital Lewisham UCC. The pilot will operate from 10:00am – 10:00pm, seven days a week and will see adults and paediatric patients. | • The new Clinical Streaming and Redirection model will be very similar to the Primary Care Assessment Pilot, with the added benefit of having a GP at the front door of the UCC.  
• Equalities data has been collected for the Primary Care Assessment Pilot over the last 10-months and shows that a diverse population is accessing and using the service. |
6.1 Eliminating Discrimination and Advancing Equality of Opportunity

6.1.1 Ambulatory Care Service (read the full Case Study in section 9)

In line with national best practice and the outcomes of 2016 Emergency Review an Ambulatory Care Service was commissioned from Lewisham & Greenwich Trust to provide assessment and same day discharges for adult patients. The Ambulatory Care Centre opened in November 2016.

The service also provides early testing (such as X-Ray and ultrasound) for local people with results reviewed by specialist consultants.

The aim of the centre is to help patients get the right care sooner, avoid unnecessary hospital admissions and reduce pressures on the hospital's emergency department.

The centre takes referrals from GPs, the UCC and A&E so that patients can come to the unit for a scheduled test – rather than attending the Emergency Department.

6.1.2 Lewisham MindCare – Dementia and Information Service (read the full Case Study in section 9)

Lewisham MindCare is a dementia information and support service for anyone in the borough / with a GP in the borough living with dementia.

The service, in line with NICE-guidelines and the Prime Minister’s Challenge on Dementia, establishes an infrastructure that provides opportunities for people living with dementia to lead fulfilling and rewarding lives for as long as possible. The service supports people living with dementia and their carers to ‘live well’ with the condition regardless of the level of need, severity of the disorder.

Lewisham’s goal is for people with dementia and their family and carers to be helped to live well with dementia, no matter what the stage of their illness or where they are in the health and social care system.

6.1.3 Hospital at Home for Children (read the full Case Study in section 9)

The Hospital at Home Service has been running as a pilot in 16/17 and 17/18, with a view to embed the service in an enhanced Children’s Community Service.

The service provides ambulatory care or rapid response in the form of in/outreach into acute adding to the capacity of the Children’s Community Nursing Team (CCNT) responsible for the provision of on-going care at home.

The service is run by specialist paediatric community nurses who visit children in their homes and provide treatment which was traditionally only available within a hospital.
Before the development of this programme, patients would have to stay in hospital to receive treatment that will be delivered at home or in the community.

6.1.4 Lewisham Sail (Safe and Independent Living) Connections

Lewisham Safe and Independent Living (SAIL) Connections is the name of Age UK Lewisham and Southwark’s quick-referral service. The project helps vulnerable older people (60 plus) living in Lewisham, and those supporting them, to access a wide range of services to support Safe and Independent Living. The project consists of a simple checklist of questions relating to services supporting: health and wellbeing, improved living conditions, fire safety and home security and financial inclusion. This checklist is completed and sent to the project coordinator, who bridges the gap between the older person and our partner organisations. This simple scheme encourages a holistic approach, and enables quick and easy referrals across multiple sectors.

Age UK Lewisham and Southwark have been hosting SAIL in Southwark for the past 4 years where it has proven to be a highly efficient and effective tool for professionals as well as protecting the older community and providing a source of information and support. The model came to Lewisham in July 2016 on an 18 month pilot. After the development of the Lewisham SAIL Connections Partnership the service was officially launched in February 2017. To date Lewisham SAIL Connections has supported 653 older people and made over 800 referrals to partner organisations.

Here is an example of how it works:

Grace is 76, lives in a housing association and is partially sighted. She was referred to SAIL. After a chat with our coordinator we referred Grace to: Blindaid, Occupational Therapy, Linkline and London Fire Brigade. Blindaid paired Grace with one of their Home visitors, who now visits regularly for a cup of tea and a chat. Occupational Therapy have made an assessment and her Home Visitor from Blindaid then helped out with measuring up the bath for some recommended equipment. London Fire Brigade also visited Grace, gave her advice about how she could leave her home safely in a fire as well as setting her up with smoke detectors. Grace has seen a great improvement in her wellbeing and feels safer at home.

6.1.5 POPPIE (Pilot study of midwifery practice and preterm birth including women’s experiences)

In December 2017, it was announced that the POPPIE project won the CLAHRC (Collaborations for Leadership in Applied Health Research and Care) Innovation Award on the strength of its partnership working. This is a prestigious award demonstrating the excellent and innovative work POPPIE is doing to reduce pre-term birth and other poor birth outcomes, all of which has demonstrable links with equalities. Further details here: [http://www.clahrc-southlondon.nihr.ac.uk/news/2017/congratulations-all-know-your-clahrc-2017-winners](http://www.clahrc-southlondon.nihr.ac.uk/news/2017/congratulations-all-know-your-clahrc-2017-winners)

1. What is the POPPIE research trial?

- Lewisham & Greenwich NHS Trust (LGT), Lewisham Clinical Commissioning Group (CCG) and London Borough of Lewisham (LBL) Public Health are working with the
South East London Collaboration for Leaders in Applied Health Research and Care (CLAHRC) to undertake research into pre-term birth (PTB) at Lewisham Hospital.

- Testing a model of care ("caseloading"), which combines pre-term birth surveillance with a continuity of care pathway from pregnancy through to postpartum period.
- Randomised controlled trial comparing outcomes for women who have received midwifery continuity of care with those who have received standard maternity care.
- Hypothesis (supported by wider research): Cohort receiving continuity of care will experience fewer PTBs than cohort receiving standard care.
- Trial also testing (and expecting improvements in) a range of other maternal and neonatal health and psychosocial outcomes associated with continuity of care.

2. Why is it important?

- Lewisham’s pre-term birth rate is the 2nd highest in London, second only to Croydon. It is also higher than London and national average. See table above.
- Complications of extreme prematurity are leading cause of death in Lewisham children and nationally.
- PTB babies at greater risk of other problems, include breathing and feeding difficulties, neuro-developmental delay, learning disability, visual and hearing impairment and other long-term conditions.
- Trial has potential to reduce PTB rate and improve other birth outcomes for mothers and babies in Lewisham, including reduced stillbirths, perinatal mental health illness and medical interventions in labour, and improved experience of care for women.
- Other expected benefits: Reduced associated costs to parents, families and health and social care economy of PTB and other poor birth outcomes, improved recruitment and
retention of midwives (MWs) and learning that can be applied across the service to improve continuity of care for all women.

- If successful, will be replicated nationally. In Lewisham, POPPIE team will be expanded to include women with other vulnerabilities and having homebirths – this is our local strategy to achieve greater continuity for as many women as possible

6.1.6 Healthier You – NHS Diabetes Prevention Programme

Healthier You: NHS Diabetes Prevention Programme (NDPP) is a joint commitment from NHS England, Public Health England and Diabetes UK, to deliver at scale evidence based behavioural interventions for individuals identified as being at high risk of developing Type 2 diabetes. All 12 South London local authorities and CCGs are amongst the first wave implemeniter sites for the programme in England. The programme launched in August 2016

The aim of the programme is to reduce people’s risk of developing Type 2 diabetes. The population of Lewisham is 303,920. In Lewisham there are over 15,000 with recorded diabetes and approximately 8,000 people with undiagnosed type 2 diabetes. If current trends in population change and obesity persist the total prevalence of diabetes is expected to rise to 9.8% by 2020 (NCIN).

54% of people diagnosed with type 2 diabetes in Lewisham are from a BAME background. In England one man in 10 (9.6%) now has Type 1 or Type 2 diabetes compared to 7.6% of women, a 26% difference (Men’s Health Forum 2017) The prevalence of diabetes is significantly higher in Black Caribbean, Indian, Pakistani, and Bangladeshi men than in the general population.

The programme was launched in Lewisham in August 2016 and has been managed as a partnership between Lewisham Council Public Health and Lewisham CCG. The programme consists of 18 group sessions over 40 weeks focussing on behavioural techniques to support individuals with weight management and increasing physical activity.

People at risk of Type 2 diabetes are referred into the programme via one of two routes:

- By searching GP practice lists to identify patients at high risk of developing Type 2 diabetes and invite them onto the NDPP programme.
- The NHS Health Check programme, commissioned by all local authorities in England, systematically invites adults between the ages of 40 and 74 for risk awareness and assessment every five years and includes a diabetes risk assessment and blood test as part of the check.

The Lewisham programme has resulted in a very successful take up by Lewisham residents. To date over 900 people have been referred onto the programme and over 70% of those have attended for an initial assessment. This is one of the highest referral rates across South London.

18 Healthier You programmes have now commenced across 4 different sites in Lewisham. Each programme is held on a different day and time to ensure choice of access.

Quote from one of the attendees of the Lewisham programme:
Future plans for the roll out of the NDPP will include providing more targeted programmes to those groups at highest risk of developing Type 2 diabetes. This will include working with Lewisham Healthwatch and Lewisham Homes to plan outreach events to promote the programme. Plans are also in place to recruit more male group leaders to attract more men to the programme and to run sessions for members of the Tamil community.

6.1.8 Sugar Smart Lewisham Campaign

In 2016 Lewisham Council was awarded national pilot status for a whole-systems approach to tackling obesity. Lewisham is one of only four local authorities participating in the pilot nationally, and the only London borough. A whole-systems approach not only supports individual behaviour change, but it also indirectly encourages healthy eating and increased physical activity by making the environment people live in less obesogenic.

A Lewisham Obesity Alliance was formed, with three key actions to create healthy environments: Sugar Smart Lewisham, the Lewisham Daily Mile and use of Lewisham’s parks. The Sugar Smart Lewisham campaign aims to reduce the amount of sugar residents consume by:

1. raising awareness of how diets high in added sugar can negatively affect health
2. gaining support from residents to start a social movement lobbying businesses and organisations to join the campaign
3. encouraging local organisations, businesses and settings to join the campaign and pledge to make simple changes to promote healthier, lower-sugar alternatives and limit less healthy choices

The Lewisham Sugar Smart campaign was officially launched at an event in October 2016. Since launching we have promoted the campaign by:

- updating the Council’s website to include information on how local businesses, organisations and individuals can support and join Sugar Smart
- writing a feature on Sugar Smart in Lewisham Life, the Council’s quarterly magazine, which is delivered to 116,000 households in the borough
- working with local newspaper, the News Shopper, to agree 12 monthly editorials advertising the campaign
- targeting local businesses directly through the Council’s weekly e-newsletter for businesses and a door-to-door letter to food businesses registered on the Food Standards Agency website
- partnering in with other Council teams that work with businesses, such as Lewisham Local, and with businesses taking part in the Healthier Catering Commitment Scheme
- Attending local assemblies across the borough as well as other key networking events such as the Lewisham CCG AGM.

Our campaign is linked with the national Sugar Smart UK campaign, and details of all our Sugar Smart businesses and organisations have been uploaded on the national Sugar Smart database.
In November 2017, we re-launched the second phase of the campaign, to harness, mobilise and activate the public to start a social movement to limit the amount of sugar in our environment. In this phase of the campaign, residents are being asked to lobby local businesses and organisations in the borough to join the Sugar Smart Lewisham campaign.

6.1.9 Homeless people – Engagement with Partners

As a part of the formal consultation on the future of the NHS Walk-in Centre and improving provision and access to primary care and through the Equality Impact Assessment – it was identified that this is where there could be a gap in services for the homeless in New Cross and Deptford.

The CCG in partnership with Lewisham Council organised a multi-agency summit to better understand the challenges faced by the homeless accessing services across the system.

A key requirement for the CCG from the homeless summit was to consider the barriers to accessing primary care services for the homeless and to inform any additional provision or services.

The multi-agency homeless summit took place on the 18th October 2017. The Summit presented a unique opportunity where representatives from agencies across the system providing services and support to the homeless came together. There were representatives from homeless charities including; Deptford Reach, 999 Club, Bench Outreach, St Mungos, Thamesreach, Lewisham & Greenwich NHS Trust, South London and Maudsley NHS Foundation Trust, Pathway, Healthy London Partnership and Healthwatch.

The CCG committed to working with GP practices located in the Waldron Health Centre, the three local homeless charities, St Pauls Church and the Salvation Army to develop an additional alternative service for the rough sleepers in New Cross and Deptford.

6.1.10 A new programme to improve HIV outcomes in South East London

Lewisham CCG 5 year Strategy notes that HIV is a long term condition (LTC) with a high prevalence in Lewisham. It notes that the burden of HIV falls on Black Africans and men who have sex with men.

The new programme of HIV treatment and care is intended to be improved for Black African community and men who have sex with men as the programme is targeting these groups by delivering testing in community and social venues used by target groups or providing testing as part of a bundle of tests in health settings, thereby overcoming HIV stigma.

The programme:

- targets the high prevalence groups and will align with LTC work across all three boroughs.
- adopts an outcomes-focused approach using a SIB (Social Impact Bond) model to identify outcomes against savings delivered.

The proposed programme partnership, led by Lambeth Council, of Lewisham and Southwark councils, Lambeth, Lewisham and Southwark CCGs, NHS England, the Big Lottery Fund and the Elton John AIDS Foundation (EJAF) was set up to establish a new programme in Autumn 2017 to improve HIV outcomes in South East London. EJAF are proposing to fund the Programme initially for two years.

The programme will:
• Reduce late diagnosis of HIV by increasing testing. The burden of late diagnosis in Lewisham is borne by the Black African community and men who have sex with men. The programme will target these groups, delivering testing in community and social venues used by target groups or providing testing as part of a bundle of tests in health settings, thereby overcoming HIV stigma.

• People living with HIV who are lost to care are more likely to have complex needs. The programme will target this vulnerable patient population, for example, by working with LTC programmes or mental health programmes.
6.2 Fostering Good Relations

6.2.1 Lewisham CCG Public Engagement Network

Lewisham CCG continues to grow its database of contacts in the voluntary sector and local communities. The CCG has collaborated with organisations to engage and inform residents and patients on specific services in Lewisham such as the GP Extended Access and Pharmacy First. Additional engagement events and focus groups have been organised to involve Lewisham residents in local consultations (over-the-counter prescriptions and malaria treatment* and the future of New Cross Walk-In Centre) and improving provision and access to primary care). The Sustainability and Transformation Plan was the central subject of our “Our Healthier London“ event that was an opportunity to show the latest information on this programme with a focus on local changes, in collaboration with the central team for Our Healthier South East London (OHSEL)*. Community and voluntary sector organisations continue to provide invaluable support extending our reach into seldom heard communities.

In January 2017, the CCG commissioned Healthwatch Lewisham to seek the views of seldom heard groups in Lewisham to support the development of the Primary Care Extended Access service organised around the needs of patients and populations.

The CCG Primary Care team were also presented to the Lewisham-wide Patient Participation Group meeting organised by One Health Lewisham in October 2017.

Lewisham CCG has created an engagement email list to communicate and promote Lewisham CCG health events, surveys and initiatives. We will use this group as a platform to disseminate Lewisham health services and local/national health campaigns.

*See below for more details

6.2.2 Lewisham CCG Public Reference Group (PRG)

The Public Reference Group (PRG) set up in 2015 with a range of local people who reflect the Borough’s diversity has continued to support the activity of Lewisham CCG during the last year, focusing on its main roles:

- Ensuring that public engagement is integrated into the commissioning cycle.
- Acting as a ‘critical friend’ across all commissioning services in respect of patient and public engagement.
- Supporting the CCG in engaging and communicating more widely with the public to gather their views, and to inform the public of the challenges facing the NHS and any proposed changes to services.

The PRG took part in the CCG’s 2017 Equality Delivery System process and joined the EDS2 Panel to discuss and agree EDS2 grading with other local people at the event.

6.2.3 Readers panel

The CCG has re-established the readers panel, a panel of local people, to ensure that their written materials provide clear, relevant and understandable information for the public.
To date the Readers Panel has not captured equalities data about its members. We plan to refresh the Panel, and capture this data to ensure that we have a group that is representative of our Public.

6.2.4 Public forum sessions at Governing Body meetings

All CCG’s Governing Body meetings take place in public. We run a public forum session prior to each meeting where members of the public are able to ask questions. These are well attended and the notes are published on our website: [http://www.lewishamccg.nhs.uk/about-us/Who-we-are/Pages/Governing-body-meetings.aspx](http://www.lewishamccg.nhs.uk/about-us/Who-we-are/Pages/Governing-body-meetings.aspx)

6.2.5 Other Public Engagement

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### Our Healthier SE London and the Sustainability Transformation Plan event June 2017

Our Healthier South East London (OHSEL) is a health and care strategy led by a partnership of NHS providers and Clinical Commissioning Groups serving the boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark, working with NHS England (London).

In summer 2017, six events took place around these six London’s boroughs. The events aimed to raise awareness of the Sustainability and Transformation Partnership (STP) in south east London, and provide an opportunity for the public to ask questions and gather feedback on key areas.

Lewisham held its local event in the centre of Lewisham (Catford - Civic Suite) on the 29 June 2017, between 5-8pm. The event was widely advertised through several channels (social media, email, leaflets, posters) and to different groups (health partners, local organisations and communities) in order to reach a wide audience representing the diverse population in Lewisham. A market place with six stations, supported by local health experts and collaborators, provided a platform for information and discussion around the main themes of the STP:

- Community based care
- Maternity services
- Children and young people
- Planned care
- Mental Health
- Urgent and emergency care
- Estates

A total of 107 attendees had the opportunity to ask questions directly to the local experts, watch a video explaining the rationale behind the STP and join the interesting final Q&A session with representation from Lewisham CCG, Public Health and Lewisham Local Authorities. Lewisham CCG lay members and some of our Public Reference Group members attended the event to support and encourage discussion with the public. Equalities information was collected in parallel with feedback and the results are now part of the Feedback Final Report prepared by the OHSEL central team.
Of the total 502 attendees in the six events, 150 completed or semi-completed equalities forms (60 of them from the event in Lewisham) covering information for the nine protected characteristics (marriage & partnership / pregnancy/maternity were not covered).

- **Age:** 0-24 (2%), 25-44 (18%), 45-69 (56%), 70+ (24%)
- **Disability:** Not disabled (59%), Disabled (41%)
- **Ethnicity:** White (72%), BME (28%)
- **Gender:** Male (35%) and Female (65%)
- **Marital Status:** Married (39%), Single (32%), Widowed (11%), Co-habiting (9%), Divorced (7%), Same sex civil partnership/marriage (1%), Separated (1%)
- **Gender reassignment:** 0%
- **Religion:** Christian (50%), Muslin (2%), Hindu (2%), Buddhist (1%), No religion (40%) and Prefer not to say (5%)
- **Sexual orientation:** Heterosexual (85%), Gay (3%), Lesbian (3%), Bisexual (9%)
- **Pregnancy and Maternity:** 0% said they were pregnant. 1% said they had had a baby in the last 12 months. (87 out of 120 responded)

### Proposed Changes to Prescribing in Lewisham Case Study: Over-the-counter prescriptions and malaria treatment

Lewisham CCG undertook a public consultation on proposed changes to prescribing in Lewisham for the following areas:

- Self-care medication for self-limiting acute illnesses and health supplements
- Malaria prevention medicines

As these proposed changes to prescribing would have an impact across Lewisham, to determine this impact on residents with protected characteristics separate Equality Impact Assessment (EIA) were completed for both proposals, with mitigating actions where applicable.

A formal engagement period took place between **29th August** and **24th October 2017**. During which, a series of patient and public engagement activities were conducted to gather responses about the proposed changes to prescribing.

To ensure that the consultation garners responses representative of the population of Lewisham, before the consultation process began a number of pre-engagement activities took place, these activities included:

- A communication and engagement plan developed which included reaching out to existing special interest groups: older people groups, carers groups, Black and Ethnic Minority (BAME) and faith groups.
- Pre-consultation survey with member GP practices for their views
- Taken to and discussed at:
  - Lewisham Council’s Healthier Communities Select Committee (HCSC)
  - NHS Lewisham CCG Governing Body
  - Local member GP neighbourhood meetings
Throughout the consultation process the CCG engaged in various events and focus groups with residents, patients and professionals. A total of 33 separate activities were conducted. In addition, the CCG received a total of 361 responses through online and paper surveys. Responses included free-text comments and questions on specific issues or concerns and areas arising from the proposals, with responses provided.

The consultation process has been comprehensive and far reaching with specific activities conducted to gather the views of different groups of people, including BAME communities. Additionally, as the proposed changes to prescribing of malaria prevention medicines may disproportionately impact the Black/ Black British: African community more than others (highlighted in an Equality Impact Assessment) increased consultation resources were directed to Black/ Black British: African organisations/charities/societies.

The consultation aimed to target the following groups:
- Patients registered at Lewisham GP practices
- Groups representing Lewisham patients (i.e. Healthwatch Lewisham, Lewisham Public Reference Group)
- Lewisham residents who may be likely to travel to countries needing malaria prevention
- Voluntary and community sector organisations as representatives of particular groups who may be affected.
- Elected representatives of Lewisham residents
- NHS provider organisations

The results of the consultation are as below:

A) Self-care medication for self-limiting acute illnesses and health supplements

- **68.7% agreed or somewhat agreed** with the CCG proposal to no longer support the routine self-care medicines for short-lived minor conditions that usually get better with time

- **27.3% disagreed or somewhat disagreed** with the CCG proposal

As part of this question respondents were also asked if they agree with the statement ‘GPs should spend less time treating people who could buy self-care medication and health supplements without a prescription’:

- **71.3% agreed or somewhat agreed**
- **23.7% disagreed or somewhat disagreed**
B) Antimalarial chemoprophylaxis

- **54.6% agreed or somewhat agreed with the CCG proposal** to no longer support the routine prescribing of malaria prevention medicines
- **36.7% disagreed or somewhat disagreed** with the CCG proposal

Of note from populations which have been identified that may be impacted more than the general population:

Black/Black British: African ethnicity respondents:
- **78.3% disagreed/somewhat disagreed**
- **21.7% agreed/somewhat agreed**

**Lewisham CCG AGM 2017**

The AGM was held on 20 September 2017 at King’s Church, Lee from 12.30-4.30pm. The objective was to increase attendance and engagement with members of the public and Lewisham GPs.

The theme was ‘Prevention and Early Action’. Prevention is necessary at all levels and affects all age groups and ethnicities. We used this event to set out the wider determinants of health (health behaviours, socio-economic factors, clinical care and built environment), with a specific focus on health behaviours.

The key messages were that to help make the NHS sustainable, we want to support local people to be more proactive about prioritising their health and wellbeing to reduce their risk of developing lifestyle related health conditions, such as diabetes. Also that many deaths could have been prevented by healthier lifestyles - 80% of heart disease, stroke and type 2 diabetes and 40% of cancers could be avoided if common lifestyle risk factors were eliminated ie unhealthy diet, physical inactivity, tobacco use and excess alcohol and drug use.

To encourage people to attend and to engage in conversations about what stops them from looking after themselves and their families better we commissioned the charity and theatre group Cardboard Citizens to develop and run a forum theatre performance. This was a creative way of encouraging engagement and interaction with the theme. A video of this is available in two sessions:

**Part 1** - a twenty minute performance with four actors: ‘Getting through’ (31 min). [https://youtu.be/0dYQc9q2tmk](https://youtu.be/0dYQc9q2tmk)

**Part 2** - interactive discussion with audience members participating in the re-run of the play (56 min) [https://youtu.be/tGJygN9zwok](https://youtu.be/tGJygN9zwok)

We also arranged for a range of partners who provide relevant services to attend and hold a stall.

The programme was well received. After an introduction from the Governing Body with the main priorities and financial data for the last CCG Annual Report and a Q&A session, Dr Angelika Razzaque introduced the determinants of health, emphasizing the importance of Prevention and Early Action in the future of Lewisham healthcare. This was followed by an
overview of the different stalls and organisations present on the day to showcase different services available in Lewisham.

The event was attended by 153 delegates, a 70% increase on 2016.

We received 43 equalities forms, some of them partially completed.

- We had good attendance from people of all age groups, but people under 45 were underrepresented: 33% of attendees were between 15 and 45 compared to the JSNA figure for the borough of around 51%.
- In terms of ethnicity the results for attendees are similar to JSNA figures.
- 20.5% of attendees had a disability compared to 15.6% in Lewisham identified as not being in good health (2011 Census)

7. **Lewisham CCG’s Equality Objectives progress in 2017**

**Objective 1 – Support for people with Long Term Conditions**

Reduce the gap between BME patients experience and White British patients experience in relation to patients feeling supported with their Long Term Conditions.

The primary equalities delivered a 3 year programme, which ends on 31st March 2018 to support improving the experience of those who identify themselves as being of Black Caribbean and Black African heritage with long term conditions.

The CCG has completed work with local practices to improve coding and recording of ethnicity, which is a key enabler to raising awareness of the barriers faced by these communities.

The CCG has commissioned the Community Education Provider Network (CEPN) that has run a series of sessions with practices and patients to begin to understand the barriers and ways to overcome them. This work will continue into 2018.

**Objective 2 – To ensure Lewisham CCG is an organisation that is representative of its population and has a workforce that is supported**

The CCG maintains an annual organisational development action plan that is based on the framework of processes, structures and relationships, and includes the monitoring of the workforce profile and outcomes of staff surveys and other feedback. The CCG has a diverse workforce that is representative of its population at most levels in the organisation.

In 2016 Lewisham CCG participated in the national staff survey for the NHS. One of the areas for improvement that came out of the survey was equality of opportunity for staff progression. A focus group for BME staff was held to gain greater understanding of this issue. As a result of the focus group and the findings of an analysis of CCG recruitment and selection data, a number of changes have been introduced to the CCG Recruitment and Selection Policy, particularly the processes and panels for shortlisting and interview. To ensure the consistent application across the CCG recruitment and selection workshops will be held early in 2018.
The Governing Body has also highlighted its need to be more reflective of the diverse Lewisham population, and this will be taken into account in recruitment plans as future Governing Body vacancies arise.

Developmental Objective 3 – the use of digital technology to support the development of the Health and Care system in Lewisham

Nationally, ‘digital’ technology has a significant role to play in the sustainability and transformation of the local health and care system. This includes supporting new care models and transforming care in line with the Five Year Forward View, delivering primary care at scale and securing seven day services. The Five Year Forward View also makes a commitment that, by 2020, there will be “fully interoperable electronic health records so that patients’ records are largely paperless”. This was supported by a Government commitment, in Personalised Health and Care 2020, that by 2020 “all patient and care records will be digital, real-time and interoperable.”

Lewisham CCG is working collaboratively with Lewisham Council and its local providers as part of HealthCare Partners executive team to lead the development of an Accountable Care System, to achieve a sustainable and accessible health and care system, to better support people to maintain and improve their physical and mental wellbeing, to assist people to live independently and have access to high quality care when needed.

During 2017, an Equality Analysis of the Partnership Commissioning Intentions (2017-2019) was undertaken. It concluded that for a number of the commissioning intentions planned, their successful service delivery was dependent on technological solutions being a key enabler. The Equality Analysis emphasized that ‘Inclusive design’ was paramount in the development of all digital products as ‘every design decision has the potential to exclude someone’ (Public Health Matters, 2016 – https://publichealthmatters.blog.gov.uk/2016/07/22/%EF%BB%BFthe-a-z-of-digital-publichealth/)

In Lewisham we are using digital technology to improve communication between health and care professionals, support the sharing of integrated records and provide coordinated care to residents and service users more effectively. We are working to use digital technology to best effect by monitoring use of services by the protected characteristics and to evaluate whether there are negative impacts on specific individual or communities. Examples of new and/or extended services which are increasingly using digital technology to access services and where such monitoring is taking place are the extension of Lewisham’s Single Point of Access which facilities people to use either the phone line or a digital channel and the online Wellbeing Questionnaire.

Building on Connect Care, our existing information sharing system, we are implementing a shared population health system, Cerner. Cerner will bring together real time data and information from multiple sources to identify specific populations who may be at risk and to improve health and care outcomes across the Borough. The population healthcare system will help us to focus on upstream health prevention and management and to shift care from acute to community settings. Also our population health system will enable commissioners and providers to work together to identify health and care inequalities and measure the impact of...
changes we make across the whole health and care system..
8. **Lewisham CCG’s Equality Delivery System performance in 2017**

The EDS enables the CCG to:

- Analyse its performance against the EDS Goals and Outcomes
- Identify any gaps or areas that require improvement
- Identify any high risk areas as priorities for setting objectives

The EDS has four Goals:

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

An NHS organisation might decide to focus on people (with particular protected characteristics) most at risk, and/or for whom considerable progress has been made. The key question of EDS2 is: how well do people from protected groups fare compared with people overall?

Lewisham CCG chose to focus the EDS2 on their commissioning responsibilities for:

- **Ambulatory Care Service** was commissioned from Lewisham & Greenwich Trust to provide assessment and same day discharges for adult patients. The aim of the centre is to help patients get the right care sooner, avoid unnecessary hospital admissions and reduce pressures on the hospital’s emergency department.

- **Lewisham MindCare – Dementia and Information Service**
  Lewisham MindCare is a dementia information and support service for anyone in the borough / with a GP in the borough living with dementia. The service supports people living with dementia and their carers to ‘live well’ with the condition regardless of the level of need, severity of the disorder.

- **Hospital at Home for Children** ambulatory care or rapid response in the form of in/outreach into acute adding to the capacity of the Children’s Community Nursing Team (CCNT) responsible for the provision of on-going care at home.

During 2017, engagement was carried out with local stakeholders and staff in order to verify the process.

In September 2017 an EDS2 Stakeholder panel considered the evidence prepared by CCG commissioners and the service providers and awarded EDS grading for the services.

The EDS2 Grading External Stakeholder Panel reviewed three services

- Ambulatory Care Service
- Lewisham MindCare – Dementia and Information Service
- Hospital at Home for Children

All three services reviewed are delivering good quality services, but only one of them was able to demonstrate (with data) that more than three or four of the nine protected characteristics is being collected and being analysed to provide assurance that there is not a group of patients with a particular characteristic who are not accessing the service, are able to access the
services or what has been the experience of patients who have particular these protected characteristics. Therefore two of the services were graded as DEVELOPING.

The CCG is developing an Equality Objective that will work with partners to improve the quality and collection of equality monitoring data.

EDS2 Grades for Lewisham CCG in 2017 to date are as follows:

![Fig. 2 Lewisham CCG Equality Delivery System (EDS) Grading for 2017](image)

<table>
<thead>
<tr>
<th>EDS2 Goals</th>
<th>Grading achieved In 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – Better Health Outcomes</td>
<td>DEVELOPING</td>
</tr>
<tr>
<td>2 – Improved patient access and experience</td>
<td>DEVELOPING</td>
</tr>
<tr>
<td>3 – A representative and supported workforce</td>
<td>To be confirmed</td>
</tr>
<tr>
<td>4 – Inclusive leadership</td>
<td>To be confirmed</td>
</tr>
</tbody>
</table>

A staff survey that contains some of the same outcomes of EDS2 Goal 3 that focuses on whether the workforce is representative and supported has been carried out. The results together with staff engagement on the results of the survey will take place in February 2018.

The CCG has started the process of collecting data for EDS2 Goal 4 Inclusive Leadership and aiming to complete the process early in February 2018.

The grades and improvement plans for all four goals will be published on the CCG’s website by March 31, 2018. They will be used to inform the CCG’s operational and organisational development plans.
9. Lewisham CCG’s Equality Case Studies

Case Study: Ambulatory Care Service

In line with national best practice and the outcomes of 2016 Emergency Review an Ambulatory Care Service was commissioned from Lewisham & Greenwich Trust to provide assessment and same day discharges for adult patients. The Ambulatory Care Centre opened in November 2016.

The service also provides early testing (such as X-Ray and ultrasound) for local people with results reviewed by specialist consultants.

The aim of the centre is to help patients get the right care sooner, avoid unnecessary hospital admissions and reduce pressures on the hospital’s emergency department.

The centre takes referrals from GPs, the UCC and A&E so that patients can come to the unit for a scheduled test – rather than attending the Emergency Department.

As well as preventing unnecessary admissions, the centre also enables some patients to be discharged sooner.

The service model is based on the National Ambulatory Care Handbook and is supported by a service specification and contractual model. The service;

- Treats adult patients who require emergency care on the same day without admission to a hospital bed at all, or treatment for only a number of hours and then send the patient home with ongoing clinical follow up as required;
- Be the default position for emergency patients unless admission is clinically indicated;
- Reduces pressure on Emergency Department (including UCC) and AMU;
- Reduces the requirement for beds

Since the Ambulatory Care Centre opened it has seen over 1500 patients. The service is reducing the number of medical admissions, reducing the number of GP referrals to the emergency department, and reducing the length of stay for some patients.

Early analysis of the activity data from by Lewisham & Greenwich Trust provides some limited demographic data about the users of the service. In terms of service uses and their protected characteristics – the age is quite broad and centred on those under 64 years. With regard to ethnicity the data for the first 4 months of the service is reflective of the local population. However, with regard to patients who completed the Family & Friend Test – more than half described that their day to day activities were limited because of a health problems or disability.

- Ethnicity: Of the 1083 attendances to the Unit from November 2016 to March 2017,
54.84% (594) described the white British, white Irish or white other; 29.69% described themselves as BME of which 24.84% were either Black African or Caribbean.

- Age: The biggest age range was the 19-40 (323 attendances) years and; 41-64 (476 attendances) years.

Feedback has been extremely positive.

The latest ‘friends and family’ survey of nearly 100 responses showed that every patient would recommend the service.

Case Study: Lewisham MindCare – Dementia and Information Service

Lewisham MindCare is a dementia information and support service for anyone in the borough / with a GP in the borough living with dementia.

The service, in line with NICE-guidelines and the Prime Minister’s Challenge on Dementia, establishes an infrastructure that provides opportunities for people living with dementia to lead fulfilling and rewarding lives for as long as possible. The service supports people living with dementia and their carers to ‘live well’ with the condition regardless of the level of need, severity of the disorder.

The service meets 5 main outcome areas:

1.1. Information and Advice
- Ensure people living with dementia and their carers have good-quality information on Dementia post diagnosis and throughout the course of their care.
- Provision of information that is comprehensive, easily read and available via whichever medium the individual prefers – telephone, email, post or face-to-face.
- Focus on the individual – empowering them to access the information they need, promoting independence, self-help, well-being, choice and control.

1.2. Advocacy
- Supporting people in accessing information in order to better understand what is happening to them
- Supporting people in exploring options, making better-informed decisions and actively engaging with decisions that are being made;
- Supporting people articulating their own views;
- Speaking on the patient’s behalf and representing them;
- Supporting people in other ways to ensure they can participate in the decisions that are made about their care and treatment.

1.3. Support and assistance accessing services and community resources
- Identify patients and carers support needs;
- Find out what resources and services are available to them;
- Work out what support package will best meet their needs and preferences (given the available resources);
- Organise and manage this support review and adapt this support over time;
- Potentially identify problems and avenues for help in resolving them.
1.4. Interface with primary care services and the Memory Service

- Work with primary care to facilitate referrals to this service and understanding of what the service offers;
- Support referrals to the Lewisham Memory service as necessary;
- Support clients to be informed about the benefits of Assistive Technology and refer to the Assistive Technology service as necessary;

1.5. Dementia Awareness Training for Carers and professionals

The Lewisham Memory Service offers comprehensive assessment, treatment and support options to anyone over the age of 18 years who is experiencing memory problems which are likely to indicate dementia in the borough of Lewisham. It is an integrated service with University Hospital Lewisham, South London and Maudsley NHS Foundation Trust, and Lewisham MindCare working with people experiencing memory problems. The service offers a full assessment followed by a range of treatment and support.

MindCare is currently providing high quality advice, information and support to people with a diagnosis of dementia and their family and carers.

Further, the service is to raise awareness in other local services (e.g. housing, personal care), through a program of training on topics about dementia and caring for people with the disease.

Lewisham’s goal is for people with dementia and their family and carers to be helped to live well with dementia, no matter what the stage of their illness or where they are in the health and social care system. The vision to achieve this is:

- **To encourage help-seeking and help-offering** (referral for diagnosis) by changing public and professional attitudes, understanding and behaviour
- **make early diagnosis and treatment the rule rather than the exception;** and achieve this by locating the responsibility for the diagnosis of mild and moderate dementia in a specifically commissioned part of the system. This will first, make the diagnoses well, second, break those diagnoses sensitively and well to those affected, and third, provide individuals with immediate treatment, care and peer and professional support as needed
- **enable people with dementia and their carers to live well with dementia** by the provision of good-quality care for all with dementia from diagnosis to the end of life

In 2016/17 Lewisham CCG was rated as ‘outstanding’ by NHS England for diagnosis rates and post diagnosis care planning.

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**Case Study: Hospital @ Home giving children care at home rather than on a ward**

The Hospital at Home Service has been running as a pilot in 16/17 and 17/18, with a view to embed the service in an enhanced Children’s Community Service.

The service provides ambulatory care or rapid response in the form of in/outreach into acute adding to the capacity of the Children’s Community Nursing Team (CCNT) responsible for the provision of on-going care at home.

This model of care also offers the opportunity for primary and secondary prevention as a result
of the links and in-reach into accident and emergency departments. Moreover, the avoidance of an admission, better discharge, and reduced follow up ratios in outpatient appointments will also benefit the health economy.

In addition, over time the ambulatory rapid response team is expected to develop and enhance links with primary care teams and this potentially could lend to the development of outreach clinics by advanced practitioner nurses in liaison with GP’s and hospital consultant paediatricians.

The main aims of the service are:-

- To improve care and outcomes for children and young people with acute and long term conditions by remodelling and bring together an ambulatory care response team to provide rapid response in/outreach into acute, admission avoidance with on-going care provided at home and community settings by the CCNT.

The objectives of this service are as follows:

1. To set up an ambulatory care paediatric response team to support early discharge from inpatient settings and reduce length of stay.
2. To provide ambulatory care in acute settings for admission avoidance and rapid response and follow-up care to prevent hospital re-admissions.
3. To provide ambulatory care nurse visits to ED/SSPAU daily.
4. To support children and families with up to three visits per day for at least two days following discharge to avoid readmission.
5. To offer extended working hours, 7 days week 08.00-22.00 and out of hours on call.

The service is run by specialist paediatric community nurses who visit children in their homes and provide treatment which was traditionally only available within a hospital. This includes the management of respiratory conditions such as asthma.

Benefits of the service include:

- Avoiding children having to stay in hospital for too long
- Avoiding children being admitted or readmitted
- Avoiding children going to A&E when they don’t have to.

Before the development of this programme, patients would have to stay in hospital to receive treatment that will be delivered at home or in the community.

Paediatric emergency activity for Lewisham CCG at Lewisham and Greenwich Trust, and specifically at University Hospital Lewisham was lower during the first six months of 2016/17 compared with the first six months of 2015/16.

The initiative has been so successful it is now being adopted by other local trusts.
Case Study: Lewisham Community Specialist Palliative Care Service Procurement

What does this case study look at?

This case study looks at the use of public, patient and carer involvement in the development of a new service specification and the documentation for the competitive tender of a new Community Specialist Palliative Care service in Lewisham.

Several engagement events were held where members of the public, carers, and delegates from organisations representing patients were invited to feedback on a proposed service specification and to give input into the development of questions that would be put to organisations tendering to provide the new service.

What events did we have?

We met with stakeholders three times:- one meeting with members of the CCG’s Public Reference Group, a second targeted meeting with professionals from local groups representing patients and carers and finally, an engagement event which was advertised widely and open to any interested members of the public, patients, carers or organisations working with these groups.

We initially met with the CCG leaders of the CCG’s Public Reference Group in order to see if there was any interest from individual members to be involved in the actual procurement process. We discussed the new Service Specification with them and invited expressions of interest from anyone who would be available to sit on the Tender Evaluation Panel. From this, two people were identified as being interested to know more. Upon further discussion the two members declined to be on the panel (mostly due to the time commitment required) but one of them asked to continue to be involved through any upcoming engagement events, and she attended both of them as a representative of the Public Reference Group and in her personal capacity as a carer for a family member.

The second engagement event was a meeting with professionals from local community organisations.

The invitations to this meeting were targets with the aim of looking specifically at the needs of service users with learning disabilities, mental health issues and members of the LGBT community. These three groups were targeted because research shows that they are some of the groups least likely to receive support from specialist services in the last year of life.

At this meeting there were also overlapping issues with the various groups- we talked about mental health at the end of life in the “general population” but we also had a representative from an LGBT mental health organisation. The feedback from this meeting focuses heavily on people from the different groups understanding how to access services, on them feeling welcome and that the services were for them, and on ensuring they knew their rights and how they could expect to be treated as patients and carers. This group came up with the idea of a “patient charter” as stressed the importance of information being written in a way that all patients and carers can understand it, whether that be in simple-text versions or different languages, as well as printed information including leaflets, websites and posters showing that a service was open and welcoming to all- through the inclusion of photographs.
of people of different ethnicities, same-sex couples, people with learning disabilities and physical disabilities, and people of all ages. We also discussed using links to other organisations and the use of symbols (i.e. the rainbow flag) to provide an easy visual sign that the service was open and welcoming.

Our third meeting was an engagement event open to any interested members of the public in including patients, carers, family members and representatives of organisations working with these groups. We gave the background to the project at the beginning of the event, and told participants about the meetings we had already had. We explained that one of the goals we had in mind was to develop a question to be included in the tender exercise based on the feedback and the work of the group present that day. This engagement event was facilitated by the CCG communications team and included a variety of activities, with staff from the CCG serving as scribes to take down all the information. By the end of the event we had gathered enough from the group to go forward and develop a specific question to be included in the “Technical and Quality Envelope” section of the tender. The data collected on the day was also used to help develop the KPIs around patient and carer engagement and inclusiveness.

What did we do with feedback?

The feedback from all of the events was used directly in the development of the final version of the Service Specification, KPIs and the questions included in the tender documents. There was also a member of Healthwatch present at the Engagement Event who expressed an interest in being more involved and who was asked to sit on the Tender Evaluation Panel. This person participated fully in the tender scoring process—evaluating and submitting a score for the Technical and Quality Envelope and sitting on the Panel for the bidder presentation.

How did we identify groups to approach?

The initial work with the CCG’s Public Reference Group was facilitated through the Communications Team, who discussed the project with the Group and identified two members that were interested in knowing more. The second meeting was with local professionals. These organisations were selected from those already working with NHS Lewisham CCG or with the London Borough of Lewisham to represent patients and carers in the fields of Learning Disability, Mental Health and LGBT people. Healthwatch was also invited to this meeting along with two members of the CCG’s Public Reference Group.

The Engagement Event was open to the public and we advertised via the Public Reference Group, by sending out invitations and flyers to local community groups, charities, and via the mailing list of interested individuals and groups held by the CCG Communications Team.

How were these used in the procurement process?

Bidders were required to answer the following question, which was created during the Engagement Event:

Service Users – The service users in Lewisham have a range of cultural backgrounds, languages and communication needs.

- Describe how you will ensure that the Service will be accessible to all, respect and understand everyone’s needs and values.

Include details of how your assessment processes will take into consideration individual needs of patients as they near the end of life and how the provision of care will be adapted, providing examples that show how this approach has been embedded in the Service.
How will they be incorporated into the contract

A series of KPIs relating to our service users were developed during the engagement process and will be included in the contract. These are:

- Is the Provider issuing each patient a "Patient Charter"?
- Are accessible information formats available (language, easy read text, adapted to disability, etc.) to patients?
- Is promotional material and information for patients and carers available which demonstrates that the service is welcoming to patients and carers of all backgrounds?

How will we feedback and monitor them?

These will be monitored during our quarterly monitoring meetings and we will write a report at the end of the first year to the Public Reference Group to update them on the results of the work done to include patient and public engagement findings in the contract and in the new service provision.

Next steps

We are currently in talks with the Preferred Bidder, working towards contract signing. Once the contract is signed and implementation begins, we will start to monitor these items and will present any written patient information, as appropriate, to the Public Reference Group for review and feedback. We will also carefully monitor the KPIS and any patient or carer compliments and complaints that may be submitted to the service provider or to the CCG.

Case Study: SEL(South East London) Integrated Urgent Care Service Procurement

This case study is a progress update on the engagement that took place to inform the procurement for a new service (building on the 111 pilot) that will deliver an access point for patients to urgent care and advice and how engagement with local people impacted and influenced the service specification.

Prior to March 2016, two patient engagement events were held and a survey was distributed to patients through the SEL CCGs’ communications and engagement leads; the resulting feedback was incorporated into the service specification subsequently approved by the SEL CCGs’ Governing Bodies (or their delegated committees) in March 2016.
Post March 2016, an information pack detailing our response to the patient feedback received – in the form of ‘you said, we did’ – and the more recent developments to the IUC design, was produced and shared with the SEL CCGs communications and engagement leads for distribution through their usual patient engagement channels. Additionally, patient groups were identified for further targeted engagement. These groups were identified on the basis of those who had access issues (Deaf or hard of hearing; patients for whom English is not their first language; patients with learning disabilities) and groups that the equality impact analysis had highlighted as not having been engaged with so far (e.g. LGBT).

Each CCG was asked to choose one of the patient groups and facilitate engagement with that group. Where possible, this was through the programme team attending an existing patient engagement meeting or convening a meeting for this express purpose. Where this was not possible, information was sent to relevant organisations that liaised with their service users and responded on their behalf. The following activity was undertaken:

- Information sent to Bromley Deaf Access group; response received providing advice relating to staff training, promotion of the service, and the use of deaf friendly language.
- Engagement session held with a Vietnamese group in Lewisham – 9 out of the 10 attendees had never heard of 111 before. Discussed the differences between 111 and 999, the translation service available through 111, the redesign of 111 and the best ways to promote the service to the Vietnamese community. The current service and the new design were both very well received.
- Information sent to a KeyRing representative who phoned members of Speaking Up – Southwark (a group for people with learning disabilities) to get their views on the new design for 111. Response received “I’ve spoken to each member of the group and unfortunately none of them have used the 111 line. This was because they haven’t needed to. They had all heard of it and said they would use it if they needed to.”
- Information sent to Metro (a SEL wide LGBT group); response received providing advice relating to staff training, promotion of the service, monitoring LGBT usage and links to voluntary services.
- Engagement session with Our Healthier SEL Patient Advisory Group – 3 attendees, knowledgeable about 111. Very detailed discussion about the current service and the proposed changes. The group approved of the proposed changes. 2 members were recruited to the SEL 111 Programme Board and IUC Procurement Evaluation Panel.

All of the feedback received has been incorporated into the revised service specification.

**Case Study: Lewisham Community Falls Team**

The Community Falls pathway has been redesigned to prevent the numbers of falls and falls related injuries for people over 65 by establishing a community based Falls Service and...
The new Community Falls Team, which is a therapist led multi-disciplinary team of specialist occupational therapists, physiotherapists, therapy assistants and postural, stability instructors has been designed to reduce the number of falls and harm suffered by people from falling. The team provide clinical triage of patients via a designated fall helpline. The newly established Falls Helpline allows a single point of access open to all to seek advice and information and make referrals to the team for further assessment. Referrals are received for patients across the whole falls and frailty spectrum. Referrals receive clinical triage and patients are then assigned to an evidence based intervention. The team also provides outreach and education to partner and tertiary organisations delivering specialist falls prevention education and advice sessions. The team is currently embarking on a new project designed to outreach and support high risk care environments – offering a programme of self-improvement to reduce the falls risk in these environments.

Community based Stable and Steady movement sessions have been set up for people who have fallen or who are at risk of falls. The data that is collected by the service can be used to ensure that classes are held in locations that are accessible without extended travel. Locations have been chosen based on geography, need and accessibility.

At the point of referral all protected characteristics are collected by the service, the data is used to support service development, training and education sessions for professionals and health promotion activities.

In the short time it has been operational the service has received 340 referrals. Patients can be seen at home, in the community or in one of the Stable and Steady classes. Interventions delivered include but are not exclusive to Multifactorial Falls risk factor assessments, Home Hazard Assessment, strength and balance training programme, gait re-education training programme, outdoor mobility and public transport access, cognitive assessment and re-education, provision of functional equipment and safety adaptations, falls prevention education and onward referrals and signposting to support services.

Below is a short case study from a service user:

Mrs M was referred to the service via her daughter. On assessment she had fallen several times, not been upstairs in her house in 2 years and was suffering from very low confidence and fear of falling. She had been in hospital for repeat admissions. Her gait and balance were abnormal. She had not accessed her shower in 2 years due to poor endurance on the stairs and fear. The team completed the Multi-factorial falls assessment. A Physiotherapist provided balance and strengthening exercise, the team Occupational therapist completed a bathing assessment and rehabilitation and the patient is now independent in the shower. A rehabilitation support worker guided the patient to purchase a 4 wheeled walker and then completed outdoor mobility and stairs re-education. Minor safety adaptations (stair rail, hand rail) and functional equipment were provided (bed lever, toilet frame). A bed lever was installed as the patient was falling from the bed. The patient has been referred to the stable and steady class in The Albany for a 25 week strength and balance re-education programme and the team provided guidance for transport options. A referral has also been made to community connections for the patient to have improved social access.
Case Study: Safeguarding Children

Children and young people under the age of 20 represent 25% of the total population in Lewisham. 76.5% of school aged children are from a minority ethnic group. Children in Lewisham have worse than national averages of child poverty, family homelessness, obesity rates and GSCE achievement. Teenage conception rates and teenage birth rates are higher than national averages.

The Joint Commissioning unit based in the Council manage the commissioning of community child health services and safeguarding on behalf of the CCG and Public Health. During 2016-2017 procurement and retendering of Health Visiting (including the Family Nurse Partnership) and School Nursing took place. The CCG Safeguarding Team contributed to the revised specifications and advised on ensuring equitable access to services and the continued drive to ensure safeguarding is considered in all contracts.

It was noted that there was a duplication of reporting for safeguarding to the CCG, for example, the same safeguarding reports were presented at the provider safeguarding committees and then again at the CCG safeguarding Assurance meetings. It was usually the same participants attending these meetings. The CCG arrangements for seeking safeguarding assurance were reviewed.

As part of the changes and to ensure continued sharing of safeguarding learning and improve safeguarding effectiveness across the local health economy; the CCG Safeguarding Leads now organise safeguarding conferences three times a year, focussing on relevant topics that affect vulnerable adults and children. All local healthcare providers to attend not just those organisations commissioned by the CCG. The first NHS Lewisham CCG Health Safeguarding Conference was held on Monday 30th January 2017 which aimed to bring together health providers and commissioners from all sectors of the Lewisham health economy to share best practice on identifying and protecting people who are at risk of experiencing domestic violence. 60 people attended, with representation from general practice, LGT, SLaM, LBL, private providers, the LSCB, the LSAB, NHS England, and nursing homes.

From this point we have supported one other Health Safeguarding Conference on neglect encompassing the risks for both vulnerable adults and children. We have another conference scheduled for December 2017 on modern day slavery.

The adults and children’s team work closely together to ensure that they provide expert advice supporting the safeguarding of the family for both adults and children.

The CCG therefore is ensuring that safeguarding arrangements for vulnerable adults and children are considered equitably

Case Study: Domestic Violence and Abuse in Lewisham – joint partners training workshop session for clinicians
Background

Refuge (for women and children against domestic violence), the National domestic violence charity is the largest single provider of services nationally, including opening the world’s first refuge in 1971. Refuge has supported victims of domestic violence and their children in Lewisham for over 20 years.

In April 2015, Refuge opened Athena, Lewisham’s first integrated gender based violence service.

**DV Statistics National and local**

- National - Between 2 and 3 women a week are killed by partner or ex – partner (Homicide Statistics, 1998)
- 3 women a week commit suicide to escape domestic abuse (Walby, 2004)

**January 2016 to December 2016, Lewisham had the fourth highest rate of recorded domestic abuse in London (21 recorded incidents per 1,000 population).**

2015/2016 Lewisham had the seventh highest prevalence in London for rape and sexual offences.

There have been two domestic homicides since 2014, since the launch of Lewisham VWAG strategy.

**DVA and Diversity**

DVA does not discriminate and happens in all groups and sections of society - regardless of race, disability, age, culture, mental health, religion, socio-economic level, or sexual orientation. All of these may also have an additional impact on the way DVA is experienced, dealt with and responded to.

Women and their children from some groups may find engagement with services more difficult and often face additional barriers and further oppression from society as a whole.

Racism or homophobia are examples of discrimination that may make it even more difficult for women to seek help and support.

Domestic violence also has an impact on elders for example and physical barriers may have an impact on access to services.

IRIS Advocate Educators will see clients in the community providing outreach work to support victims of DV to improve accessibility to services.

**DV and Health**

Women experiencing abuse have an increased use of both primary and secondary care services (Ulrich et al, 2003). Women with DVA experience more operative surgery, visits by and to doctors, hospital stays, visits to pharmacies and mental health consultations. Women who have depression, PTSD or are suicidal as a result of DVA have approximately twice the level of usage of general medical services and between three and eight times the level of usage of mental health services. Admitted to hospital more often and issued more prescriptions.
IRIS - is a general practice-based domestic violence and abuse (DVA) training support and referral programme that has been evaluated in a randomised controlled trial. It is aimed at women who are experiencing DVA from a current partner, ex-partner or adult family member. IRIS also provides information and signposting for male victims and for perpetrators.

IRIS (Identification & Referral to Improve Safety) is a collaboration between primary care and third sector organisations specialising in domestic violence and abuse (DVA). The pilot study, Preventing Domestic Violence and Abuse (PreDoVe) was conducted to measure the prevalence of domestic violence (DV) among women attending general practice in Hackney, London. The results showed a high prevalence of DV experienced by women attending general practice substantially higher than that recorded in the general population. It concluded that health care professionals should maintain a high level of awareness of the possibility of DV among their patients.

Women attending intervention practices were 22 times more likely than those attending control practices to have a discussion with their clinician about a referral to an advocate. This resulted in them being six times more likely to be referred to an advocate.

Women attending intervention practices were three times more likely than those attending control practices to have a recorded identification of DVA in their medical record.

The results also showed IRIS to be a cost effective intervention.

DVA Training workshop session for Clinicians in Lewisham 2017

In April 2017 Lewisham CCG, Athena (run by Refuge) held a training workshop session as part of a health safeguarding conference for Lewisham GPs and other clinicians that gave them the opportunity to better understand domestic violence and how to respond to patients experiencing domestic violence when they present themselves in healthcare settings.

The health safeguarding conference and had approximately 60 clinicians attending across the health economy of Lewisham including for example GP’s, practice nurses, care workers and managers from nursing and residential homes and social work practitioners from local borough Lewisham as well as other delegates such colleagues from joint commissioning and others.

By the end of the session participants would be able to:-
- Understand why DVA is a health issue and what to do about it in practice
- Identify patients who may be experiencing DVA – how to ask, respond, refer on and record.

10. Our Partnerships

Lewisham CCG works in partnership with other commissioners to deliver high quality support and care. Lewisham CCG aims to work in partnership with the community in the commissioning of services. There is a good record of partnership working and strong relationships with:

- **South East London Clinical Commissioning Groups** - The six CCGs in South-East London, Lewisham, Lambeth, Southwark, Greenwich, Bexley and Bromley, have
established collaborative arrangements to meet their shared and interdependent commissioning responsibilities.

- **Health and Wellbeing Board** - is a partnership that encourages local service commissioners and providers to work together to advance the health and wellbeing of the area.
- **London Borough of Lewisham** - to jointly commission services for children and young people, learning disability, mental health, physical disabilities and emerging client groups, and older adults services.
- **Lewisham Public Health** that transferred to LBL in April 2013
- **Lewisham Healthwatch**
- **Voluntary** and community organisations.
- **Healthcare providers** such as local acute, community and mental health hospital Trusts.

Please refer to the *Partnership Commissioning Intentions* in Section 5 and *Case Studies* in Section 9 that include examples of partnership working.

### 10.1 South East London Sustainability and Transformation Partnership

As we described in section 5.1.1, the south east London Sustainability and Transformation Partnership (STP) is one of our key strategic plans, focused on implementing the Five Year Forward View and covering the period up to March 2021.

The south east London draft plan was submitted 30 June 2016. The STP is the “umbrella” plan for south east London and draws extensively on the Our Healthier South East London (OHSEL) strategy which has been in development since 2013. The STP process, however has broadened the OHSEL plan and has taken it much further by bringing organisations together within a governance framework:

- A single responsible officer supported by a quartet leadership and a strategic planning board to provide direction and oversight
- Collaborative oversight and decision-making bodies at various levels
- A single reporting structure
- A single plan setting out our challenges, including our financial challenge

Over the next five years the SEL STP commitments are to:

- Support people to be in control of their health and have a greater say in their own care
- Help people to live independently and know what to do when things go wrong
- Help communities to support each other
- Make sure primary care services are consistently excellent and have an increased focus on prevention
- Reduce variation in outcomes and address inequalities by raising the standards in our health services
- Develop joined up care so that people receive the support they need when they need it
- Deliver services that meet the same high quality standards whenever and wherever care is provided
- Spend our money wisely, to deliver better outcomes and avoid waste

These priorities have been informed by a case for change that includes population health needs, by an equalities impact assessment carried out in 2014 that identified approaches and considerations in the further development of the OHSEL strategy, and by a further equalities
analysis in 2015 that made recommendations in respect of priority groups for further engagement and for reaching ‘seldom heard groups’.

### 10.2 Our Healthier SEL Equalities Steering Group

Lewisham CCG is a member of the Our Healthier SEL Equalities Steering Group (OHSEL ESG). The role of the group is:

- to ensure that the Our Healthier South East London STP meets the requirements of the Equality and 2010 and specifically the Public Sector Equality Duty
- to ensure that the Our Healthier South East London strategy meets the requirements of the Health and Social care Act 2012, with specific reference to tackling health inequalities
- to commission and approve independent equalities analyses and impact assessments as appropriate
- to monitor progress on meeting the equalities requirements set out above and to produce reports for IEG and the Communications and Engagement Steering Group as appropriate
- to promote a best practice approach to equalities work and highlight any concerns.

Lewisham CCG’s Chief Officer is the Senior Responsible Officer for the Engagement and Communication aspect of the programme. The CCG has ensured that OHSEL engagement activities are appropriate and reflect Lewisham’s diversity.

### 11. Our Main Provider Organisations

NHS Lewisham CCG has in place mechanisms to meet its duties to ensure that key provider organisations comply with their equality duties, working in partnership with main provider organisations to include equality, diversity and human rights clauses within its contracts.

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<td>Lewisham &amp; Greenwich NHS Trust</td>
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<td>✓</td>
<td>✓</td>
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<tr>
<td>South London and Maudsley NHS Foundation Trust</td>
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Lewisham CCG's quality and performance teams regularly review provider’s patient experience and staff engagement data from our main provider. Lewisham CCG manages the Clinical Quality Review Group (CQRG) for Lewisham & Greenwich NHS Trust (LGT) by clinical directors, senior officers and CSU contractor colleagues.

Lewisham CCG also commissions significant number of acute hospital services from Guys & St Thomas’s NHS Foundation Trust (GSTT) and King’s College Hospital NHS Foundation Trust.
(KCH) for our local population, as well as a range of other hospital services from other London NHS providers.

Lambeth CCG is the Lead Commissioner for GSTT and responsible for ensuring equality reporting and progress. Southwark CCG is the Lead Commissioner for KCH. When necessary, Lewisham CCG has requested equality reporting from both CCGs if it has not been possible to find information from the Trusts themselves.

Equality progress can be found for GSTT here http://www.guysandstthomas.nhs.uk/about-us/equality/equality-and-diversity.aspx
Equality progress can be found for KCH here https://www.kch.nhs.uk/about/corporate/equality-and-diversity

11.1 Lewisham & Greenwich NHS Trust

Lewisham CCG is the lead commissioner for monitoring quality of this organisation and ensures that it meets its legal duties in relation to equality, diversity and human rights by including clauses within its contract. This also requires the Trust to monitor workforce and service activity in relation to the Public Sector Equality Duty (PSED).

On 17 August 2017 the Care Quality Commission published its report of its March 2017 inspection of Lewisham & Greenwich NHS Trust. The Trust’s overall rating is “requires improvement”. Areas where the Trust must make improvements include monitoring and improving the quality and safety, improving risk management and audit processes, increasing staffing levels in line with national standards and service specifications and appropriate and timely care. The trust will now address the findings and recommendations through action plans. http://www.cqc.org.uk/provider/RJ2?referer=widget3

The CQC report highlighted a number of areas where the Trust has improved since the last inspection in 2014, and the CQC acknowledges several areas of good and outstanding practice. The Trust’s community services for children, young people and families were rated as “Outstanding”, and community services for adults rated as good. A wide range of hospital services at both Queen Elizabeth Hospital and University Hospital Lewisham were rated as “Good”.

Following the publication of the CQC report, NHSE has applied formal Directions to Lewisham CCG from 1 September 2017 in relation to the failure of the CCG to discharge its commissioning function effectively in response to significant issues raised relating to urgent and emergency care at Lewisham and Greenwich NHS Trust. The requires the CCG to work with and cooperate with Southwark CCG as necessary to enable Southwark CCG properly to exercise Lewisham CCG’s acute commissioning functions and to enable Lewisham CCG to ensure the development and implementation of the U&EC Recovery Plan in accordance with NHS England Directions.

Whilst recent improvements have been made, the CCG recognises further improvement is needed to support sustainable delivery of outcomes for our local community and to address both performance and quality standards.

Lewisham & Greenwich NHS Trust has been implementing the Equality Delivery System that is linked to the Trust’s Equality Objectives for 2015-2017. Progress reported to the Trust’s Equality Steering Group. Equality and diversity progress in Lewisham & Greenwich NHS Trust can be found at their website.
11.2 South London and Maudsley NHS Foundation Trust

South London and Maudsley NHS Foundation Trust (SLaM) provides mental health services in Lewisham.

The Trust delivers general and specialist mental health and substance misuse services to Lewisham’s population. They provide services for adults, as well as specialist services for young people. These include daycare, inpatient care and community services.

The quality of services provided by SLaM are monitored at “four borough” CQRG attended by Lewisham CCG clinical directors and senior officers.

The Trust is currently delivering seven CAG equality objectives (2017-20). The Trust is also developing Trust-wide equality objectives for service delivery and workforce as part of a new Trust equalities strategy that will be submitted to its Board in 2018 (date tbc).

SLaM has been using the Equality Delivery System as a framework to identify where they need to focus their attention to improve on equality since 2013. In 2015 SLaM developed a substantial Workforce Equality Objective that brings together a number of strands and work streams. An integral component to the objective is the implementation of the Workforce Race Equality Standard (WRES) that is now a national contract requirement and expectation of all NHS Provider Organisations. SLaM published a WRES report for 2016 that compares results in 2015. The 2017 WRES report was discussed at a Board to Board meeting between Lewisham CCG and SLaM in November 2017. Issues raised are being followed up and reported by to the CQRG meetings in 2018.

On 31 October 2017 the Care Quality Commission published its report of its July 2017 inspection of SLaM’s Community-based mental health services for adults of working age. The overall rating of Requires improvement was given. http://www.cqc.org.uk/sites/default/files/new_reports/AAAG6826.pdf

The latest Annual Equality Reports South London and Maudsley NHS Foundation Trust can be accessed by following this link http://www.slam.nhs.uk/about-us/equality

11.3 Friends and Family Test

Patients have an opportunity to routinely give their feedback after receiving care or treatment through the Friends and Family Test (FFT). This test aims to assess the quality of patient experience from responses to the simple question “Would you recommend this service to your friends and family?” A snapshot of results for Lewisham CCG Providers are as follows:

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<th>NHS Provider</th>
<th>Month/Year</th>
<th>Percentage that would recommend service</th>
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<tr>
<td>Lewisham &amp; Greenwich NHS Trust (In Patient)</td>
<td>September 2017</td>
<td>96% (of 1,770 responses)</td>
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<tr>
<td>Lewisham &amp; Greenwich NHS Trust (Community)</td>
<td>September 2017</td>
<td>99% (of 201 responses)</td>
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In addition to the core clinical and outcomes data, CQRGs review the results of the Friends and Family test and other sources of patient feedback. In 2015-16, the CCG identified that Lewisham and Greenwich NHS Trust were underperforming when it came to responding to complaints within the agreed timescale. The CCG provided significant support which has led to an improvement in their performance from a low of 20% to the current position where 80% of complaints are responded to within the agreed timescale. The Trust achieved its complaints response time target of 95% in November 2016 and then for six consecutive months between February and August 2017 until staff shortages led to a fall to 88% in September. The Trust expects to see improvement again by November.

The CCG is represented at CQRGs of other acute providers by clinical directors and senior officers of respective host commissioning CCGs. Reports including trends and benchmarking data are presented for discussion at the CCG’s CQRG meetings with acute and mental health providers, ensuring any issues are discussed and addressed quickly and providers are held to account to improve patient experience. Where improvements are being made this is recognised.

12. Safeguarding in Commissioning

As a commissioning organisation Lewisham CCG is required to ensure that all health providers from whom it commissions services (both public and the independent sector) have comprehensive, single and multi-agency policies and procedures in place to safeguard and protect adults and children at risk from abuse and the risk of abuse itself.

The CQRGs (Clinical Quality Review Groups) for each organisation present a range of metrics to the CCG on a monthly basis, for example

- Number of safeguarding referrals made,
- Percentage of staff compliance in training in safeguarding adults and children
- Percentage of compliance in DBS (Disclosure and Barring Service) checks
- Compliance in the Mental Capacity Act 2005

The CCG receives both quarterly and annual safeguarding returns, reports and dash boards to support analysis of safeguarding assurance from providers.

The safeguarding nurse advisor supports nursing and residential homes for quality and safeguarding acting as critical, friend, coach and mentor to support the sustainable raising of standards. The CCG is supporting a number of training days to support these providers in key areas for improvement such as care planning, documentation standards, tissue viability and safeguarding referral pathways. An annual audit development is in progress and the homes are regularly visited and reports generated and shared with partners. Feedback is generated and shared with the provider at the time of visit and any actions for improvement.
The CCG attends the Safeguarding Committee meetings of the South London and Maudsley NHS Foundation Trust (SLaM) and Lewisham & Greenwich NHS Trust (LGT) so to enable the CCG to challenge performance at both meetings. The CCG is a member of Provider Concern meetings chaired by local borough Lewisham and the Acute Pressure Ulcer Panel providing expert clinical advice. The CCG is a member of the Violence Against Women Steering Group, the Serious Adult Review Group, the Domestic Homicide Review Group and the Prevent Steering Group providing expert safeguarding and clinical advice to partners in order to support providers.

The CCG chairs the Community Pressure Ulcer Panel and conducts delegated health inquiry under S42 of the Care Act 2014. This enables and encourages providers in a learning environment to understand the causes of community acquired pressure ulcer.

In addition the CCG holds quarterly Health Safeguarding Assurance meetings whereas safeguarding provider assurance is reviewed. Operational Safeguarding meetings for the CCG Safeguarding team are held monthly for strategy development.

The CCG supports safeguarding supervision for safeguarding professionals in provider areas of Lewisham and employs Designated Nurses and a Doctor and a Consultant Nurse in adult safeguarding.

Annual reports are produced for Adults and Children’s Safeguarding and we also contribute to the Annual reports of the LSAB (Lewisham Safeguarding Adult Board) and LSCB (Lewisham Safeguarding Children Board) Lewisham.

The CCG also holds Health Safeguarding conferences three times a year involving the whole Lewisham Health economy such as domestic violence, self-neglect and modern day slavery. All providers are invited and have been well attended.

13. Complaints

Lewisham CCG manages the PALS and Complaints services which aim to improve:

- Liaison with our patients
- Understanding of the types of concerns affecting Lewisham residents
- Feedback for CCG staff
- Handling complaints as close to the patient/source as possible, for the best outcomes
- Accuracy reporting of issues or concerns so that CCG can be warned earlier of gaps or failings in services.
- Wider engagement with our community

Complaints numbers for 1st April 2016 – 21st March 2017:

- Total interactions: 93
- Formal complaints requiring a CCG response: 25
- Equality and Diversity monitoring forms received back: 5

The complaints are a combination of complaints about CCG commissioning / complaints about Provider services.

Learning from the CCG’s investigations into complaints has resulted in changes and learning, for example:
• In response to a complaint about the Continuing Healthcare process, a new interim Continuing Healthcare Manager was put in post and reviewed all retrospective CHC assessments completed by previous staff before they were presented to panel for CCG ratification;

• In response to a complaint about delays to finding out the outcome of, and ensuring accuracy in, a Continuing Healthcare application, the CCG procured a new NHS Continuing Healthcare Electronic patient database that has an interface with the NHS Spine that will provide timely updates and can be used by the team to verify patient records. In addition, all eligibility letters are now issued within 7 working of the panel meeting;

• In response to a complaint about being referred to Cantilever House for a clinic appointment, we contacted the system lead and the practice GP responsible for booking the appointment to ensure correct booking in the future and that Cantilever House will not be indicated as a clinic for attendance. We have ensured any computer programming error in the automated booking system is corrected. Our review has confirmed that the error was a one-off incident, and we have double-checked the referral processes for accuracy and to ensure any issues do not happen again in the future;

• In response to a complaint about the New Cross Walk-in Centre, a notice board displaying the waiting time has been installed.

14. Workforce Race Equality Standard

The Workforce Race Equality Standard (WRES) is a benchmarking tool introduced by NHS England to assess the progress of race equality within NHS organisations annually, following an initial evidence baseline gathered in 2015. The WRES is based on new research on the scale and persistence of such disadvantage and the evidence of the close links between discrimination against staff and patient care.

The Standard highlights any differences between the experience and treatment of White staff and BME staff in the NHS with a view to closing those metrics through an action plan. The WRES definition of White and BME staff is as follows:

“White” staff includes White British, Irish and Any Other White. The “Black and Minority Ethnic” staff category includes all other staff except “unknown” and “not stated”. “Any Other White” contains minority groups including white European.

14.1 Workforce Race Equality Standard in Lewisham CCG

Lewisham CCG has gathered data against the nine WRES metrics for 2017. The data does not have to be published due to the small numbers reported and to protect staff identity under the Data Protection Act. However, the CCG has agreed to publish the metric regarding BME
staff in bands 8-9 and VSM (Very Senior Management) compared to the workforce overall – please see chart below for details:

---

**BME staff in bands 8-9 and VSM compared to the overall workforce - 30-NOV-2017**

<table>
<thead>
<tr>
<th></th>
<th>Total - Workforce</th>
<th>Bands 8-9 and VSM</th>
</tr>
</thead>
<tbody>
<tr>
<td>White - British</td>
<td>45.45%</td>
<td>56.41%</td>
</tr>
<tr>
<td>White - Irish</td>
<td>1.30%</td>
<td>1.30%</td>
</tr>
<tr>
<td>White - Any other</td>
<td>6.49%</td>
<td>5.13%</td>
</tr>
<tr>
<td>White - Any other</td>
<td>38.96%</td>
<td>28.21%</td>
</tr>
<tr>
<td>BME</td>
<td>7.79%</td>
<td>0.26%</td>
</tr>
<tr>
<td>Not Stated</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

---

**Analysis:**

The percentage of BME staff in bands 8-9 and VSM is 28% which is 8% less than in 2016 and 10% less than the CCG representation of BME employees in the CCG’s workforce that is 39%.

The percentage of BME Governing Body members is also 20% which is 5% less than last year and less that the percentage of BME staff in bands 8-9 and VSM.

The CCG has noted that both BME figures do not reflect the percentage of BME people in the Lewisham population which is 46.5%. A WRES action plan is being delivered to improve the percentages/representation of BME staff at senior levels and Board membership.
14.2 Workforce Race Equality Standard in Lewisham CCG’s Providers

Since 2015-2016, all CCGs need to demonstrate that they are giving “due regard” to using the WRES indicators, and assurance that their Providers are implementing the WRES.

An analysis of performance across the CCG’s Providers in 2015 has been reviewed by the CCG Equality and Diversity Steering Group.

In 2017, through the contractual arrangement, the CCG’s will receive reports at the Clinical Quality Reference Groups from local Providers, who are expected to:

- Carry out a comparison of baseline data from April 2015 with April 2016 including steps underway to address key shortcomings in data, or significant gaps between the treatment and experience of white and BME staff.
- Publish WRES data for March 31st 2017 on Trust web site and share with Board and staff.
15. Lewisham CCG Workforce Information

The Public Sector Equality Duty requires that information on the make-up of the workforce must be published where public authorities have 150 or more employees. The data does not have to be published by organisations with less than 150 employees to protect staff identity under the Data Protection Act. Lewisham CCG has a total of 77 employees and also purchases additional commissioning support services from NEL Commissioning Support Unit.

The workforce is a critical factor in the effective delivery of Lewisham CCG business. A quarterly workforce monitoring report is submitted to the senior management team of the CCG including workforce information relating to numbers of staff in post, turnover and sickness absence and an equalities profile relating to six of the nine protected characteristics and highlights key differences and/or issues to the senior management team.

15.1 Lewisham CCG Workforce Race Equalities profile

Although Lewisham CCG has no legal duty to publish our workforce data, as the CCG employs less than 150 staff, the CCG has chosen to do so as part of our good practice. The following tables are a snapshot profile of the organisation (by percentage), relating to six of the nine WRES metrics as at 30th November 2017. Monitoring will continue to identify any priority areas to address.

The data below for Race/Ethnicity shows that the CCG has a representation of BME employees in its workforce of 39% compared to the demographics (according to the 2011 National Census) BME people make up of around 46.5% of Lewisham’s population. This figure has remained the same as in 2016. The CCG is working towards reflecting the communities that its serves at all levels of the workforce.

![Race/Ethnicity Chart]

- A White - British: 6.49%
- B White - Irish: 1.30%
- C Other White: 1.30%
- D Mixed - White & Black African: 1.30%
- E Mixed - Any other mixed background: 5.19%
- F Asian or Asian British - Indian: 2.60%
- G Asian or Asian British - Pakistan: 2.60%
- H Asian or Asian British - Bangladeshi: 0.00%
- I Asian or Asian British - Chinese: 0.00%
- J Asian or Asian British - Other: 0.00%
- K Black or Black British - Caribbean: 7.79%
- L Black or Black British - African: 7.79%
- M Black or Black British - Any other: 7.79%
- N African or Any Other Black: 3.90%
- O Other Ethnic Group: 5.19%
- P Not Stated: 9.09%
Gender

<table>
<thead>
<tr>
<th></th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>74.03%</td>
</tr>
<tr>
<td>Male</td>
<td>25.97%</td>
</tr>
</tbody>
</table>

Disability

<table>
<thead>
<tr>
<th></th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>83.12%</td>
</tr>
<tr>
<td>Not Declared</td>
<td>12.99%</td>
</tr>
<tr>
<td>Yes</td>
<td>3.90%</td>
</tr>
</tbody>
</table>
Age

Sexual Orientation

Heterosexual

I do not wish to disclose my sexual orientation

64.94%

35.06%
Religion

- Atheism: 10.39%
- Christianity: 33.77%
- Hinduism: 5.19%
- I do not wish to disclose my religion/belief: 38.96%
- Islam: 3.90%
- Other: 7.79%
15.2 Equality and Diversity Training for Lewisham CCG Staff and governing Body

In terms of training and development, we have agreed a training package with the SECSU to provide and monitor mandatory and statutory training including Equality and Diversity training. Further training may be commissioned following a training needs analysis.

During 2017, both CCG Staff and Governing Body members have attended a range of training sessions, workshops and inductions as detailed below:

<table>
<thead>
<tr>
<th>Type of Training</th>
<th>Who Attended</th>
<th>Delivered by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equality and Diversity briefing for new staff as part of induction Throughout 2017.</td>
<td>Commissioners, Patient and Public Participation staff</td>
<td>Equality, Diversity &amp; Inclusion Manager NEL Commissioning Support Unit (NELCSU)</td>
</tr>
<tr>
<td>Equality Delivery System briefings and workshop May-September 2017</td>
<td>Lewisham Public Reference Group</td>
<td>Equality, Diversity &amp; Inclusion Manager NELCSU</td>
</tr>
<tr>
<td>Equality Delivery System and the CCG experience in 2016 presentation July 2017</td>
<td>All CCG Staff who attended staff meeting.</td>
<td>Equality, Diversity &amp; Inclusion Manager NELCSU</td>
</tr>
<tr>
<td>Equality Analysis Training workshops covering the theory and reviewing exemplar EAs. May and October 2017</td>
<td>CCG Staff that signed up to attend.</td>
<td>Equality, Diversity &amp; Inclusion Manager NELCSU</td>
</tr>
<tr>
<td>Strategy and Development Workshop Embedding equalities in the CCG December 2017</td>
<td>Governing Body members</td>
<td>Deputy Director (Strategy &amp; Organisational Development) Equality, Diversity &amp; Inclusion Manager NELCSU</td>
</tr>
</tbody>
</table>
## Useful Information

<table>
<thead>
<tr>
<th>Name of document</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint Strategic Needs Assessment</td>
<td><a href="http://www.lewishamjsna.org.uk/reports">http://www.lewishamjsna.org.uk/reports</a></td>
</tr>
<tr>
<td>Lewisham Health Profile 2017</td>
<td><a href="http://www.lewisham.gov.uk/inmyarea/Pages/Census-2011.aspx">Lewisham Health Profile 2017.pdf</a></td>
</tr>
</tbody>
</table>
Integrated Governance Committee
Minutes of Meeting held on Thursday 23rd October 2017

Present
Dr Jacky McLeod (JM) Senior Clinical Director (Chair)
Dr David Abraham (DA) Clinical Director
Diana Braithwaite (DB) Director of Commissioning and Primary Care
Dee Carlin (DC) Head of Joint Commissioning
Dr Charles Gostling (CG) Clinical Director
Dr Sebastian Kalwij (SK) Clinical Director
Shelagh Kirkland (Ski) Lay Member
Dr Faruk Majid (FM) Clinical Director
Prof. Simon Mackenzie (SMa) Secondary Care Doctor
Dr Angelika Razzaque (AR) Clinical Director
Tony Read (TR) Chief Financial Officer
Dr Marc Rowland (MR) Chair
Ray Warburton (RW) Lay Member

Attending
Mike Hellier (MH) Head of System Intelligence
Graham Hewett (GH) Associate Director of Quality
Heather Hughes (HH) Joint Commissioning Lead Complex Care & Learning Disability
Susanna Masters (SM) Corporate Director (Deputy for MW)
Corinne Moocarme (CM) Joint Commissioning Lead, Community Support and Care
Sarah Osborne Associate Director - Performance (ICDT)
Neil Stevenson (NS) Associate Partner (BGL), CSU
Hannah Reeves (HR) Corporate Admin Manager (Minutes)

Apologies
Alison Browne (AB) Nursing and Quality Director
Martin Wilkinson (MW) Chief Officer

1. Welcome and Introductions
JM, as acting Chair, welcomed all to the meeting.

2. Apologies for Absence
Apologies were taken and noted.

3. Declaration of Interests (DoI)
There were no new interests declared.

4. Minutes of Previous Meeting (28th September 2017)
The minutes were agreed as an accurate reflection of the meeting, with one minor amendment to draw out an action from the narrative.

4.1 Review of Action Log/Tracker
The action log was reviewed and updated.

5. Matters Arising
There were no matters arising at the meeting.
6. Integrated Performance Report

6.1 Quality

6.1.1 Patient Experience Surveys - Cancer Patient Experience

The Committee received the cancer patient experience survey which demonstrated overall improvement for Lewisham registered people diagnosed with cancer in 2016. It was highlighted that work is ongoing to maintain and improve on all indicators, especially relating to care plans. The Committee heard that there is an issue regarding the difference in knowledge and perceptions of care plans, which needs to be addressed. The Committee queried what actions had been undertaken that resulted in such important improvements, MHe confirmed there is a system wide meeting scheduled to look into the results and that he would report back to IGC regarding the outcomes of this meeting.

Action: MHe to feedback on the link between results of survey and what actions led to the significant improvements.

The Committee agreed that it would be useful to link this data to reported data received by the Primary Care Commissioning Committee. The Committee also agreed that LCCG should set a target to hit in relation to care plans, to ensure improvement. It was agreed that the Primary Care Operational Group (PCOG) should set this standard.

Action: PCOG to set care plan standard, on behalf of the IGC and PCCC.

The Committee commented on the response rate to the survey and whether this is something that can be improved upon. It was agreed that the ICDT would look into this.

Action: SO to investigate options for improving survey uptake rates.

6.1.2 Patient Experience Surveys – A&E Patient Experience

The Committee received the A&E patient experience survey, which was undertaken by the CQC and focused on patients served in the main A&E departments, which are known as type one. The survey results place LGT in the bottom quartile for waiting to be examined, cleanliness, access to food and drink and assessment of living conditions. The Committee queried whether the work that is underway in relation to LGT A&E improvements is the right work to be carrying out and whether further actions need to be put in place. The Committee was reminded that there is a delay in receiving this data so it would be expected that the significant work underway would have a positive impact on these results if and when the survey is redone.

The Committee commented that whilst it was beneficial to receive data regarding this, it would have been more enlightening for the IGC to receive narrative from LGT regarding how these points have or will be addressed. The Committee agreed to task the AEDB with looking into these points further from an LGT perspective and that a report should come back to IGC.

Action: MW to feedback on interpretation of survey results and actions being taken by AEDB

6.1.3 Large Residential Care Home in Lewisham

The Committee was informed that since the last meeting of the IGC further unannounced visits have been undertaken along with review meetings to discuss the action plans in place and the implementation. The Committee was informed that significant improvements have been noted, especially regarding interactions between staff and patients, the management of patients’ hydration levels. The Committee heard that, despite the improvements there remains some caution as concerns related to admitting new clients could not be monitored due to the homes self-imposed embargo. The Committee was informed that the embargo will be lifted from 1st November and monitoring of care given to new clients will be monitored as part of unannounced visits, along with meetings with the provider to go through how to best sustain all the improvements made.
The Committee commended HH for her work and requested that an update come back to IGC in January 2018.

The Committee were assured that the large residential care home has significantly improved to enable the embargo to be lifted and requested that a further update comes back to IGC in January 2018.

6.1.4 Healthwatch: Q2 Intelligence Report

The Committee received the Q2 intelligence report from Healthwatch and noted the 5% increase in good news stories for Lewisham. The report highlighted the increase in conversation and understanding of online access and service, although this is still accompanied by discussions regarding the older demographic not being online and still having issues accessing GP services on the telephone. It was noted that there is an increased awareness regarding the GP Extended Access service.

The Committee noted the reported issues regarding internal communications at University Hospital Lewisham and how some patients were unaware that patients and families could be involved in the care plan process.

The Committee was informed that experiences of utilising Lewisham services are still significantly varied across the patients Healthwatch have spoken to. It was agreed that the data collected in the Healthwatch intelligence reports should be used routinely in the CCG work streams, to aid service design and to ensure patient experience is continuously considered in the commissioning process.

Action: Healthwatch intelligence data to be routinely used in work streams – CDs and SMT to consider how to take this forward.

6.1.5 Healthwatch: Hospital Discharge Report

The Committee received the hospital discharge report from Healthwatch. The report findings focused on the good dialogue between patients and nursing staff, however the issue of poor internal communication was raised, with patients noting a disconnect between nursing staff and consultants. The report also noted that a significant number of patients felt they were not adequately involved in the decision making processes regarding their discharge plan.

The Committee agreed that, in light of the report, further training was required for LGT staff, specifically around involvement of patients and family, to ensure they are engaged in the process as well as discharge process training. The Committee discussed how the CCG might support Healthwatch in improving these issues.

Action: CCG to monitor implementation of action plan by LGT

6.2 Performance Report

6.2.1 Cancer waiting times – GP RTT 62 Days

The Committee was informed that the CCG is significantly below the standard in August 2017, with inter provider transfers between LGT and the tertiary centre by day 38 stood at approximately 77.8% against the 85% standard. The Committee was informed that there is a high risk that sustainable improvement will not be met in 2017 / 18 as GSTTs performance is not planned to deliver the standard. The Committee heard that a number of work plans are in place across the system, including looking at independent diagnostic providers and actions regarding priority tumour groups. The Committee was also informed that mitigating actions such as the Somerset System and MDT Coordinator posts are being implemented.

The Committee agreed to report to the LCCG Governing Body that the IGC is not assured on:

A. Delivery of standard by March 2018
B. Equitable access post day 38 for Lewisham patients

6.2.2 A&E 4 hour Performance

The Committee was informed that performance did not meet the standard in September 2017 and also did not meet the improvement plan trajectory. The Committee received the improvement plan which fulfils the requirement on the CCG to submit an A&E recovery plan as requested in Directions. The Committee was informed that the plan includes the winter plan which was submitted to NHS England on 11th October 2017. The Committee heard that the winter plan is not currently fully funded and does request funding support, which has yet to be confirmed. The Committee agreed there is significant risk regarding the funding support for the winter plan and whether the lack of a contingency plan if the requested funding support is not received.

The Committee agreed it would be necessary to receive a full report looking at the implemented actions during September and October and the progress being made, it was agreed that this report would come back to the November IGC meeting.

The Committee asked the executive team to consider the differing management practices of LGT at the A&E departments at the two separate sites, in connection with delivering the A&E standards, in order to open this up to a Governing Body discussion further down the line.

The Committee queried whether it would be possible to prioritise engagement strategies to ensure that the public are fully sighted on the issues faced by the CCG and how local health services may need to be organised differently in order to be sustainable.

The Committee confirmed its expectation to regularly receive detailed and robust information and reporting from the A&E Delivery Board, to maintain grip from a CCG perspective.

Actions:

1. The Committee requested a report on the achievement of plan milestones in September and October 17 at its next meeting.

2. CDs and SMT to add to forward agenda planner A&E and Urgent Care systems across LGT and how to prioritise engagement to support this.

3. A&E Delivery Board to submit regular reports to IGC

The Committee agreed to report to the Governing Body that the IGC is not assured regarding the performance and improvement plans.

6.2.3 RTT 52 week breaches

The Committee was informed that NHS England have recently written to the CCG Chairs requesting assurance on over 52 week waiting patients and how they have been clinically reviewed and that although there are currently none in Lewisham, some Lewisham patients do make up those waiting at KCH and GSST. The Committee was informed that LGT currently review patients at 40 weeks.

The Committee recorded their disappointment at the lack of improvement in this area, especially considering the different plans that have been implemented to try and improve the position. The Committee agreed to report to the Governing Body that they are not assured, despite the new trajectories in place which have been signed off by NHS England and NHS Improvement.

The Committee agreed to report to the Governing Body that the IGC is not assured.

6.3 Month 6 Finance Report

The Committee was informed that at Month 6 the CCG is reporting on plan and also forecast to deliver an in year break even position and a cumulative surplus of £9.38m for the year. The Committee heard that the acute overspend may change as a result of the Q1 close down process.
However it is not expected to change significantly. Overspends continue as per Month 5 in CHC, prescribing and mental health. In addition there is reported slippage in QIPP plans. The CCG has had to utilise all available contingencies as mitigations. There is overall negative net risk in the position and the delivery risk for the financial targets is high.

FIC is overseeing financial performance and QIPP in more detail this year.

The Committee was informed that the Primary Care budget is forecast to be close to breakeven at year end. The allocation reserve relating to primary care has been utilised along with all other contingencies and reserves to manage the CCG’s overall financial position as reported in the Month 6 report. However the CCG does routinely spend considerably more than its primary care allocation on primary care services, such as the co-ordinated care contract.

The Committee was informed that to aid the QIPP recovery, Clinical Director leads have been allocated to schemes. The QIPP recovery plans are currently being reviewed and assessed by the Clinical Directors and Senior Management Team as well as the Finance and Investment Committee.

The Committee questioned what the impact on the CCGs financial position would be if funding bids are unsuccessful for supporting the winter plan. Potentially it would create a cost pressure if winter plan expenditure was higher than budget. It was agreed that this would be discussed by the Finance and Investment Committee.

7. CQC Inspection of LGT – Update report

The Committee received the update report detailing the agreed areas of key concerns for LCCG and LGT and the proposed structure and process for implementing the anticipated action plan. The Committee was informed that the CQC is expecting the agreed action plan from LGT by 26th October 2017.

The Committee was informed that once the action plan has been agreed by NHS England and NHS Improvement discussions will be held with the wider system in order to agree one merged quality improvement plan to be monitored through Contract Management Board (CMB) quality arrangements e.g. CQRG.

8. Summary of providers WRES performance (LGT & SLaM)

The Committee received the providers WRES performance report and agreed the recommendation that the CQRG reports back to the Committee in April 2018 after it has received progress reports on WRES improvement plans from both LGT and SLaM.

It was confirmed to the IGC that providers currently have action plans in place which are monitored through the CQRG mechanisms. The Committee requested that members of the CQRG on behalf of Lewisham CCG request that these reports are escalated to the relevant provider boards.

The Committee agreed that further reflection on the diversity of the LCCG Board should be taken into consideration going forward, especially when discussing the diversity of provider boards and the reflection of these boards in line with the demographics of the populations they serve.

The Committee discussed the link between this work and the self-assessment on leadership, including the IAF indicators. It was agreed that this would be a relevant future topic for a Strategy and Development Workshop and should also be considered in line with STP level information.

Action: WRES indicators, IAF indicators and the Governing Body self-assessment results and the link to STP level information to be added to the future agenda planner for the Strategy and Development workshop.

9. Corporate Objectives Q3 & Q4
The Committee endorsed the refreshed Q3 & Q4 Corporate Objectives, noting the priority milestones and success measures.

10. Risks (Board Assurance Framework)

The Committee queried the assessment of the current target scores for two risk areas:

A&E System wide delivery (Risk ID 78) - the current score has decreased to 4 (Impact) x 3 (likelihood). The view of the Committee was that the current score should be 4 (Impact) x 4 (likelihood) on the basis that it was considered that currently it is probable that we would not achieve the agreed A&E trajectory by the end of the financial year.

QIPP Schemes 2018/19 and 2019/2020 (Risk ID 83) the current score has decreased to 4 (Impact) x 3 (likelihood). The view of the Committee was that the current score should remain at 4 (Impact) x 4 (likelihood) on the basis that the delivery of QIPP this year has proven very challenging this year and it will be even more challenging to deliver in the next financial year.
Minutes of the meeting of the Strategy & Development Committee held on
Thursday 5th October 2017
Rooms 1 & 2 Cantilever House

Members
Dr David Abraham (Chair) (DA) Senior Clinical Director
Magna Aidoo (MA) Healthwatch Representative
Alison Browne (AB) Registered Nurse Member
Aileen Buckton (ABu) Executive Director Local Authority
Dr Charles Gostling (CG) Clinical Director
Anne Hooper (AH) Lay Member
 Shelagh Kirkland (SKi) Lay Member
Dr Dr Faruk Majid (FM) Clinical Director
Professor Simon MacKenzie (SMa) Secondary Care Doctor
Dr Jacqueline McLeod (JM) Senior Clinical Director
Dr Angelika Razzaque (AR) Clinical Director
Tony Read (TR) Chief Financial Officer
Ray Warburton OBE (RW) Lay Member
Martin Wilkinson (MW) Chief Officer

In Attendance
Dee Carlin (DC) Head of Joint Commissioning
Carmel Langstaff (CL) Deputy Director (Strategy & Organisational Development)
Charles Malcolm-Smith (CMS) Corporate Director
Susanna Masters (SM) Corporate Director
Ashley O’Shaughnessy (AOS) Programme Lead, Whole System Model of Care
Sarah Wainer (SW) Programme Lead, Whole System Model of Care

Apologies
Diana Braithwaite (DB) Clinical Director
Dr Sebastian Kalwij (SK) LMC Chair
Dr Simon Parton (SP) LMC Chair

1 Introductions and Welcome

The Chair welcomed all to the meeting.

2 Declarations of Interest

The Chair reminded members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of Lewisham Clinical Commissioning Group. Declarations declared by members of the Strategy and Development Workshop are listed in the CCG’s Register of Interests. The Register is available either via the Corporate Services Officer or the CCG website.

3 Summary notes of the workshop on 2017

The minutes of the previous meeting were reviewed and agreed as an accurate record with one amendment, to add Professor MacKenzie to the attendee list.
The action log was reviewed and updated. It was agreed that action: August 9 would remain open on the action log until the documents are received and circulated. This will mean having a due date of “on going”.

4 Lewisham Health and Care Partners – CBC Vision

The group received the vision for community based care, presented by SW. The Committee were asked to agree the vision, which will provide the framework for provider and commissioning activity and inform the development of local strategies and plans.

SW informed the group that the next step will be to focus on how this vision is communicated to the wider system and the public, which was meaningful and engaging; this could include case studies.

Members raised concerns regarding the level of detail included in the vision. It was stated that whilst the vision has to be agreed by all the Partners involved, it is important that it also contains the right level of detail to open constructive conversations about developing plans going forward.

In response to the section on ‘we want community based care to be’ the group discussed the importance of ensuring that ‘accessible to all’ also discusses the appropriate setting for accessible care, it was agreed that this would be added to the vision.

**Action:** SW to amend the vision document to include ‘in the right setting’ to the accessible to all information and ensure the vision frames this appropriately.

The group requested that the vision includes more detailed information regarding the LHCPs commitment to public engagement and how they intend to inform and involve the public at an early stage.

**Action:** More information about the partners’ commitment to public engagement to be included.

The group discussed the importance of ensuring the vision appropriately frames the intentions of the LHCP and how this may change over time - the how, where and when services are delivered including services currently delivered in an acute setting being transferred to a community setting.

**Action:** Include more narrative regarding how this vision will lead to changes in “how where and when services are delivered” including moving services out of hospital settings into the community.

The group highlighted that although the vision states that it is responding to issues raised previously by the Public and stakeholders, it is important to include further information about this focusing on how the system has responded and how the vision supports this.

**Action:** Ensure the vision includes the response to the issues raised by service users, patients, residents and staff in previous consultation and demonstrate how the vision is addressing these points.

A final version of the vision is to be circulated to the Governing Body members following presentation to the Lewisham Health and Care Partners Executive Board.

5 Accountable Care System – to take it forward

MW presented to the group the overview of an Accountable Care System in Lewisham, covering the functions of:

- a system oversight board to make shared decisions and be held accountable for delivery;
• an integrated strategic commissioning function between the CCG and Council to enable health and care commissioners to work collaboratively;
• an alliance of provider organisations to respond collectively to commissioner contracts and hold one another to account.

MW highlighted the need to recognise that this system would need to work within wider systems, such as the STP and that there would be national requirements to meet to achieve ACS status.

MW informed the group that the STP programme has recently engaged Creedo Consultancy to test what stage boroughs have reached in developing an ACS. It was recognised that it would be important to note that Lewisham providers work across multiple boroughs and are therefore involved in a wider STP footprint.

The group discussed the importance of involving the CCG Governing Body Members in the governance arrangement conversations and articulation of how the CCG Governing Body will function in the ACS structure in the future. This work would also consider how the acute system fits into the ACS, the scope of the framework and the implementation of an ‘at scale team’ to advise how to contract differently to support this.

**Action: ACS Governance Arrangements workshop to be arranged within the next 6 months**

Provider Alliance

The group discussed the formation of an alliance of provider organisations and the importance of ensuring there was a fair mix of providers included in this, to ensure there is not one dominant provider and to ensure accountability. It was confirmed that the provider alliance had been formed and that work is now required to formalise ‘informal’ conversations and decide how they might start responding to the Partnership Commissioning Intentions. It was agreed that it was imperative the providers now work to identify what support and resource is needed.

**Action: ABu to task the Provider Alliance with identifying resource needs and the desired infrastructure to aid moving forward.**

Integrated Strategic Commissioning – draft delivery plan

DC presented to the group the ambition for the integrated strategic commissioning draft delivery plan, that sets out that there will be, by 2020, a governance structure across the CCG and LBL for joint commissioning, an integrated strategic commissioning function for all adults and children’s commissioning, a greater pooling and alignment of budgets and a competent local commissioning workforce.

The group was informed that there are five key work streams to take forward Strategic Commissioning for 2017/18:

1. Governance Arrangements
2. Outcomes Framework for CBC
3. Commissioning Intentions – Frailty (over 65 years)
4. Commissioning Intentions – Transition (from children’s to adults services for young people)
5. Workforce development

The group was informed that the two priorities of frailty and transition are being used to test out the new way of strategic commissioning, working in collaboration with local providers.
It was confirmed that the outcomes framework is currently in a draft format and comments are welcomed. It was agreed that patient access and patient experience should be added as outcome measures. The group agreed that the outcomes measures could not be agreed in isolation and that the whole process requires commissioning staff engagement before conversations regarding existing and required competencies can commence.

The group reviewed the proposed governance structure; it was highlighted that due to the imminent election it would be important to have at the very least a shadow/interim arrangements in place by December 17 / January 18.

The group was informed that currently money is aligned via the Section 75 agreement and that the BCF and iBCF budgets are pooled. It was confirmed that the ambition would be to have a population based budget. It was agreed that this will be a long and complex journey and that there will be a need to reassess risks along the way.

It was agreed that it would be imperative to have a clear understanding of what success will look like and how to hold onto the ambitions of this plan whilst still delivering the constitutional standards and QIPP plans.

The group endorsed the ambition, scale and pace of the outline Delivery Plan for Strategic Commissioning.

6 Multi-disciplinary working

Interim Evaluation Report – Neighbourhood 1 pilot

Carmel Langstaff (CL), Portfolio Manager: Whole System Model of Care, joined the group to discuss this pilot, which was developed to test a new approach to multi-disciplinary working at a practice level in Neighbourhood 1. It was agreed that the pilot would support patients / service users with two or more long terms conditions, who are frequent visitors to the GP practice and require support from both the DN service and Adult Social Care. The pilot was developed to test and refine key elements of the Community Based Care vision.

Members of the MDT included a GP, a mental health professional, a senior district nurse, a senior social worker, social worker, occupational therapist, support planner and neighbourhood co-ordinator. These members met weekly, which it was commented may be ambitious when considering scalability of the pilot across the borough.

The group questioned whether the voluntary sector had been approached, to be included in these meetings, and a consideration of its broader role played in the community.

Concerns were raised regarding the idea that cases considered in these meetings may be ‘queue jumping’ ahead of other patients waiting for case review, however, the pilot wanted to include a look at early intervention and the benefits. It was commented that the pilot has highlighted the significant waiting times and delays, especially for OT reviews in the Community. ABu stated that this is something which is important to tackle now, taking into account the recruitment and retention issues, at a system level and will take this action on.

Action: ABu to ‘take back’ issues regarding OT review delays and the need to review resources to use them in a different way.

The following questions were asked by the group:

1. What was it that engaged the different disciplines?
a. It is reported that whilst staff may not have been enthusiasts before the pilot began, they were enthused by it, especially the professional barriers that were broken down and the sharing of knowledge being quick and accessible. This was aided by the dynamism around the table, with questions answered quickly and the team working collaboratively.

2. How might patients be involved moving forward?
   a. It was confirmed that this would be involved, ensuring the patients were involved in the right context and how this might work for neighbourhoods with larger populations.

3. How were the meetings led and how was this decided?
   a. CL confirmed that during the meetings, it would be decided by the group who would lead on a case, based on the context of the case and what the different roles could achieve.

The group agreed that affordable ways of promoting and sustaining this work needs to be agreed and that it would be important to link in with the Federation when considering borough wide promotion.

6 Public Engagement

AH presented to the group the public engagement update, which focuses on broader, more strategic engagement, based closely on the CBC vision and incorporating themes of proactive and preventative, accessible and coordinated care.

It was confirmed that following agreement of this strategy, it would be important to work on a narrative that is easily read by all who may pick it up, including alignment with staff engagement, across LHCP.

In line with this the group agreed it would be important to ensure the strategy is future proof, with the priorities still being still relevant in 18 months, looking at Health and Care literacy, links to self-help and self-management, taking into account beliefs and relationships, specifically the professional and patient relationship. It was agreed that it is important to equip people and use supporting work and strategies to open up self-care conversations.

The group agreed the main focus should be on consistency with messaging, relevance of the messages being circulated and addressing inequalities. It was agreed that perhaps the best way to agree how to engage with the public would be through to ask our PRGs and PEEF meetings to consider how we should engage with the Public. It was agreed that transparency relating to financial constraints and parameters of decision making was key in long term consistent messaging.

The group agreed the direction of travel and the high level themes.

Action: It was agreed that an update on the Public Communication and Engagement Plan would be provided at the next Governing Body meeting, with a further report later in the year.

7 Any Other Business

Effective Leadership – How to take it forward

MW stated that this subject has been highlighted by the recent red rating in the IAF reporting. It was agreed that it would be important to look at how the CCG positions itself in relation to an ACS and
the SEL collaborative work and whether the process by which the Governing Body makes decisions requires review.

It was agreed that a further conversation was required, weaving in the Governing Body self-assessment results. This conversation will need to look retrospectively and be forward viewing, potentially taking into account the contrast between Lewisham CCGs leadership style in comparison with neighbouring boroughs.

**Action:** To identify time to discuss ‘Effective Leadership’ in the forward planner.
ATTENDANCE

PRESENT: Mayor Sir Steve Bullock (Chair); Dr Marc Rowland (Vice Chair); Cllr Chris Best (Cabinet Member for Health, Wellbeing and Older People); Aileen Buckton (Executive Director for Community Services, LBL); Brendan Sarsfield (Chief Executive, Family Mosaic); Folake Segun (Director, Healthwatch Bromley and Lewisham); Dr Simon Parton (Chair of Lewisham Local Medical Committee); and Peter Ramrayka (Voluntary and Community Sector Representative).

IN ATTENDANCE: Martin Wilkinson (Chief Officer, Lewisham Clinical Commissioning Group); Sarah Wainer (Programme Lead, Whole System Model of Care, LCCG); Carmel Langstaff (Portfolio Manager, Whole System Model of Care); Bobbie Scott (Programme Support Officer, Whole System Model of Care); Salena Mulhere (SGM Inter-agency, Service Development and Integration) and Stewart Snellgrove (Clerk to the Board, LBL).

APOLOGIES: Val Davison (Chair of Lewisham & Greenwich Healthcare NHS Trust); Dr Danny Ruta (Director of Public Health, LBL); Roger Paffard (Chair, South London and Maudsley NHS Foundation Trust); Sara Williams (Executive Director for Children & Young People, LBL); Gwen Kennedy (Interim Director of Nursing South London, NHS England); and Tony Nickson (Director, Voluntary Action Lewisham).

Welcome and Introductions

The Chair welcomed everyone to the meeting and shared the apologies from those Board members not in attendance.

1. Minutes of the last meeting
   1.1 The minutes of the last meeting were agreed as an accurate record.

2. Declarations of Interest
   2.1 There were no declarations of interest.
3. **Better Care Fund Plan 2017-19**

3.1 Martin Wilkinson and Aileen Buckton presented this report. The purpose was to provide Board members with an oversight of the Better Care Fund (BCF) Plan 2017-19 for their sign-off.

3.2 The BCF Plan has been overseen by Lewisham Council and Lewisham Clinical Commissioning Group (CCG). Activity supported through the BCF has been developed jointly by commissioners and providers and the Plan has been shared with Lewisham Health and Care Partners (LHCP).

3.3 The BCF Plan 2017-19 covers two financial years and is an evolution of the 2016-17 Plan. A report outlining progress made in 2016-17 was presented at the Health and Wellbeing Board on 6 July 2017.

3.4 The 2017-19 Plan continues to fund activity in the following areas:

- Prevention and Early Action
- Community based care and the development of the Neighbourhood Care Networks
- Enhanced Care and Support to reduce avoidable admissions to hospital and to facilitate timely discharge from hospital
- Estates and IMT

3.5 In 2016-17 the financial contribution to the BCF from the CCG was £20.164m, and this has increased in 2017-18 to £20.525m and in 2018-19 to £20.915m. The financial contribution from the Council in 2016-17 was £1.781m, this has been increased in 2017-18 to £1.882m and in 2018-19 to £1.996m. The IBCF grant to Lewisham Council has been pooled into the BCF and totals £7.595m in 2017-18 and £10.470m in 2018-19. The total pooled BCF budget for 2017-18 in £30.002m and £33.381m in 2018-19.

3.6 The IBCF is additional funding to local authorities to recognise the growing demand on Adult Social Care. The grant doesn't eliminate all of the existing pressures on Adult Social Care, but it is helping to maintain the foundations of current service provision, particularly in relation to Delayed Transfers of Care and the need for stability and continuity in the care market.

3.7 The financial contributions to the BCF have been agreed by the CCG and the Council and agreed through the CCG’s and Council’s formal budget setting processes.

3.8 The BCF arrangements are underpinned by pooled funding arrangements with a section 75 agreement. The Section 75 Agreement Management Group (Adults) oversaw the 2016-17 BCF Plan and will also oversee the 2017-19 BCF Plan and expenditure.

3.9 The 2017-19 Plan also outlines targets and plans to deliver against the four national metrics:

- Non elective admissions
• Admissions to residential and care homes
• Effectiveness of reablement
• Delayed transfers of care (DTOC)

3.10 The allocation of resources to DTOC will be monitored and reviewed in-year to ensure that they are being used to best effect.

3.11 The BCF Plan has now been shared in draft form with regional colleagues. Further edits are required before the formal submission deadline, including requested changes that demonstrate the interface between the VCS and housing issues (e.g. how SAIL supports older people with housing concerns).

3.12 Both a London and National moderation process will follow over the next few weeks to ensure equity across all BCF Plans.

3.13 The Board raised the following questions regarding the BCF Plan 2017-19:

Q: How does monitoring of the BCF work in practice?
A: Quarterly returns must be submitted to demonstrate compliance against national conditions. Some elements contained with the BCF are already part of our core data sets. There are potential financial consequences of not meeting IBCF targets (especially DTOC targets), although these have not yet been formalised. If metrics are not met for emergency admission reductions that have been planned for, we have a joint risk share. This enables the CCG to use BCF funds to pay for this over-activity, that is then provided by hospitals, as a result of BCF schemes not working.

Q: Does local capacity exist to deliver the BCF Plan?
A: The capacity exists, though in the short-term this may come at a financial premium. Attracting and retaining nurses for community based care and care homes is an issue, likewise for social workers some of whom prefer the flexibility offered by agency employment. Further capacity to undertake strategic service redesign and modelling is needed to test out alternative ways of doing things without taking risks with people’s care. A bigger challenge is ensuring that the workforce has the appropriate skillset (e.g. in domiciliary care). Workforce development plans need to address these issues, though these are not unique to Lewisham.

Q: What are we doing more or less of in the BCF?
A: The Integration and Transformation programme is wider than the parameters of the BCF Plan itself and the proposed expenditure is not simply propping up what we are doing already. There is a greater focus on early intervention, proactive self-management and the leading of healthier lifestyles. Where multiple conditions present themselves the emphasis is on community-based care, maintaining independence for as long as possible and avoiding hospital admission, where appropriate.

Q: Does the fact that funding for Lewisham and Greenwich NHS Trust is linked to patient admissions present a conflict of interest?
A: LGT is recognised as a provider of acute services and any potential conflict of interest is managed through different contracting processes. LGT contributions and expertise in relation to the BCF Plan is separately aligned through their involvement with other providers like SLAM and GP Federation and through the Lewisham Health and Care partners work which is regularly reported to the Health and Wellbeing Board. The BCF Fund is managed via the Section 75 Agreement Management Group and the BCF Plan is not specifically discussed at Lewisham Health and Care Partners.

Q: Why is there a proposed reduction in the budget for carers' breaks in 2018/19?
A: There is no intention to diminish the carers' breaks service. Not all funding for this service is via the BCF.

Q: How can we ensure that the budget for the Disabled Facilities Grant (DFG) is not underspent?
A: The DFG is used for private rented and Lewisham Homes residents. It is not the only allocation in the borough as RSLs get their own DFG funding. The challenge with DFG awards is in getting the necessary planning permissions, qualified builders etc. Most awards entail substantial alterations to prevent residents from becoming housebound.

3.14 Action: The Board agreed to sign-off the Better Care Fund Plan 2017-19.

The meeting ended at 15:35 hours.