AGENDA

A meeting of the Governing Body in public

Date: 12 March 2015
Time: 9:30 – 12:00
Chair: Dr Marc Rowland

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

Voting Members

Dr Marc Rowland  Chair  Lewisham CCG
Dr David Abraham  Senior Clinical Director  Lewisham CCG
Prof. Ami David MBE  Registered Nurse Member  Lewisham CCG
Dr Hilary Entwistle  Clinical Director  Lewisham CCG
Dr Faruk Majid  Senior Clinical Director  Lewisham CCG
Dr Jacky McLeod  Clinical Director  Lewisham CCG
Dr Angelika Razzaque  Clinical Director  Lewisham CCG
Mr Tony Read  Chief Financial Officer  Lewisham CCG
Ms Diana Robbins  Lay Member  Lewisham CCG
Mr Tan VanDal  Secondary Care Doctor  Lewisham CCG
Mr Ray Warburton OBE  Deputy Chair, Lay Member  Lewisham CCG
Mr Martin Wilkinson  Chief Officer  Lewisham CCG

Non-Voting Members

Ms Aileen Buckton  Executive Director, Community Services, Lewisham Council
Ms Rosemarie Ramsay  Chair, Healthwatch Lewisham
Dr Simon Parton  Chair of Local Medical Council
Dr Danny Ruta  Public Health Director, Lewisham Council

Quorum

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

A member who is present at Governing Body meeting and is conflicted by a particular agenda item will not contribute to the quoracy of the meeting for the duration of that agenda item.
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>
</thead>
<tbody>
<tr>
<td>9:30</td>
<td>Presentation from Save Lewisham Hospital Campaign – letters to Monitor For information</td>
<td>Enc A</td>
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<tr>
<td>1. 9:40</td>
<td>Welcome and introductions</td>
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<td>Chair</td>
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<tr>
<td>2.</td>
<td>Apologies for absence</td>
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<td>3.</td>
<td>Declarations of Interest Members should discuss any potential conflicts of interest with the Chair prior to the meeting</td>
<td>Enc 1</td>
<td>Chair</td>
</tr>
<tr>
<td>4. 9:45</td>
<td>To agree minutes of previous meeting and review the action log</td>
<td>Enc 2</td>
<td>Chair</td>
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<tr>
<td>5.</td>
<td>Matters arising</td>
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<tr>
<td>6. 9.50</td>
<td>Chair’s Report To receive and note for information</td>
<td>Verbal report</td>
<td>Dr Marc Rowland</td>
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<tr>
<td>7. 10:00</td>
<td>Chief Officer’s Report To receive and note for information</td>
<td>Enc 3</td>
<td>Martin Wilkinson</td>
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<tr>
<td>8. 10:10</td>
<td>Audit Committee Chair’s report – from meeting held on 3 March 2015</td>
<td>Enc 4</td>
<td>Ray Warburton</td>
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<tr>
<td>9. 10:20</td>
<td>Finance and Investment Committee Chair’s Report – from meeting held on 20 January 2015</td>
<td>Enc 5</td>
<td>Tan VanDal</td>
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**INTEGRATED GOVERNANCE**

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<tr>
<td>10. 10.30</td>
<td>Risk Management and Board Assurance Framework To receive and endorse the report and exception reports</td>
<td>Enc 6</td>
<td>Martin Wilkinson</td>
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<tr>
<td>11. 10.40</td>
<td>Delivery Committee – Chair’s report from the meetings held on 22 January/ 26 February 2015</td>
<td>Enc 7</td>
<td>Martin Wilkinson</td>
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<tr>
<td>12.</td>
<td>Integrated Performance Report Including Quality, Finance, QIPP and Performance To receive and endorse the reports</td>
<td>Enc 8</td>
<td>Dr Faruk Majid/Tony Read</td>
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</tbody>
</table>
### 13. Public Engagement: Quality Summit Next Steps

*To note updates to Quality Summit Report Summary, organisational responses and proposed next steps and receive presentation*

| Enc 9 | Diana Robbins |

### 14. Questions in relation to agenda items from members of the public

| Chair |

### STRATEGY AND PLANNING

| 15. 11:05 | Strategy and Development – Chair’s report from meeting held on 5 February 2015 | Enc 10 | Dr David Abraham |

| 16. | CCG Strategic Framework
*To receive and agree the CCG 5 Year Strategic Framework* | Enc 11 | Dr David Abraham |

| 17. | Proposed constitutional amendments for Primary Care Co-Commissioning and other technical amendments
*To approve the proposed changes to the CCG’s Constitution.*

**Revised Conflict of Interest Policy**
*To receive and approve the policy*

| Enc 12 | Dr Marc Rowland |

| Enc 13 | Dr Marc Rowland |

| 18. | Operating Plan and Corporate Objectives 2015/16
*To note and agree the recommendations in the report* | Enc 14 | Tony Read |

### ANY OTHER BUSINESS

| 19. 11:45 | Potential Audit and Risk Management Issues
*To identify any issues which the Governing Body consider would benefit further scrutiny by the Audit Committee* | Chair |

| 20. | Any Other Business |

| 21. | Questions from members of the public |

### FOR INFORMATION ONLY

| 22. | Domestic Homicide Report | Enc 15 |

| 23. | Safeguarding Children’s Annual Report | Enc 16 |
### 24. Approved Committee minutes for information only

- **Delivery Committee** (18 December 2014 and 22 January 2015)
- **Strategy and Development** (4 December 2014)
- **Health and Well Being Board** (November 2014)
- **Clinical Strategy Committee** (20 November 2014)

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#### 25. 12:00

**Date of next meeting – 14 May 2015 ; 9:30 – 12:00**

Kings Church meeting rooms, 21 Meadowcourt Road, Lee, SE3 9EU

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.
8.4.5 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.

8.4.6 Where the chair of any meeting of the Group, 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.

8.4.7 Any declarations of interests, and arrangements agreed in any meeting of the clinical commissioning group, committees, sub-committees, working groups or the Governing Body, will be recorded in the minutes.

8.4.8 In any transaction undertaken in support of the clinical commissioning group’s exercise of its commissioning functions (including conversations between two or more individuals, e-mails, correspondence and other communications), individuals must ensure, where they are aware of an interest that they conform to the arrangements confirmed for the management of that interest. Where an individual has not had confirmation of arrangements for managing the interest, they must declare their interest at the earliest possible opportunity in the course of that transaction, and declare that interest as soon as possible thereafter. The individual must also inform either their line manager (in the case of employees), or the Governing Body, of the transaction.

8.5 Managing Conflicts of Interest: Governing Body [and all other committees]

8.5.1 Individual members of the Governing Body will comply with the arrangements determined by the Governing Body for managing conflicts or potential conflicts of interest.

8.5.2 Where a Governing Body member is aware of an interest, which has not been declared, either in the register or orally to the Governing Body, they will declare this at the start of the meeting. The Governing Body will then determine how this should be managed and inform the member of their decision. The member will then comply with these arrangements, which must be recorded in the minutes of the meeting.
8.5.3 Where more than 50% of the members of the Governing Body 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 interests or potential conflicts of interests, the remaining chair will determine whether or not the discussion can proceed.

8.5.4 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 group’s standing orders. 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, owing to the arrangements for managing conflicts of interest or potential conflicts of interests, the chair may invite on a temporary basis one or more of the following to make up the quorum so that the group 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 a relevant Health and Wellbeing Board;

c) a member of a governing body of another clinical commissioning group.

8.5.5 These arrangements must be recorded in the minutes.
THE LETTERS TO MONITOR  
The aim of the letters to Monitor is to support the CCG in avoiding competition and tendering for new contracts or extensions of old contracts.

For some time we have approached Lewisham residents to sign a letter to Monitor - copy attached. To date 3,360 Lewisham residents and 244 from out of borough have signed. In June 2014 the first batch of 2,000 Lewisham letters was handed in to Monitor and a disk giving details of all these was given to Lewisham CCG. Since then a further 1,360 letters from Lewisham residents have been collected and these are presented to the CCG today. For convenience we have included the previous disk so that you now have all 3,360 the Lewisham letters, albeit in different formats. The out of borough letters will be sent to Monitor.

When people gave us permission, we passed a copy of their letter to their practice. Many GPs will have seen them in the records. The wording of the letter specifically relates to that in the Health and Social Care Act.

We have done this because we want to protect the CCG and Lewisham residents from the following risks:

Private or NHS provider of clinical services – it does matter.

The private sector:

- needs to take a profit, so their service usually costs more to the NHS over time. A bit like PFI...
- tends to cut costs and staff expertise to make the bottom line work
- tends to fragment pathways when the whole drive in SE London is towards integration
- leaves when it cannot make a profit, making provision unstable. Some providers are now leaving the market for that reason.
- like supermarkets, will offer short term deals which drive out other providers
- is not ultimately concerned with the welfare of patients

Competition costs. It takes time and money to tender

- competition has not been shown to improve outcomes for patients
- estimates of the annual cost of competition to the NHS range from £1 to £10billion
- it costs the CCG time and effort to tender

Monitor allows CCGs to avoid tendering if that can be shown to be in the patients' best interests.

“CCGs must not act in an anti-competitive way unless they can demonstrate it is in the interests of patients.” [source](http://www.mills-reeve.com/files/Publication/89a67df7-81eb-481d-97ef-1930a8b7eba3/Presentation/PublicationAttachment/5416f7af-4d10-41b3-831b-1c8e8eb126f6/91947781_3.pdf)
The Monitor letters show that many Lewisham residents do not see competition and outsourcing to be in their best interests.
There was an enthusiastic response. We could have gathered many more letters but we are limited by our resources.

The Monitor letters give the CCG a clear, safe opportunity to avoid tendering.
We urge you to avoid tendering for clinical services.
If you disagree with this, we would like you to explain why. We expect you to consult with the wider membership

Thank you for discussing this.

Dr Brian Fisher and Dr Louise Irvine
On behalf of the Save Lewisham Hospital Campaign
Dear Monitor,

As a patient of the Lewisham Clinical Commissioning Group (CCG), I want to record my choice of NHS provider for your future reference.

I do not believe that it is in my best interests, as a patient, for my CCG to undertake contracts with outsourcing companies when a traditional public sector alternative is available.

This is because:
1. Services supplied by such companies have shown problems with understaffing and inadequate data when claiming payments from the NHS.
2. I do not believe such services can approach the standard of safety offered by public sector alternatives. (In many other sectors including care homes, the quality and safety of privatised services have gone down and costs have increased.)
3. Since they need to make a profit, commercial operators are likely to be competitive on price only if they cut corners on services.

I do not agree that competition is in my best interests; I am a patient not a customer. It is only in the interests of commercial operators and will prejudice the necessary integration of NHS services.

Two other problems will occur as a result of competition. Total NHS costs will rise: commercial competition tends to lead to supplier-induced demand and unnecessary treatment. Secondly, if traditional NHS providers lose their funding to commercial operators, those NHS providers may end up dismantled unit by unit as core services are outsourced, and the NHS providers ultimately collapse. This will remove any alleged competitive benefit.

If new private providers challenge a CCG commissioning decision in Lewisham, please take this letter into consideration as my express wish on how my best interests should be protected.

Yours faithfully,

A patient in Lewisham

cc Dr

& Lewisham CCG
### Directorships, including non-executive directorships, held in private companies or PLCs

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<tr>
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<th>Role</th>
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<tbody>
<tr>
<td>Dr David Abraham</td>
<td>Clinical Director</td>
<td>South East London Doctors Co-operative</td>
<td>None</td>
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<tr>
<td>Dr Danny Ruta</td>
<td>Senior Partner</td>
<td>Jenner GP Practice</td>
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<tr>
<td>Dr Tan Vandal</td>
<td>Partner</td>
<td>Combella Medical Practice</td>
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<tr>
<td>Dr Hilary Entwistle</td>
<td>Chair</td>
<td>Lewisham Local Medical Committee</td>
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<tr>
<td>Dr Rosmarie Ramsay</td>
<td>Director</td>
<td>South East London Doctors Co-operative</td>
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### Ownership or part-ownership of private companies or PLCs

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<td>Supervisor</td>
<td>Triager, Referral Support Scheme</td>
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### Professional or part-time work undertaken in capacity as chair of Lewisham LMC

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<tr>
<td>Dr Tony Read</td>
<td>Chief Officer</td>
<td>South East London Partnership CCG</td>
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<tr>
<td>Dr Aileen Buckton</td>
<td>Chief Executive</td>
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### Other roles or relationships which you believe could impair or otherwise influence your judgment or actions in your role as a member of the CCG

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### Research funding/grants that you have received or that any organisation you have an interest in or role in has received

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### Any personal healthcare needs or those of your partner

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### Research/teaching undertaken in health care organisations (Private and Public), including part-time positions and those with a collaborative aspect

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### Media appearances where you have appeared in the capacity as a medical professional

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### Positions of authority in an organisation (eg charity or voluntary organisation) in the field of health and social care

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Governing Body meeting

Minutes of the meeting of the Lewisham Clinical Commissioning Group (LCCG) Governing Body held on Thursday, 8 January 2015 at 9:30 at Civic Suite

Dr Marc Rowland  Chair, LCCG
Dr David Abraham  Senior Clinical Director, LCCG
Ms Aileen Buckton  Executive Director Community Services, LB Lewisham
Dr Hilary Entwistle  Clinical Director, LCCG
Dr Faruk Majid  Senior Clinical Director, LCCG
Ms Katrina McCormick  Deputy Director Public Health, LB Lewisham
Dr Jacky McLeod  Clinical Director, LCCG
Dr Simon Parton  LMC Chair
Ms Rosemarie Ramsay  Chair, Healthwatch Lewisham
Dr Angelika Razzque  Clinical Director
Mr Tony Read  Chief Financial Officer, LCCG
Ms Diana Robbins  Lay Member, LCCG
Mr Tan VanDal  Secondary Care Doctor, LCCG
Mr Ray Warburton OBE  Lay Deputy Chair, LCCG
Mr Martin Wilkinson  Chief Officer, LCCG

In Attendance

From Lewisham CCG, South London CSU or London Borough of Lewisham:

Ms Lesley Aitken  Board Secretary (notes), LCCG
Ms Faith Abola-Ellison  Joint Commissioners
Ms Karen Bates  Associate Director of Nursing and Quality, LCCG
Ms Diana Braithwaite  Commissioning Director, LCCG
Mr Dip Chudgar  Pharmacist, LCCG
Mr Graham Hewett  Head of Integrated Governance, LCCG
Mr Mike Hellier  Head of Systems Intelligence, LCCG
Ms Mina Jesa  Interim Head of Engagement, LCCG
Mr Charles Malcolm-Smith  Head of Strategy and Organisational Development, LCCG
Ms Susanna Masters  Corporate Director, LCCG
Ms Cheryl Reynolds  Joint Commissioners
Ms Kelly Scanlon  Communications Lead, SLCSU
Mr Colin Stears  Neighbourhood 2 Lead

There were 8 members of the public present.

Apologies

Prof. Ami David MBE  Nurse Member, LCCG
Dr Danny Ruta  Public Health Director, LB Lewisham

LEW 15/01  Welcome and Announcements

Dr Rowland welcomed all to the first meeting of 2015.

LEW 15/02  Declarations of Interest
There were no interests declared which would knowingly affect the business of the meeting. Dr Rowland said that the nature of the co-commissioning item would not preclude the Clinical Directors from discussing.

**LEW 15/03 Previous Minutes**

The minutes of the previous meeting were taken as a true record subject to the amendment that LEW 14/126 should read ‘quoracy could be a majority of GP members (3) and one management member and 2 independent members’.

**LEW 15/04 Action Log and Matters Arising**

Updates were given and the action log was reviewed and revised.

**LEW 15/05 Chair’s Report**

Dr Rowland said that there had been a useful discussion at the Public Forum session which is held prior to each Governing Body meeting at 9am. The notes of this meeting would stored on the website available publically. Any feedback on that meeting should be given to Mr Malcolm-Smith.

The Chair’s report was given and the following highlighted:

- Co-commissioning primary care services and some specialised services will be devolved to CCGs from April 2015 which will have an impact on Lewisham, South East London and London as a whole.
- Local Care Networks (Neighbourhoods) are developing steadily in Lewisham and across South East London but it is recognised that working within them is a learning experience for primary, social care and mental health.
- It is hoped that the General Election will not bring radical structural changes in commissioning arrangements on top of any changes currently occurring.

The Governing Body NOTED the report.

**LEW 15/06 Chief Officer’s Report**

Mr Wilkinson gave the report and highlighted the following:

- Better Care Fund (BCF) – The Lewisham BCF Plan which was resubmitted to NHS England (NHSE) has now been fully approved. Dr Rowland congratulated all those involved from the CCG and Local Authority.
- Joint Commissioning Intentions – These are now out for engagement. A summary of the intentions was attached to the Chief Officers report for information.
- Planning for 2015/16 – the CCG Operating Plan is to be refreshed to ensure that it is informed by national planning guidance ‘the Forward View into action’.
- Strategic Commissioning Framework for Primary Care Transformation – NHSE have launched its engagement programme on the framework.
- Annual Engagement Report – the CCG’s annual engagement report, which was assessed by the Patient and Public Voice Team at NHSE, has been rated as Green. Ms Robbins was congratulated in leading the programme on behalf of the Governing Body as well as the Public Engagement Team.

In response to a question from Ms Robbins, Mr Wilkinson explained that his understanding of the co-creating of new models of care (page 25 2nd bullet point) as set out in the national planning documents was the work being undertaken by elements of NHS and local providers.

The Governing Body NOTED the report.
Mr Warburton gave a verbal report from the meeting held on 6 January 2015. The following was highlighted:

- The recruitment of an independent person with financial management experience to the Audit Committee was discussed. Members, with Mr Read have agreed a person specification and a process for recruitment and selection. The Governing Body is asked to approve this recruitment.

- There was a deep dive into Objective 2 – the financial governance objective. Members were assured that financial controls appear to be working well.

- A report from our Internal Auditors, KPMG, on QIPP delivery was received. Members were pleased to see that management had readily accepted the findings reported, and improvements will be made going forward. Members wondered if there is a connection between how well QIPP schemes are set up and how well they deliver, and have referred this question to the Finance and Investment Committee.

- External Auditors, Grant Thornton, reported on their work to date, and laid out the timeline for their work on the CCG’s accounts for 2014/15. They also reported on CCG arrangements to secure Value for Money (VFM) and described characteristics of proper arrangements for securing financial resilience, and economy, efficiency and effectiveness. These characteristics appear to provide a useful set of questions that we might routinely apply to the way we work. For example, does the “Governing Body scrutinise and challenge financial performance effectively holding officers to account”?

- The work plans of TIAA, the new provider of Counter Fraud and Security Management, for the final six months of 2014/15 were noted and welcomed. Members noted that a Counter Fraud and Bribery Awareness Training session was run on 27 November 2014 for CCG staff. Governing Body members are advised to read TIAA’s newsletter “Fraudstop”. Future training sessions for Governing Body members was discussed.

- Members commented and noted the process for drafting, finalising and approving the Annual Report and Accounts for 2014/15. The intention to produce just one public-facing set of documents was welcomed and that a Readers Panel will be set up to help comment on the language used in the draft Annual Report. Members asked that the Annual Report fairly reflects both our achievements and challenges.

- The Accounting Policies that will be used to draft and finalise the accounts for 2014/15 were approved.

- A verbal report was received from Faruk Majid on the development of a Quality Improvement Strategy for the CCG. It will prioritise positive patient experience. Members warmly welcomed this initiative.

The Governing Body NOTED the report and APPROVED the recruitment of an independent person with financial management experience to the Audit Committee

LEW 15/08    Finance and Investment Committee Chair’s Report

Mr VanDal gave the report from the meeting held on 18 November 2014. He highlighted the following:
• The approval of the Business Case for intermediate care services, approved by Chair’s action, was ratified.
• The CCG’s draft procurement policy was discussed and comments passed to the management team. The policy is presented to the Governing Body at agenda item 21. Ethical procurement was discussed at the meeting and whether to adopt a formal position was passed to the management team for them to develop a recommendation.
• The promotion of a step up model of care through focused neighbourhood engagement was discussed at the meeting.

The Governing Body NOTED the report.

LEW 15/09 Risk Management and Board Assurance Framework

Mr Wilkinson gave the report. He explained that the BAF is the tool by which the Governing Body can be assured that risks to achieving the Corporate Objectives are being managed and review whether sufficient controls are in place. He highlighted the substantive changes:

• Quality Risk 1 - Additional external support is being provided to develop the Quality Improvement Strategy. Quality indicators for community and mental health are being discussed with providers to strengthen assurance given to the CCG. The residual risk has been raised to High 8 as a consequence.
• Quality Risk 2 – This risk has been raised to Very High 16 because of performance challenges around the CCG and local provider’s ability to deliver the constitutional and contractual commitments.

It was noted that risks to achieving the A&E targets and associated quality issues were detailed in Quality Risk 2.

Mr Wilkinson explained that the text in red on the BAF showed where we had received negative assurances, this includes an Internal Audit report following a review of the South East CSU’s Business Continuity Plans for ICT which the CCG were pursuing with the CSU to strengthen our assurance of this matter.

Mr Read would circulate the response received from King’s regarding the Information Governance concern after review by the Information Governance Steering Group via Delivery Committee reporting.

ACTION: Tony Read

The Governing Body NOTED the Risk Management Report, APPROVED the BAF as evidence that the CCG is aware of the full range of risks presenting to the Corporate Objectives and that the CCG has adequate controls in place and that there are credible action plans in place for where existing controls have not reduced the residual risk score to the target.

LEW 15/10 Delivery Committee Chair’s Report

Mr Wilkinson gave the report from the Delivery Committee meetings held on 27 November and 18 December 2014. The following was highlighted:

• At the December meeting the requirement to update the Operating Plan 2015/16 was discussed. It was decided that it will be most effective for the Delivery Committee to oversee the coordination of the work associated with updating the CCG’s Operating Plan. The Governing Body noted that the responsibility to oversee the updating of the CCG’s Operating Plan will transfer to the Delivery Committee from the Strategy and Development Committee for 2015/16. It was agreed that the Strategy and Development Committee would assure that the Operating Plan was in alignment with CCG strategies.
• Dementia – there was an action plan in place and work was underway with members to support improvements in diagnosis rates with firstly ensuring that clinical records (i.e. calls
related to life threatening conditions) were accurately coded. There was further work to do though it was recognised that progress had been made with residential care homes.

- The London Ambulance Service (LAS) performance had dropped for Category A calls. The For Action Learning Group (FLaG) were looking at these concerns in discussions with the lead commissioners for the LAS.

The Governing Body NOTED the report

### LEW 15/11 Integrated Performance Report

Mr Read introduced the report.

#### 11.1 Performance and Finance

Mr Read reported that NHSE has identified the Top 8 Performance Indicators from the NHS Constitution and expected these to be the primary focus of CCGs. The Corporate Objectives already include recovery action for poor performance in three of these: RTT, A&E and cancer waiting times.

The following was highlighted:

- A&E targets continue to be a challenge with the position worsening in the New Year.
- RTT is now on track to meet the target.
- Trauma services performance is not going to plan because of Sector Provider capacity restraints.
- Cancer waiting time performance also remains a challenge. The tracking system between GSTT and LGT has been in place since December which aims to speed jointly managed patients along the system.
- There is underperformance on the Better Practice Payments Code (BPPC) but the aim is that this is recovered by the financial year end.
- The CCG is on track to deliver its statutory financial duties, subject to the BPPC recovering.

It was reported that at Month 8 the CCG is on target to deliver its planned surplus at year end. This would require the release of at least £1.2m reserves (full year forecast) to offset overspending budgets; in particular acute contracts. This will require additional savings to be made in 2015/16, over and above the CCG’s future plans.

#### 11.2 Quality

Dr Majid gave the report and highlighted the following:

- Concerns around the meeting of Cancer targets
- District Nursing – the high number of quality alerts
- Quality Improvement Strategy – FLaG are looking at the patient’s experience using information from the Quality Summit and Lewisham People’s Day and incorporating the national indicators from the Lewisham perspective to inform the commissioning intentions.

Mr VanDal raised the issue of cancer waiting times. It was reiterated that the joint tracking system for GSTT and LGT was in place with the aim to improve performance. There is a review underway into the problems with endoscopy capacity with a strategic outline case for LGT being agreed with LGT now developing a business case. The action arising from the recent clinical Cancer Summit were being taken forward regarding delivery of referrals, in particular the two week wait for lower GI results and would be reported through via the Delivery Committee. The recently appointed McMillan funded GP would begin to work with members and through Neighbourhoods.

Asked about the situation now with A&E, Mr Read reported that the performance since 7 December 2014 had worsened at Lewisham and Queen Elizabeth Hospitals and surrounding hospitals. An
The Governing Body has noted the reports:

**LEW 15/12 Pressure Ulcers update report**

Ms Karen Bates, Associate Director of Nursing and Quality, gave the report which detailed work undertaken over the past 15 months across the four boroughs of Lewisham, Bromley, Bexley and Greenwich. She highlighted the following:

- The Patient Passport will be piloted in Bromley in January 2015 with a review being undertaken in April 2015 with the intention to rolling out the passport to all the other boroughs thereafter.
- Engagement with care homes is positive.

Dr Majid added that FLaG is monitoring the pressure ulcer issue and that there is now a process in place with one mechanism for undertaking investigations.

Ms Robbins congratulated Ms Bates on the work but pointed out that only the last two sentences in the report gave patient’s views. This area needs to be highlighted more in the report.

Mr Warburton asked that the integrated work is good and asked who held the passport? It was confirmed that this was held by the patient or carer/next of kin if there is a mental capacity issue for the patient.

**The Governing Body NOTED the report**

**LEW 15/13 Public Sector Equality Duty Annual Report**

Mr Malcolm-Smith gave the report which set out how the CCG has commissioned services during 2014 whilst fulfilling the aims of the Equality Act 2010 and reducing health inequalities as required by the Health and Social Act 2012. He explained that the report had been to the Strategy and Development Committee. It was confirmed that Dr Abraham is the Governing Body lead for equality.

Mr Warburton pointed out that not all of the Governing Body members had participated in the Equality Delivery System (EDS) self-assessment of ‘Goal 4: Inclusive Leadership’, which had been
rated as ‘Developing’. If more members had taken part the grading might have been better. He added that the CCG undertakes much good work on equality and Governing Body members clearly understand its importance. He explained that we need to explicitly express the importance of equality, and our commitment to it, in exercises such as the EDS self-assessment, in public documents, from public platforms, in public engagement and in other ways. In this way the diverse communities we serve can gain confidence about commitment to equality and the action we are taking. There are many positive examples from our work in, and engagement with, the community which could be used.

The report was NOTED and would be approved by Chair’s action subject to the incorporation of comments given and published on the website by the end of January.

LEW 15/14 NHS Lewisham CCG Annual Report and Accounts to the Audit Committee

Mr Read gave the report. He said that lessons learned from writing the Annual Report last year included that work needed to be started earlier on some sections of the strategic report. This has already been started by the management team. The management team have requested three nominated members of the Governing Body to work with as an editorial group which would include a clinical director and a lay member. The document will also go to a Reader’s Panel. The 2014/15 NHS Lewisham CCG unaudited Annual Report and Accounts have to be submitted to NHSE in draft form on 23 April 2015 and as a final audited version by 29 May 2015.

Mr Warburton said that last year the CCG had commented to NHSE on the tightness of timetable, but this year it is even tighter. Mr Read would take the Audit Committee through a draft set of accounts using M9 data before its 3 March meeting.

It was noted that the Governing Body would be required to receive the accounts and that the timeline should include taking the documents to the membership.

The Governing Body NOTED the timeline for approving and preparing the 2014/15 Annual Report and Accounts, AGREED that the Delivery Committee will oversee the co-ordination of the Annual Report and DELEGATED the authority to the Audit Committee to approve the 2014/15 Annual Report and Accounts.

LEW 15/15 Remuneration Committee Terms of Reference (TOR)

The revised Remuneration Committee Terms of Reference which were taken to the December 2014 meeting of the Committee were tabled. Mr Warburton reported that the earlier version of the TORs had identified an inconsistency that stated under ‘purpose’ section the committee was to make recommendations to the Governing Body but that under the ‘areas of focus’ identified areas where the committee could make recommendations.

It was confirmed that issues related to remuneration to staff on Agenda for Change grades do not go through the Remuneration Committee.

The Governing Body APPROVED the proposed changes to the Remuneration Committee’s Terms of Reference.

LEW 15/16 Questions in Relation to Agenda Items from Members of the Public

Q – On page 25 of the papers in the Chief Officers report under the item ‘Planning for 2015/16’ it states that an additional £480m of the extra funding will be used to support transformation in primary care, mental health and local health economies.

A – Mr Wilkinson said that this is national money for all services. Vanguard sites will be developed to help the national team in setting out the care models within the Five Year Forward View and some of this national extra funding will be used for this purpose.
LEW 15/17  Strategy and Development Committee Chair’s Report

Dr Abraham introduced the report from the Strategy and Development Committee held on 4 December 2014. The key continuing challenges were discussed at the meeting on improving outcomes for cancer these included early detection and the referral process.

The Governing Body NOTED the report.

LEW 15/18  Primary Care Co-commissioning Model and CCG Constitutional amendments

Mr Wilkinson gave the report on Primary Care (General Practice) Co-commissioning. He reported that three models have been offered to CCGs by NHSE:

Model 1 – Greater involvement in Primary Care Decision Making
Model 2 – Joint Commissioning Arrangements
Model 3 – Delegated Commissioning Functions

There was significant engagement with the Membership which resulted in overwhelming support for the principles underpinning co-commissioning with the majority supporting models 2 or 3 and with no members objecting to co-commissioning. Two key themes members had required clarification on were:

1. Finance; the safeguarding of the associated GMS, APMS and PMS budgets.
2. Resources; the capacity and resources required to support full delegation to the CCG.

Model 2 – this model enabled CCGs to hold responsibility for jointly commissioning primary medical services via a joint committee arrangement with NHSE. Contract management remains with NHSE under this model.

Model 3 – this model offers CCGs the opportunity to have full responsibility for commissioning general practice services with accountability back to NHSE for the effective delivery of the function.

The following comments were given:

- Mr Colin Stears, Lead for Neighbourhood 2, said that ‘we are at the start of a journey which is welcomed as a membership organisation. It was felt opting for Model 2 was the right decision but with the aim to swiftly move to Model 3.’

- Primary Care co-commissioning is due to be discussed at the Health and Wellbeing Board and Healthier Communities Select Committee at their meetings in January 2015 alongside the CCGs primary care strategy.

- Ms Robbins asked whether there were any opportunities for the CCG to hold discussions with members of the public as there will be concerns and this could be the time to explain the positives. Mr Wilkinson responded that this document referred to engagement with the membership and that engagement with the public so far had focussed on the Primary Care Strategy with sessions being held with Healthwatch.

- Dr Rowland added that there are different threads of engagement being undertaken, but it’s recognised that the public need to be more engaged. The Public Engagement Group will discuss plans for the primary care public engagement before April.

ACTION: Susanna Masters/Diana Braithwaite

- Mr VanDal said that the co-commissioning conversations seem to be organisation focussed and that emphasis of the benefit of opting for Model 2 needs to be highlighted.

- Dr Majid stated that the level of access to primary care (GP practices) was the biggest problem reported by members of the public and also that the public need to know why the CCG is making changes. Out of area GPs could be used if any conflicts of interest were flagged, Mr Wilkinson confirmed work was in hand to review and strengthen our conflicts of interest policy considering primary care co-commissioning.
• The CCG should not lose local sovereignty whilst taking forward co-commissioning in collaboration with the SEL CCGs and NHSE.

• The proposal for governance is for a SE London Committee in Common which will consist of Lewisham Governing Body members delegated with authority to act in Lewisham CCG’s interest in the committees. This will be confirmed through the committee’s terms of reference which will be agreed in due course by the Governing Body.

• Dr Entwistle said that there needs to be appropriate premises to be able to do things differently within primary care or this will limit CCGs ability. It was responded that discussions were being held with NHSE at present regarding premise issues.

The Governing Body APPROVED the recommendation for the CCG (along with the SE London CCGs) to submit an expression of interest for level 2 joint commissioning to NHSE for co-commissioning of General Practice on 30 January 2015 subject to the comments received and to be taken to the relevant committees with any changes to the Constitution to be taken to the Membership. It was agreed that the Chief Officer to put in place, before 1 April 2015, the necessary arrangements to implement ‘joint commissioning’ (Model 2) of primary care. Progress will be reported at the March 2015 Governing Body meeting along with constitutional changes.

LEW 15/19  Lewisohn Clinical Commissioning Group Strategy and South East London Strategy

Mr Malcolm-Smith gave the report.

The CCG Strategy was agreed in October 2013 with revisions taken through the Strategy and Development Committee. At the Governing Body Workshop it was agreed that the definition of Best Care will be high quality care for everyone – care should be provided at the simplest level and at the right place, this does not just mean geographical but also the most appropriate setting.

Regarding the South East London Strategy, Mr Wilkinson explained that the ‘Our Healthier South East London’ health and care whole system model (Appendix A Enclosure 15) highlights the alignment with our local strategy and starts with the person at the centre and local care networks (our neighbourhoods). Mental health is not specifically mentioned as it was acknowledged that this area should be everywhere through all healthcare. The SE London Strategy report is an update on progress with our partners across SE London. Modelling and testing of the model and assumptions was required. A new finance group had been formed which included providers and local authorities. There would be deeper engagement with the population, which was highlighted in the paper, which will inform the models of care. If there are any significant service changes proposed further consultation will be undertaken later in the year.

Ms Buckton added that further thought may be needed on how to communicate the whole system approach to the public, highlighting the positives. Ms Ramsay agreed and added that there should be a communications strategy at every stage. Healthwatch need to be more actively involved.

Mr Wilkinson said that the Communication and Engagement Strategy is being refreshed.

Mr Warburton added that the different strategies should address the concerns of the population with any themes drawn out rather than engagement on strategies separately.

Ms Robbins added that it should be highlighted where there are Lewisham specifics within the SE London work. Mr Wilkinson explained that it is a bottom up strategy involving local care networks with good representation locally across all the clinical leadership groups.

In referring to the clinical case for change, Mr Warburton highlighted that the SEL Strategy was about collective action although much of the whole system model, particularly local care networks were more for local action so greater distinction was required between local and collective action, with greater transparency and reporting on this.

The CCG Strategy Update was NOTED and progress of the Our Healthier South East London Programme was NOTED.
LEW 15/20  **Lewisham CCG Procurement Policy**

Mr Wilkinson presented the report. He explained that the Procurement Policy was approved by the Finance and Investment Committee (FIC) on 18 November 2014. Ms Diana Braithwaite, Commissioning Director, confirmed that there is a statement in the policy and a briefing paper is to be developed to support further discussions on ethical procurement as requested by the FIC.

The following comments were made by members of the Governing Body:

Ms Robbins said that there was good work in the policy on public engagement. However, that there should be involvement of a lay person from the beginning of the process. Mr Warburton commented on the need to support market development for smaller providers and concurred with Ms Robbins comments on the need to have involvement of local people in the commissioning process including procurement through inclusion in procurement panels/processes.

The Governing Body RATIFIED the Lewisham CCG Procurement Policy subject to an amendment in section 7.4 (page 10) to include ‘public/patient representation’ in the procurement team.

LEW 15/21  **Potential Audit and Risk Management Issues**

There were no issues at this meeting.

LEW 15/22  **Any Other Business**

Ms Ramsay wanted it noted that the Healthwatch Lewisham contract is not going to be renewed by the current host and that Lewisham Council as commissioner will be running a procurement process as a result.

LEW 15/23  **Questions from Members of the Public**

A comment was made that the SEL Strategy is a whole system model. There is a view that work programme Phase 1 (page 187) is threading water until the election. Phase 2 which involves significant service change is a concern.

Mr Wilkinson responded that he did not agree as significant work was being undertaken across the programme and through the clinical leadership groups to test, refine and develop the whole system model and its component parts further.

LEW 15/24  **Reports Taken for Information**

- Audit Committee Terms of Reference

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

- Delivery Committee (October and November 2014)
- Strategy and Development Committee (October 2014)
- Health and Wellbeing Board (September 2014)

LEW15/25  **Date of Next Meeting**

The next meeting of the Governing Body would be held on Thursday 12 March 2015; 9:30 – 12:00,
<table>
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<th>Action</th>
<th>Responsible Person</th>
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<th>Status/Comments</th>
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<td>Tony Read</td>
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<td>15/18</td>
<td>Regarding Primary Care Co-commissioning - The Public Engagement Group will discuss plans for the primary care public engagement before April.</td>
<td>Diana Braithwaite (Primary Care)</td>
<td>April 2015</td>
<td>05.03.15: The CCG undertook engagement with key stakeholders on Co-commissioning but recognises that wider engagement with the public/patients is necessary on primary care. The Primary Care Development Group will be discussing and agreeing proposals on public engagement plans and input into primary care changes. The CCG Primary Care Strategy, agreed by the Governing Body in 2014, is being further refined to support ‘real’ conversations with the public. As a part of the CCG neighbourhood improvement scheme – conversations with the public via PPGs commenced this month on primary care.</td>
</tr>
<tr>
<td>November 2014</td>
<td>The Audit Committee would share the HFMA self-assessment with the Governing Body and another would be circulated for comparison.</td>
<td>Ray Warburton/Charles Malcolm-Smith</td>
<td>December 2014</td>
<td>08.12.15 – It was agreed that the HFMA self-assessment was audit orientated so would therefore not be shared with the Governing Body. A draft Governing Body self-assessment has been sent to the Chairs of the Governing Body and</td>
</tr>
<tr>
<td></td>
<td>Description</td>
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<tr>
<td>14/129.1</td>
<td>A report to come back to the Governing Body regarding Health Visiting in Children’s Services via the Delivery Committee</td>
<td>Warwick Tomsett</td>
<td>February 2015</td>
<td>This item would be covered in the February 2015 Governing Body workshop.</td>
</tr>
<tr>
<td>14/131</td>
<td>Capacity in community care places to be investigated.</td>
<td>Martin Wilkinson/Dee Carlin</td>
<td>January 2015</td>
<td>Work is currently being undertaken with the provider on proposals to use some of the Local Authority winter pressures money to develop step up/step down beds using the existing void stock.</td>
</tr>
<tr>
<td>14/133</td>
<td>The Strategic Plan would come back to a future meeting.</td>
<td>Susanna Masters</td>
<td>January 2015</td>
<td>Agenda Item for the Governing Body meeting</td>
</tr>
<tr>
<td>14/135</td>
<td>To discuss the relevance of the BAF and Integrated Performance Reports at the Audit Committee meeting.</td>
<td>Susanna Masters/Tony Read</td>
<td>January 2015</td>
<td>This is on the agenda for the January Audit Committee meeting</td>
</tr>
<tr>
<td>14/137</td>
<td>The response to a question from the member of the public with regard to 111 will be answered outside of the meeting because of time restraints. The response will be reported in the minutes for information.</td>
<td>111 team/Lesley Aitken</td>
<td>January 2015</td>
<td>The response is detailed on the minute 14.37 (page 10)</td>
</tr>
<tr>
<td>106.3b</td>
<td>Further information on the GSTT overspend to be provided to the Delivery Committee.</td>
<td>Tony Read</td>
<td>November 2014</td>
<td>Completed. See Finance Report</td>
</tr>
</tbody>
</table>
1. **Primary Care Co-commissioning**

Lewisham CCG submitted its expression of interest to NHS England for co-commissioning of General Practice on 30th January 2015. The CCGs preferred option for the financial year 2015/16 of ‘Joint Commissioning Arrangements’ from April 2015 has been approved by NHS England. The CCG will continue work in partnership with the SEL CCGs on developing the functions to deliver this change into 2015/16. Further actions are contained at enclosure 12 (item 17) for the Governing Body to consider the necessary constitutional changes to support this arrangement following membership consultation.

2. **Update on Connect Care**

The Connect Care branding has been agreed as:

The benefits realisation workstreams have commenced with commissioners and Lewisham and Greenwich NHS Trust, this will build on the work previously undertaken by the CCG. The full functionality of Connect Care requires Windows 7 or later. The delays to the roll out of Windows 7 in Lewisham and Greenwich will delay the full benefits of Connect Care, a version of Connect Care will run on Windows XP in the meantime.

The bid to the Digital Technology Fund for the project extension to Greenwich and Lewisham Social Care has been successful with £1.3m being awarded. The roll out to GP practices will be in four phases commencing March 2015. Practices will need to sign up to the Information Sharing Agreement.

Attached to this report at Appendix 1 is a briefing paper that provides further information about Connect Care; which includes a public and staff FAQ section.

3. **Contracting update – acute, community and mental health contracts for 2015/16**

Contract discussions are progressing with our main local acute and mental health providers. The national changes to the Payment by Results tariff has generated additional pricing complexity and additional work. Nationally the expectation is now for contracts to be agreed and signed by end of March.

4. **National New Models of Care Programme (Forerunner Sites)**

The CCG has supported a bid by Lewisham Health and Care Partners (LH&CP) as part of the ‘new models of care’ programme. The application is for the development of a Primary and Acute Care System (PACS). The partnership collectively provides health and social care services for the population of Lewisham and comprises

- Lewisham General Practitioners (GP) Federation: primary care services;
- London Borough of Lewisham Community Services: Section 75 adult social care services;
- South London and the Maudsley Foundation Trust: acute and community mental health services; and
- Lewisham and Greenwich NHS Trust: community and general acute health services.

The vision is to achieve a viable and sustainable ‘One Lewisham Health and Social Care System’ that will enable the local population to maintain and improve their physical and mental wellbeing, enable
independent living, and have access to person-centred, evidence informed, high quality, yet cost-effective pro-active care, when it is needed.

We have made considerable progress against these aims already through the Adult Integrated Care Programme. Our current priorities are to build on this success and to:

- Invest in workforce skills development for all our health and social care staff to enable them to work differently across the whole care pathway to coordinate care safely and effectively.

- Fully integrate our existing neighbourhood teams at an operational level and to develop clear operational protocols and relationships with health and care professionals across the whole pathway.

- Leverage the full benefits of our new virtual care record system (Connect Care) which links health and care records across health and social care the first stage of which will go live in February 2015.

- Improve our physical infrastructure and estate and unlock the potential for change that exists by viewing it as a shared asset of LH&CP.

- Establish an appropriate financial re-imbursement and contracting arrangement which supports the LH&CP to allocate resources to achieve the best outcomes for patients.

Achieving these objectives will change the experience of our service users, families and carers and our staff, galvanising their support for integration and a whole systems model.

Our person centred indicators of success will be:

- Service users, their carers and families will have a different relationship with the providers of health and social care as co-producers of the their care in partnership with health and care professionals who put the service user at the centre of all they do;

- Care will be delivered in the most appropriate setting for the service user’s needs including in their own home if that is the right place;

- Service users will experience pro-active primary health care that is joined up with mental health, community services, social care and acute services in ways that it has not been before;

- Staff will be able to articulate in their own terms what integrated whole system care means in Lewisham and how it has changed the way in which they work with service users and with each other; and

- Staff will demonstrate the behaviours that put care coordination around the needs of the service user at the centre of their practice.

We believe that the new PACS model will:

- Deepen and strengthen the integration initiatives in Lewisham which the partners have been implementing since 2010;

- Provide a sustainable long-term neighbourhood driven solution which best meets the needs of the Lewisham population and which will galvanize the support of the local community;

- Complement the service redesign work which is also taking place in neighbouring boroughs which exhibit different population health needs; and

- Be an anchor point for the Lewisham element of the wider South East London transformation programme, “Our Healthier South East London”.

Chair: Dr Marc Rowland

Chief Officer: Martin Wilkinson
The PACS submission has been shortlisted nationally and Lewisham has attended a workshop on Monday 2 March to support the national decision making. We expect to hear the outcome week beginning 9 March.

5. **Our Healthier South East London programme update**

The six Clinical Commissioning Groups (CCGs) across south east London published a draft of a joint five-year commissioning strategy in June 2014. The strategy was presented to and approved by the CCG Governing Body, prior to its submission to NHS England for a national deadline of 20 June.

The Governing Body has received regular updates on the progress of the strategy as it develops and received a detailed update on the progress of the strategy in January 2015.

The attached paper (at Appendix 2) is the latest bi-monthly update for the Governing Body, summarising progress since January. It includes updates on refining outcomes and indicators for the whole system model and outputs from key meetings during a busy period for the programme.

6. **Clinical Strategy Committee Update**

The Clinical Strategy Committee (a committee in common of the six CCGs in south east London) met on 20 November and the minutes of that meeting are shown at the items for information at the end of the agenda. These were approved by the committee when it met on 15 January. The January meeting considered items relating to:

- London primary care transformation: a presentation was received from NHS England and current arrangements for consultation on the proposed specification for primary care were noted
- Collective governance: members discussed proposals for the governance of strategic decision making across south east London and agreed a process to take this forward. This will be the subject of further discussions with each governing body
- The Health Innovation Network (HIN): there was a presentation on the role of the HIN and its role in supporting the dissemination of research findings and translation into practice and detailed information on the HIN’s work on diabetes. Discussion included how to make the most of the opportunities for working in partnership with the HIN.
- The South East London Stakeholder Reference Group: Peter Gluckman, the independent chair of the group, reported on the group’s work over the two years of its existence. Members recognised the valuable work undertaken by the group and subsequently approved the continuation of the Stakeholder Reference Group through 2014/15
- Brief progress reports were also received on the re-procurement of the 111 service and work on specialised services across London

The next meeting of the committee will take place on 19 March.

7. **Don’t just go to A&E winter campaign**

The ‘Don’t just go to A&E’ winter campaign has been running across Lewisham since last November. The boroughs that bought into the campaign include all of south east London, Merton and North West Surrey. People who live in some south west boroughs which did not run the campaign were also questioned to compare data across boroughs that ran the campaign and those that didn't. Headlines show:

- Over a third of the residents from the bought in boroughs recognised ‘Not A&E’ campaign materials (38%). The evaluation company has worked on similar campaigns in other areas and these figures are significantly higher than previously experienced.
Prompted recognition of the ‘Not A&E’ campaign is significantly higher in bought in areas with residents twice as likely to have seen the specific campaign materials (38% compared with 17%).

The majority of those who are able to recall that they have seen advertising relating to the NHS 111 service or to A&E and alternative sources of healthcare unprompted, also recognise the ‘Not A&E’ materials (67%) when prompted. Many individuals are able to describe key elements of the materials, such as the colour schemes and the ‘A&E won’t kiss it better’ slogan, without being reminded of what materials look like, indicating that images are retained in memory.

In Lewisham, 48% of 148 people surveyed recognised the campaign when prompted. This is above average when compared with the other boroughs that bought-in to the campaign.

Of those that recognised the campaign, nearly half recall posters while over one third recall bus ads.

The core messages of the campaign translate well, with the majority understanding that A&E is not always the most appropriate place to go in the event of an accident or illness.

Impacts of the campaign are also encouraging, with nearly half of responses made up of ‘Will make me think more in the future about where the right place to get care is’, ‘Will mean I can advise others better on where to go when they are ill’ and ‘Will make me try other health services when it is more appropriate than A&E’. The most popular answer after this was ‘No impact’, typically because the campaigns did not give any new information.

The full evaluation report also provides recommendations for the design of further campaigns going forward.

8. Safeguarding Adults at Risk

In April 2015 the Care Act will become statute; the Act introduces statutory partners to the Safeguarding Adults Board and sets out accountability for all agencies who are involved in the health, wellbeing and social care of Adults at Risk within the community it represents.

In relation to the Care Act, NHS England have requested that all NHS health partners complete a GAP analysis reflecting their current compliance in relation to the changes introduced in the Act by 9th March. This analysis has been completed for the CCG and the work required to offer assurance for compliance relates to policy changes following the introduction of Self Neglect, Modern Slavery and Domestic Abuse, others areas that needs further assurance is the culture change in terms of recognising and reporting abuse. An action plan has been developed and will be monitored at FLAG. The action plan requires full compliance by 30/06/2015. The CCG Health Safeguarding Group will be asking all health providers NHS and private to bring their completed GAP analysis for discussion and review in June 2015.

The publication in February of NHS provider reports relating to the Saville inquiry supports the recommendations published in 2014 operation Yewtree report. The Secretary of State in his address to Parliament outlined that 13 of the 14 recommendations will be carried forward with further consideration of the 14th to be made.

The CCG has developed a template action plan of key recommendations relating to the employment of staff and management of VIP/celebrities and asked that all providers of NHS and private care complete and return the action plan for discussion and review at the Health Safeguarding Committee on 2nd June 2015.
It is to be noted that this action plan has been shared with the 5 CCGs in South London to share with their providers.

9. **Monitor Decision to Open a Formal Investigation into the King's College Hospital NHS Foundation Trust Trust's Compliance with its Licence**

Monitor has opened the investigation to support sustainable solutions to operational and financial performance challenges in relation to the Princess Royal University Hospital (PRUH). Monitor and the Trust have notified the CCG and we will monitor progress.

10. **London-wide Transformation Programme**

The Governing Body has had regular updates on the collaborative arrangements across London’s 32 CCGs working together with NHS England where it makes sense and where it adds value to all. A report is being prepared which sets out the progress in the development of London-wide commissioning activities to respond to the London Health Commission Report *Better Health for London* and the NHS Five Year Forward View, this report will go to the CCG Strategy and Development Committee in April with a report back to the Governing Body in May.

*Martin Wilkinson*
Chief Officer – Lewisham CCG
March 2015
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For further information contact the project team: LG.ConnectCare@nhs.net
1 Introduction

Connect Care is a person‐centric health and social care record which will provide a unified view of key information from across primary, acute, community and social care settings. This will be rolled out across Lewisham and Greenwich initially but may later be extended to other South East London boroughs.

Person Identifiable Data will only be available to those directly involved in delivering care. Information will be available to authorised users in view-only mode on a need to know basis.

2 Document purpose

This document is intended for the Caldicott Guardians, Information Governance leads and senior management of the organisations involved in the Connect Care programme.

It provides key information about Connect Care, including:
- what information will be available;
- when and where it is being launched;
- information governance considerations and the consent model; and
- the communications plan to raise public and staff awareness.

The following are provided as annexes:
- Privacy Notice
- Communications Plan
- FAQs

Additional Information Security documentation is under development and available upon request; this includes:
- Privacy Impact Assessment
- Password Policy
- Audit SOP

3 Which organisations are participating?

The participating organisations for the 1st phase are:
- Lewisham and Greenwich NHS Trust
- Lewisham GP Practices
- Greenwich GP Practices

The following organisations will join soon after (planning underway):
- Oxleas NHS Foundation Trust
- London Borough of Lewisham (social care)
- Royal Borough of Greenwich (social care)

The programme is supported by:
- NHS Lewisham Clinical Commissioning Group
- NHS Greenwich Clinical Commissioning Group
4 What information will be available in Connect Care?

In the first release Connect Care will display key information from some of the main systems in use at Lewisham and Greenwich NHS Trust, as well as the GP practice systems across Lewisham and Greenwich.

Role Based Access Control (RBAC) rules will control access on a need to know basis.

From LGT systems:
- Demographics, including ethnicity and religion
- Past hospital attendances (IP, OP, ED)
- Pending hospital activity (waiting lists, future appts, planned admissions)
- Community team referral information
- Child Health immunisations
- Pathology and radiology test results and images
- Inpatient Discharge Summaries (QEH only in Phase 1)

From the GP record:
- Demographics
- Summary view (current problems, current medications, allergies and recent tests)
- Problem view (current and past problems)
- Diagnosis view (current and past diagnoses)
- Medications (current, past, and medication issues)
- Risks and Warnings (allergies and contraindications)
- Procedures (operations, vaccinations/immunisations)
- Investigations
- Examinations (blood pressure only)
- Events (encounters, admissions, referrals)

Data from the GP record is shared via the Medical Interoperability Gateway which is supplied by the GP system software suppliers. The information from the GP record is not stored in Connect Care – it is retrieved in real-time at the time of viewing. Only READ coded information from the GP system will be shared with Connect Care. Certain READ codes are excluded. Further detail about the information to be shared, and the specific exclusion codes, is available in Schedule 1 of the Information Sharing Hosting and Processing Contract.

At a later date Connect Care will be expanded to include key information from Oxleas NHS Foundation Trust, Lewisham and Greenwich social care systems, as well as urgent care information from ADASTRA and additional information from Lewisham and Greenwich NHS Trust. Planning for these additional information sources is underway and further details will be published in due course.

5 When and where will Connect Care be available?

Connect Care will go-live in early March 2015. For approximately 6 weeks following the launch Connect Care will be available to a small number of users (see below). During this period it may be necessary to discontinue access to the current system. Connect Care will go live for all users once the system has been tested and any necessary changes have been made. Further details about the access arrangements will be published in due course.
time we will continue to refine the system by adding in some more information sources, and ironing out any last minutes glitches, before publishing to a wider user base.

The users for the initial 6 week period are:

- GP practices:
  - Hilly Fields
  - South Lewisham Group
  - Brockley Road
  - Conway PMS Surgery
- A small number of staff from Lewisham and Greenwich NHS Trust

In mid-April Connect Care will be available more widely across the various participating organisations. To start with the rollout will be focused on supporting emergency pathways at QEH and UHL, integrated care services such as admissions avoidance and supported discharge, GP practices across both boroughs, and key pharmacy services including the medicines optimisation service (LIMOS).

Further rollout will be prioritised based on services / areas which will receive the most benefit from Connect Care.

6 What about training?

Connect Care is a web-based, view-only system. The system is very simple and intuitive, and involves no data entry; training needs are therefore minimal.

Connect Care training sessions will be in the style of demonstrations lasting approximately 20 minutes.

Where possible the training sessions will be incorporated into existing meetings and forums to ensure minimal disruption to the provision of care. The simplicity of Connect Care will support on-the-job, super-user, and peer-to-peer training.

7 Is patient consent required?

The Government’s response to the Information Governance Review said: “Sharing information to support care is essential. It is not acceptable that the care a patient or service user receives might be undermined because the different organisations providing health and care to an individual do not share information effectively”.

The general public already expect their information to be shared appropriately across the various organisations and services involved in their health and care. Connect Care operates exactly in line with national guidance: “implied consent to share, explicit consent to view”. This places an onus on the organisations to ensure that their patients are aware of the new data sharing arrangements, and means that a Connect Care record will be automatically created, but may only be accessed if consent has been given.
Connect Care is not capturing new information. Connect Care will provide a more effective means of sharing information that is already being shared. A Connect Care Privacy Notice (available as Appendix A) has been developed to ensure that the public are aware of this new way of sharing their information. The Connect Care Privacy Notice must be published by all participating organisations to ensure that their patients/service users are aware of the introduction of this new, more efficient information sharing system.

The Connect Care Communications Group, in collaboration with the Connect Care Information Governance Group, has developed a public awareness campaign to ensure fair processing and a lawful basis for the Connect Care implied consent model. The communications plan includes the approach for publication of the Connect Care Privacy Notice across the various organisations, and the other methods that will be used to raise public awareness of Connect Care such as advertisements in Lewisham Life, meeting with the Pensioners Forum, etc. See Appendix C for further details.

Whilst the basis of information sharing via Connect Care is implied consent as described above, in keeping with best practice each record will be sealed initially and explicit consent to view sought at the point of care. Provision for breaking the seal (where appropriate) is also supported e.g. emergency care, safeguarding concerns, pre-consultation.

7.1 What if a person does not want their information to be shared?

If an individual does not want a Connect Care record they have the right to opt-out.

It will also be possible for a person to change their mind and opt back in again at a later date.

Privacy Notices, information posters and leaflets will direct people to the Connect Care website (currently under construction) to download the opt-out form, or to call a number at Lewisham and Greenwich NHS Trust. This number is an answering machine and someone from the PALS team at the trust will call the person back to discuss their options and, if requested will post an opt-out form. The opt-out form will include FREEPOST details for return of the form.

It is important that anyone deciding to opt-out is fully aware that as a consequence this may adversely impact their care. The opt-out form will include examples of where not having a Connect Care record might mean they won’t receive the best possible care. Health and care professionals will also be able to provide specific examples relevant to the individuals they are caring for.

Different levels of opt-out are supported:
- The default opt-out will be that the record is sealed and completely hidden from view in Connect Care to any user, however will still exist in the database and will continue to accumulate information. The rationale for this default position is that should a person change their mind and opt back in again their historic information will be available to view. This will be stated on the opt-out form. The default option will be available on Day 1.
• Should an individual not be satisfied with the default opt-out approach and insist that their information is not shared / is deleted if already uploaded, then an alternative opt-out can be offered. A technical solution for these types of requests is under development – this will not be available on Day 1 therefore the records will be put beyond use until the technical solution is available. There are 2 scenarios:

  o If the record has not already been created / uploaded a technical solution to prevent creation of a record can be offered. This will not be available on Day 1 therefore the records will be put beyond use and deleted when the technical solution is available. Should a person change their mind and opt back in again their historic information will NOT be available to view and the record will start from that point forward. This will be stated on the opt-out form.

  o If the record has already been created and information uploaded then deletion can be offered. This will not be available on Day 1 therefore the records will be put beyond use until the technical solution is available. Should a person change their mind and opt back in again their historic information will NOT be available to view and the record will start from that point forward. This will be stated on the opt-out form.

7.2 What if a patient does not want their GP to share their information with Connect Care?

In addition to the consent model in Connect Care, GP systems can optionally use READ codes to record a person’s expressly withheld consent for “local sharing” of their GP record. The patient will still have a Connect Care record but this will not include information from the GP system. Patients need to be made aware that not having the information from the GP record available to view in their Connect Care record might mean they won’t receive the best possible care.

At this time it is understood that, of the source systems feeding Connect Care, only the GP systems can offer the ability to record consent / dissent for local information sharing.

8 How is the system governed?

Best practice indicates that for integrated digital care records it is advisable to put in place a legally binding contract between the data processor and all organisations that are data controllers. Lewisham and Greenwich NHS Trust is both the data processor for Connect Care and a data controller.

A Connect Care Information Sharing Hosting and Processing Contract has therefore been developed. During development of this contract feedback was sought from a wide range of reviewers across the participating organisations, and from the Londonwide LMC.

Schedule 1 of the contract sets out the information to be shared, including details of specific exclusions.
All participating organisations will need to sign the contract and each participating organisation must ensure that it complies with the rules in the agreement to assure that data is protected.

A Connect Care Governing Group will manage information sharing risk across the signatories and assurance of on-going compliance. This group will have representation from each participating organisation and members of the public. This Governing Group is described in more detail in the Information Sharing Hosting and Processing Contract.
9 Annexes

9.1 Annex A: Privacy Notice

Connect Care Privacy Notice V1 8.pdf

9.2 Annex B: Communications Plan

Comms Strategy - February 2015.docx

9.3 Annex C: FAQs

FAQs.docx
Introduction

This briefing is for CCGs to share with their Governing Body members as a monthly update on the *Our Healthier South East London* programme.

A fuller progress report was provided for Governing Bodies to consider at their meetings in public, in January, covering the progress between June and the end of 2014. This report is available on the programme website [www.ourhealthiersel.nhs.uk](http://www.ourhealthiersel.nhs.uk).

Strategy development progress

Whole system model outcomes

Further work was carried out with the Partnership Group (attended by providers, local authorities and PPVs) in January to refine the outcomes and indicators for the whole system model. Specifically, the following questions were asked:

- Have the correct indicators been identified to achieve the whole system outcomes?
- Do the indicators reflect a whole system approach (e.g. social care, physical and mental health) and which indicators should be prioritised /will deliver the greatest impact?

The main themes to emerge from these discussions were to consider reducing the number of outcomes and an emphasis on the importance of being able to measure the indicators.

Next steps

- Set the detailed metrics, ambition and timelines for achievement
- Identify the sources of data for the metrics and develop a process to capture and measure

Clinical Commissioning Board, Thursday 15 January

The Clinical Commissioning Board took stock of a range of issues across the programme in January:

- The progress of the Clinical Leadership Groups (CLGs)
- Feedback from the Partnership Group, including a discussion on the outcomes for the whole system model
- The current work on finance and modelling
- The programme’s forward plan
- Development of the supporting strategies

The Board also noted the work in hand to ensure that the strategy and CCGs’ operational plans are aligned.
The Clinical Executive Group discussed presentations from three of the CLGs: planned care, children and young people, and maternity. Again, the discussion included how the different parts of the whole system would work together, and further work and modelling that is needed.

The discussion also touched on CLG next steps and the need to continue developing models and impacts to ensure that these are as robust as possible. The group also noted that the finance and modelling work is in progress; and considered the communications and engagement plan. It was agreed that it was vital that we continue to communicate our key messages as widely as possible.

**Workforce supporting strategy workshop, Wednesday 4 February**

Workforce will be a central aspect to the successful delivery of Our Healthier South East London – 85% of the current health workforce will still be in place in five years’ time. Therefore, we need to understand the impact the proposed models of care will have on staff, the skills and capabilities they will need and the new ways of working that will need to be adopted. We know that change is as much about changing behaviours as it is about changing roles.

This was borne out at our first workforce workshop on Wednesday 4 February. Bringing together senior managers with workforce experience from local authorities, commissioners and providers – as well as Health Education South London and the Health Innovation Network – the workshop gave participants the opportunity to consider the challenges that lie ahead and how we might address them.

This was a very early view of what needs to be accomplished, but everyone’s commitment to the strategy was evident – as was their willingness to work in partnership to identify the most appropriate solutions. All agreed that workforce is a huge challenge but also a huge opportunity, and one that needs to be embraced.

**Engagement update**

**Patient and Public Advisory Group (PPAG)**

On Friday 23 January, PPAG elected Gaby Charing and Lyn Wheeler as Vice-Chairs.

There was an initial reflective discussion about programme outcomes as well as an update on the forward plan. A further workshop to discuss programme outcomes in more detail is being arranged.

Membership of PPAG is being reviewed to ensure that it is representative of as many different groups as possible, including those with protected characteristics. Three new patient and public voices (PPVs) are due to be recruited to replace colleagues who have stepped down, with the aim to
Wider engagement

Bexley patient and public stakeholder event, Tuesday 10 February
Greenwich & Lewisham public engagement event, Tuesday 17 February

Two deliberative events were held recently by the programme. Around 50 patients and members of the public attended a deliberative event in Bexley and around 40 attended an event in Greenwich to talk about their experiences and ideas for improving services in the community and in hospital in south east London. Discussions were lively and wide-ranging, specifically focusing on community based care, planned care and urgent and emergency care. Outcomes will be fed back into the programme and the development of the clinical models.

Communications update

Provider and local authority communications briefing, Friday 16 January
Communications and engagement leads from NHS providers and our Local Authority partners attended a briefing about the programme. The group discussed how to work together in future and, importantly, how to increase reach and visibility about the programme within our partner organisations.

The programme team will be producing written materials for internal newsletters in the first instance and planning further communications and engagement events as we go forward.

Communications and engagement workshops

Two communications and engagement workshops were held in February.

On Tuesday 3 February, the communications and engagement steering group met for a workshop to look in depth at the community based care and urgent and emergency CLGs; and to plan and agree an engagement strategy and actions over the next few months. Engagement will be at local level, supported by central events and by materials developed in partnership between Innovation Unit, the programme team and CCG leads. Mapping of events and audiences will aim to cover a range of groups and ensure diversity and equality in engagement.

The second workshop, on Friday 13 February, looking at CCG and south east London-wide engagement plans, was another positive meeting, resulting in the development of an engagement calendar, communications and engagement materials, gap analysis to highlight communities to target, development of the engagement workshop structure, and events toolbox. As part of this process, the programme team is working with each of the CCGs to develop local narratives and we
During March, the programme will publish an Issues Paper, setting out a summary of the case for change, the national context and some of the emerging ideas, with questions for the public and stakeholders to consider. This approach is emerging best practice for public bodies considering service change, effectively setting out all the issues and considerations in one short document. The document will be on the programme website and will be circulated to key stakeholders. We will also be producing two short films about the case for change and the whole system model, to support public and stakeholder engagement.

**Online**

Two public updates were published on the programme website: [www.ourhealthiersel.nhs.uk](http://www.ourhealthiersel.nhs.uk)
The Audit Committee met on 3 March 2015. Highlights are as follows.

We received reports from our Internal Auditors, KPMG, on Collaborative working and Risk Management. Both reviews were awarded grades of “significant assurance with minor improvement opportunities”. Key findings were that whilst our collaborative arrangements with the Council are strong they could be even stronger through better risk assessments and improved contractual performance expectations. For risk management a deep dive review was conducted on three risks within the Board Assurance Framework (BAF). Areas for improvement include more formal consideration of risk tolerance levels by the Governing Body and extending our management of risks over a longer time period than each financial year. Management has agreed the recommendations and implementation will be monitored by the Audit Committee on an exceptions basis. The Audit Committee congratulated KPMG on the excellence of both reviews.

Because the Audit Committee met early in March, there had not been sufficient time for Management and KPMG to discuss a draft Internal Audit Plan for 2015/16. However, it was noted that good progress is expected in the coming weeks, with the Committee being kept in the loop.

The interim Service Auditor Report by Deloitte on the control environment, design and operation within the South East CSU was received and the initial CSU management response noted. The report identifies a number of weaknesses in the operation of controls concerning IT security, integrity and business continuity and also the financial accounting environment. The report is generic to the whole CSU client base and as such the impact on Lewisham CCG is not explicit. The Chief Financial Officer is monitoring the CSU’s action plan which should when fully implemented should provide adequate assurance by year end.

Our External Auditors, Grant Thornton, reported on their preliminary work for the 2014/15 audit. No issues of concern were identified. (Prior to the meeting, the Committee was pleased to be walked through what to expect from the layout and content of the accounts for 2014/15 by the Chief Financial Officer.)

A progress report against the Counter Fraud and Security Management work plans for the final six months of 2014/15 was received together with draft work plans for 2015/16. NHS Protect has recently issued national counter fraud standards and the draft work plan will be refreshed by the Chief Financial Officer in light of these standards and incorporating the results of an impending Fraud Risk Assessment for the CCG.

Similarly for Security Management, national standards have recently been published by NHS protect. A draft work plan for 2015/16 will be received at the April meeting of the Committee.
Members noted that the Governing Body is asked to delegate the compilation of the Annual Report to the Delivery Committee and that delegation has been agreed for the Audit Committee to approve the draft Annual Report and Accounts on behalf of the Governing Body. Committee meetings have been scheduled to allow this. Members endorsed the approach to produce a single Annual Report and accounts document that would be digestible by the wide range of audiences of the report.

The Governing Body at its meeting in January agreed for the appointment of an independent Audit Committee member. Recruitment is expected to commence in March once job role and person specifications have been agreed. The role will be referred to the Remuneration Committee.

There have been no losses, special payment or instances to waive Standing Financial Instructions since last reported by the Audit Committee.

Full minutes of the meeting will be made available to the GB after approval at the April meeting of the Committee.

Ray Warburton  
Chair, Audit Committee  
NHS Lewisham CCG

5 March 2015
Governing Body meeting on 12th March 2015

Report from the Chair of the Finance and Investment Committee
Date of Meeting(s) reported: 20th January 2015
Author: Tan Vandal, Chair of Finance and Investment Committee

1. Main Issues discussed

1.1 Primary Care Dietetic Services

1.1.1 The meeting considered and approved a business case to extend the Primary Care Dietetic Services for adults from April 2015 with some specification enhancements to support:

- Individuals with learning disabilities, mental health problems in care homes
- Care home residents
- Patients recently discharged from hospital

1.1.2 The service supports the strategic objectives to develop Local Care Networks.

1.1.3 The procurement of the new service has commenced and contract award is expected for September 2015.

1.2 GP practice telephone appointment booking system

1.2.1 The meeting considered and rejected a business case for a GP practice telephone appointment booking system. The system would enable patients to contact their practices 24/7 to cancel, check, rebook or book appointments

1.2.2 The Committee was particularly concerned that telephone access is only one small aspect of patient concerns about access to primary care services and specifically the proposal would not assist in reducing the competition for available appointments

2. Key achievements

2.1 Continuation and enhancement of dietetics services for adults in Lewisham

3. Key challenges addressed

3.1 Although the business case for a GP practice telephone appointment booking system was not approved, the Committee noted that the CCG would include this in the capital proposals to NHS England for 2015/16.

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

4.1 None identified

5. How did the meeting promote quality and safety?
5.2 Through the approval of the business case for continuation of and enhancement to the dietetics services.

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

6.1 The dietetics service expansion will enable more patients to be appropriately cared for in new care settings, such as care homes.
A meeting of the Governing Body
12th March 2015

ENCLOSURE 6
Risk Management Report and Board Assurance Framework

<table>
<thead>
<tr>
<th>CLINICAL LEAD:</th>
<th>Dr Marc Rowland</th>
<th>Post Chair</th>
</tr>
</thead>
<tbody>
<tr>
<td>MANAGERIAL LEAD:</td>
<td>Susanna Masters</td>
<td>Post Corporate Director</td>
</tr>
<tr>
<td>AUTHOR:</td>
<td>Graham Hewett</td>
<td>Post Head of Integrated Governance</td>
</tr>
</tbody>
</table>

RECOMMENDATIONS:

The Governing Body is asked to:

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

Risk Management Report
The BAF (Attached) groups the risks to achieving the Governing Body’s five Corporate Objectives into seven broad overarching risks. New or amended text since the last Governing Body has been shown in *italics* to make it clear where changes have been made. Negative assurances are shown in red text. Residual risk scores for the component parts of the overarching risks have been assessed. The overarching risk score is shown as the highest score of the component parts of the risk.

There has been no change to the residual risk score in any of the overarching risks since the last Governing Body meeting.

Substantive changes:

Quality Risk 1
Updates to the assurances given.
**Quality Risk 2**
New assurance gap added to b1) “Failure to achieve cancer 62 weeks wait target”
Updates to the assurance given.

**Financial Governance**
Updates to the assurance given.

**Non-financial governance**
New assurance gaps and associated actions added
Minor changes to residual risk scores for some controls

**Public engagement.**
Additional detail added to the Control at e)

**Primary care**
A negative assurance given added at a5) with associated assurance gaps and actions.
New assurance gaps identified and associated actions added.

**Neighbourhoods**
New assurance gaps identified and associated actions added.

The Heat Map shows the distribution of the residual risk scores for all the risks.

**Heat Map**

<table>
<thead>
<tr>
<th>Risk Matrix</th>
<th>Impact</th>
<th>Negligible</th>
<th>Minor</th>
<th>Moderate</th>
<th>Major</th>
<th>Catastrophic</th>
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</thead>
<tbody>
<tr>
<td>Likelihood</td>
<td></td>
<td>1</td>
<td>2</td>
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<td>Rare</td>
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<td>Possible</td>
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<td>Financial Governance Quality 1</td>
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<td>Likely</td>
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<td>Primary Care Quality 2</td>
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<td>Almost certain</td>
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<td></td>
<td>Neighbourhoods</td>
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</table>

<table>
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<tr>
<th>Impact</th>
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<th>Minor</th>
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<th>Major</th>
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<tbody>
<tr>
<td>Financial Governance</td>
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<td>Non Financial Governance</td>
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<td>Public Engagement</td>
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<td>Neighbourhoods</td>
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<td>Quality 1</td>
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<td>Quality 2</td>
<td></td>
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</table>
CORPORATE AND STRATEGIC OBJECTIVES
The Board Assurance Framework supports the Governing Body’s objective to ensure that the CCG has robust governance arrangements in place.

CONSULTATION HISTORY INCLUDING MEMBERS ENGAGEMENT:
• Risk Management Group January and February 2015.

PUBLIC ENGAGEMENT
• There has been no public engagement and none is planned other than presentation of the report at the Governing Body held in public.

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 will identify if there are risks that the CCG will not meet its Health Inequality and Public Sector Equality duties and the controls and actions taken to mitigate these risks.

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

AUTHOR CONTACT:
Name: Graham Hewett
NHS Lewisham Board Assurance Framework

Date Printed 05/03/2015

Enclosure 6.1

Key:
Risk Matrix
NHS Lewisham CCG uses the standard NHS 5*5 risk scoring matrix shown above. The impact or consequence of the risk should it occur is measured on the x axis and the likelihood of the risk occurring is measured on the y axis.
Risks are evaluated using the matrix x * y, shown as I * 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.
The risks in the BAF are scored in the coloured box at the top right of the page.
Inherent Score – the risk score before any controls are applied
Residual Score – the risk score after the controls have been applied
Target Score – the risk score the plans to achieve once all the controls are fully applied and proved to be effective.

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

Format
New amendments and additions to the text made since the last Governing Body meeting are shown in italics
Negative assurances, where evidence shows that the controls are not fully effective, are shown in red text.

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Changes Made</th>
<th>Who by</th>
</tr>
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<tr>
<td>1.1</td>
<td>17/10/2014</td>
<td>Added front page and version control. Added Response and Residual Risk Score columns non financial governance risk Added EA+ or IA+ suffixes to all assurances in non financial governance risk Used Italics on new entries Used red text for negative assurances</td>
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<td>06/11/2014</td>
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<td>04/01/2015</td>
<td>Updated Primary Care</td>
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<td>2.7</td>
<td>04/01/2015</td>
<td>Updated Neighbourhoods</td>
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<tr>
<td>2.8</td>
<td>04/01/2015</td>
<td>Updated for RMG - Financial, non financial governance &amp; public engagement</td>
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<td>2.15</td>
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<td>2.16</td>
<td>05/03/2015</td>
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### Risk Scoring Matrix

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<td>Risk Description</td>
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### Controls

- **Objective:** 14/15 - 10. Commission high quality care services today

<table>
<thead>
<tr>
<th>Controls</th>
<th>Response</th>
<th>Assurance Source</th>
<th>Assurance Given</th>
<th>Assurance Type</th>
<th>Assurance Level</th>
<th>Assurance Gaps</th>
<th>Action Required</th>
<th>Action target date</th>
<th>Residual Score (PL)</th>
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</thead>
<tbody>
<tr>
<td>a) Quality Assurance Framework.</td>
<td>Mitigate</td>
<td>Quality Indicators presented to CQOs.</td>
<td>Quality Assurance Framework agreed by GB 2013.</td>
<td>Management</td>
<td>Adequate</td>
<td>Outcomes and inequalities data is invited</td>
<td>To develop a quality strategy and action plan to improve the quality assurance processes.</td>
<td>01/04/2015</td>
<td>02/04/2015</td>
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<tr>
<td>The CCG has developed a clear Quality Assurance Framework which specifies how assurance is agreed from its providers across the health economy. The CCG has clear policies for Safeguarding, Serious Incident Management and managing Complaints.</td>
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<td>b) Quality Indicators presented to CQOs.</td>
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<td>c) Quality Assurance Framework agreed by GB 2013.</td>
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<td>d) Management</td>
<td>Adequate</td>
<td>Outcomes and inequalities data is invited</td>
<td>To develop a quality strategy and action plan to improve the quality assurance processes.</td>
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<td>e) Quality Indicators presented to CQOs.</td>
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<td>f) The CCG has clear policies for Safeguarding, Serious Incident Management and managing Complaints.</td>
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<td>g) The CCG has developed a clear Quality Assurance Framework which specifies how assurance is agreed from its providers across the health economy. The CCG has clear policies for Safeguarding, Serious Incident Management and managing Complaints.</td>
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<td>h) Quality Assurance Framework agreed by GB 2013.</td>
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<td>i) Management</td>
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<td>Outcomes and inequalities data is invited</td>
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### Effect

- A serious safeguarding incident or failure to recognise institutional abuse or neglect in commissioned services
- Harm to patients
- Inequalities are not reduced
- Financial loss due to compensation payments

### Committee

- FLAG
- Delivery Committee

### Causes:

- a. The CCG does not monitor quality standards (patient experience and inequalities) outcome and trends with robust and valid data.
- b. The CCG does not effectively triangulate quantitative and qualitative data to gain an intelligent view of current issues.
- c. Other stakeholders do not share relevant quality data in a timely way with the CCG and NHS England. Health watch Lewisham, SLAM, CQC.
- d. The CCG does not act upon quality issues at the appropriate pace and escalation given the severity.
- e. The CCG does not have adequate arrangements for adult and / or child safeguarding.
- f. The CCG does not hear the public’s voice on quality.
- g. The CCG does not have sufficient capacity and / or capability to monitor quality / equality.
- h. The CCG does not effectively triangulate quantitative and qualitative data to gain an intelligent view of current issues.
- i. The CCG’s does not monitor quality standards (patient experience and inequalities) outcome and trends with robust and valid data.

### Inherent Score

- Modest 4

### Target Score

- Moderate 4

### Residual Score

- High 8

### Movement Point

- Very High 20

### Risk Description:

Commissioned services are not safe, timely or consistent, provide a positive patient experience or not clinically effective and do not improve health outcomes and reduce inequalities.
### b. The CCG does not effectively triangulate quantitative and qualitative data to gain an intelligent view of current issues

<table>
<thead>
<tr>
<th>Controls</th>
<th>Response</th>
<th>Assurance Source</th>
<th>Assurance Given</th>
<th>Assurance Type</th>
<th>Assurance Level</th>
<th>Assurance Gaps</th>
<th>Action Required</th>
<th>Action target date</th>
<th>Residual Score (%)</th>
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<tbody>
<tr>
<td>c1) Working in partnership</td>
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<tr>
<td>The CCG works in partnership with key providers at the Clinical Quality Review Groups. Providers are asked to inform the Groups of emerging quality concerns not covered on the agendas.</td>
<td>Accept</td>
<td>Serious Incident reports from Strategic Executive Information Service (STRES) within 24 hours of incident occurrence</td>
<td>Health watch reports to FLAG April, May, June, July, Aug, Sept Oct Nov Dec 2014 Jan 2015</td>
<td>Management Adequate</td>
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<tr>
<td>Primary care quality data is reviewed at the For Learning and Action Group. CQC information is shared with the CCG weekly via a regular email bulletin. A regular meeting is held with the local CQC manager. NHS England &amp; NTA represented at LGT CQRG.</td>
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<tr>
<td>d1) Serious Incident Management</td>
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<tr>
<td>A clear and formal process for responding to Serious Incidents reported by providers is in place and monitored at Clinical Quality Review Groups and the For Learning and Action Group. A pressure ulcer Serious Incident reported by Lewisham and Greenwich Trust is reviewed in multi-disciplinary team meetings across 4 Boroughs.</td>
<td>Accept</td>
<td>Serious Incident reports from Clinical Quality Review Groups and the For Learning and Action Group</td>
<td>Health watch reports to FLAG April, May, June, July, Aug, Sept Oct Nov Dec 2014 Jan 2015</td>
<td>Management Adequate</td>
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<tr>
<td>e1) The public voice</td>
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<tr>
<td>The CCG receives regular reports from Health watch at its Clinical Quality Review Groups and the For Learning and Action Group. Quality issues are regularly discussed at Public Engagement Events.</td>
<td>Accept</td>
<td>Reports to the Clinical Quality Review Groups and the For Learning and Action Group</td>
<td>Health watch reports to FLAG April, May, June, July, Aug, Sept Oct Nov Dec 2014 Jan 2015</td>
<td>Management Adequate</td>
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<tr>
<td>The CCG has a clear and effective complaints handling process.</td>
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<tr>
<td>f1) The CCG does not hear the members views on quality</td>
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<tr>
<td>g1) The Membership Voice on Quality</td>
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<tr>
<td>GP Members of the CCG are encouraged to send Quality Alerts to the CCG where they can identify that the quality of care has been compromised. There is a developing system to ensure that actions are taken at providers in response to the Quality Alerts.</td>
<td>Accept</td>
<td>GP Raised Quality Alerts reports</td>
<td>GP Raised Quality Alerts report to FLAG April, May, June, July, Aug, Sept Oct Nov Dec 2014 and to Delivery Committee and G8</td>
<td>Management Adequate</td>
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<tr>
<td>Controls</td>
<td>Assurance Source</td>
<td>Assurance Given</td>
<td>Assurance Type</td>
<td>Assurance Level</td>
<td>Assurance Gaps</td>
<td>Action Required</td>
<td>Action target date</td>
<td>Residual Score (F%)</td>
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<tr>
<td>g) Capacity and Capability</td>
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<tr>
<td>Director of Nursing is Safeguarding Executive lead.</td>
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<tr>
<td>Director of Nursing is director lead for quality.</td>
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<tr>
<td>Head of Integrated Governance supports on quality.</td>
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<tr>
<td>Designated Nurse - Vulnerable Adults.</td>
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<tr>
<td>Data support provided by Systems Intelligence Officer.</td>
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<tr>
<td>Care Home Liaison Nurse recruited.</td>
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<tr>
<td>Care Home Support Team commissioned from LINT.</td>
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<tr>
<td>Mandatory Training for all staff.</td>
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<tr>
<td>Serious Incidents management team in place.</td>
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<tr>
<td>Equality and Diversity support provided under contract from Commissioning Support Unit.</td>
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<td>g1) Capacity and Capability</td>
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<tr>
<td>The CCG does not have sufficient capacity and / or capability to monitor quality / equality.</td>
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<td>g1) Capacity and Capability</td>
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<td>g2) Safeguarding</td>
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<tr>
<td>CCG policies and frameworks for safeguarding in line with London wide procedures.</td>
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<tr>
<td>All CCG staff complete mandatory safeguarding training.</td>
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<tr>
<td>CCG Safeguarding team for adults and children fully staffed.</td>
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<tr>
<td>All providers including the private mental health providers are now invited quarterly to provide assurance to the CCG.</td>
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<tr>
<td>g2) Safeguarding</td>
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<tr>
<td>The CCG does not have adequate arrangements for adult and / or child safeguarding.</td>
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<tr>
<td>g3) Services that flex around people’s needs</td>
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<tr>
<td>The CCG receives regular reports from Health watch at its Clinical Quality Review Groups and the for Learning and Action Group.</td>
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<td>Quality issues are regularly discussed at Public Engagement Events.</td>
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<tr>
<td>Public engagement in the commissioning process.</td>
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</tbody>
</table>

Residual Score: 5*1

Residual Score: 2*2
Objective: 14/15 - Commission high quality care services today

Risk Ref: Quality two
Risk Owner: Diana Braithwaite
Risk Description: Provider services do not deliver against financial, performance and/or quality standards

Risk Scoring Matrix

<table>
<thead>
<tr>
<th>Risk Matrix Dimension</th>
<th>Inherent Score</th>
<th>Residual Score</th>
<th>Target Score</th>
<th>Assurance Type</th>
<th>Assurance Level</th>
<th>Assurance Gaps</th>
<th>Action Required</th>
<th>Action target date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.4 - Very High</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>Adequate</td>
<td>No Identified</td>
<td>None</td>
<td>Review and develop a new community services contract and service specification</td>
<td>Apr-15</td>
</tr>
<tr>
<td>1.2 - Moderate</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>Substantial</td>
<td>None</td>
<td>None</td>
<td>Continued regional tripartite scrutiny. Implement revised recovery plan for A&amp;E.</td>
<td>Apr-15</td>
</tr>
<tr>
<td>1.3 - High</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>Implement recovery plan for cancer 62 day waits.</td>
<td>Apr-15</td>
</tr>
</tbody>
</table>

Causes:
- a. Contracts are not appropriately defined and agreed with providers
- b. Providers fail to deliver contractual and NHS Constitutional commitments
- c. The CCG does not utilise all available resources and processes to manage contract variations against financial, performance and quality standards

Effect
- The CCG does not meet its statutory duties to achieve financial balance
- The CCG is unable to invest in its 5-year strategy to deliver the shift from secondary to community and primary care settings
- Poor patient experience
- Loss of reputation

Committee
- Delivery Committee

Control
- a1) The CCG uses the national NHS Standard Contract
- a2) The CCG has established contract management dashboards for quality and performance
- a3) The CCG has developed a 5-year commissioning strategy outlining its intentions

Response
- b1) The CCG has employed an expert multi-disciplinary team from the CSU and the CCG is developing an internal contract management multi-disciplinary team to support

Assurance Source
- CSU Service Auditors Reports (SARs)
- Monthly Performance Reports to Delivery Committee
- Strategy Monitoring Framework
- Contract Management Board Minutes
- Performance Reporting to Delivery Committee
- Quality reports to monthly FLAG meetings

Assurance Given
- Signed contracts and contracts register
- Performance reporting to Delivery Committee
- Monthly Performance Reports to Delivery Committee
- Strategy Monitoring Framework

Residual Score (FL)
- 1

L1 - Low Score
- 1

L2 - Medium Score
- 2

L3 - High Score
- 4

L4 - Very High Score
- 8

Action Required
- Review and develop a new community services contract and service specification
- Continued regional tripartite scrutiny.
- Implement revised recovery plan for A&E.
- Implement recovery plan for cancer 62 day waits.
- External consultancy support being commissioned for 6 weeks for BGL whole system.
- Develop a new quality dashboard for community services

Assurance Gaps
- None identified

Residual Score (FL)
- Apr-15
<table>
<thead>
<tr>
<th>Controls</th>
<th>Response</th>
<th>Assurance Source</th>
<th>Assurance Given</th>
<th>Assurance Type</th>
<th>Assurance Level</th>
<th>Assurance Gaps</th>
<th>Action Required</th>
<th>Action Target date</th>
<th>Residual Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>b2) System Resilience Group established to manage demand and capacity across the system System Resilience Plans agreed Cross Boroughs Council Group Established to support demand management and discharge arrangements</td>
<td>Mitigate</td>
<td>Monthly monitoring at Systems Resilience Group of Urgent Care Dashboard Dashboard of KPIs for each of the winter planning schemes</td>
<td>NHS England approved Systems Resilience Plans NHS England have approved Tranche 1 &amp; Tranche 2 schemes</td>
<td>Management</td>
<td>Adequate</td>
<td>Improvement trajectory to be developed to deliver achievement by April</td>
<td>Assess the recovery work across the whole system with support from an external consultancy company</td>
<td>Apr-15</td>
<td><strong>3</strong></td>
</tr>
<tr>
<td>c. The CCG does not utilise all available resources and processes to manage contract variations against financial, performance and quality standards</td>
<td>Mitigate</td>
<td>Contract Monitoring Board minutes (monthly)</td>
<td>Performance and quality reports to Delivery committee monthly</td>
<td>Management</td>
<td>Adequate</td>
<td>Contract monitoring of the community services contract has not been robust during 2013/14</td>
<td>Implement new contract monitoring processes for the community contract at LGT</td>
<td>Apr-15</td>
<td><strong>3</strong></td>
</tr>
<tr>
<td>(d) The CCG has a Contract Management Board with appropriate sub committees for its major contracts</td>
<td>Mitigate</td>
<td>Contract Monitoring Board minutes (monthly)</td>
<td>Performance and quality reports to Delivery committee monthly</td>
<td>Management</td>
<td>Adequate</td>
<td>Contract monitoring of the community services contract has not been robust during 2013/14</td>
<td>Implement new contract monitoring processes for the community contract at LGT</td>
<td>Apr-15</td>
<td><strong>3</strong></td>
</tr>
<tr>
<td>(e) The CCG has included appropriate penalty clauses in its major contracts</td>
<td>Mitigate</td>
<td>Contract Documentation</td>
<td>Contract Monitoring Board minutes (monthly)</td>
<td>Management</td>
<td>Adequate</td>
<td>None identified</td>
<td>None</td>
<td>Apr-15</td>
<td><strong>3</strong></td>
</tr>
</tbody>
</table>
**Risk Description:** The CCG fails to meet its statutory financial duties and fails to deliver NHS England’s targeted surplus

**Risk Ref:** Financial governance  
**Risk Owner:** Tony Read

### Causes:
- a. The CCG does not have effective arrangements to control expenditure
- b. The CCG does not have effective cash management arrangements
- c. The CCG does not have adequate management and reporting arrangements

#### Effect:
- Failure to manage within revenue resource limits.
- Failure to manage within combined resource limits.
- Failure to manage within draw down limits.
- Failure to deliver a 1% revenue surplus.
- Failure to achieve the better practice payments code.

### Committee
- Delivery Committee
- Finance & Investment Committee
- Audit Committee

### Controls Response Assurance Source Assurance Given Assurance Type Assurance Level Assurance Gaps Action Required Action target date

#### a. The CCG does not have effective arrangements to control expenditure

<table>
<thead>
<tr>
<th>Category</th>
<th>Response</th>
<th>Assurance Source</th>
<th>Assurance Given</th>
<th>Assurance Type</th>
<th>Assurance Level</th>
<th>Assurance Gaps</th>
<th>Action Required</th>
<th>Action target date</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Expenditure Controls</td>
<td></td>
<td>Prime Financial Policies and schemes of delegation approved by GB</td>
<td></td>
<td>Management</td>
<td>Substantial</td>
<td></td>
<td>Service Auditor Report recommendations have yet to be fully implemented by the CCG</td>
<td>31/03/2015</td>
</tr>
<tr>
<td>b) Cash controls</td>
<td></td>
<td>Monthly Performance report to Delivery Committee and Governing Body</td>
<td></td>
<td>Management</td>
<td>Substantial</td>
<td></td>
<td>Continued Monitoring On-going</td>
<td></td>
</tr>
<tr>
<td>c) The CCG does not have adequate management and reporting arrangements</td>
<td></td>
<td>Monthly Performance report to Delivery Committee and Governing Body</td>
<td></td>
<td>Management</td>
<td>Substantial</td>
<td></td>
<td>Continued Monitoring On-going</td>
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</tbody>
</table>

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### Risk Scoring Matrix

<table>
<thead>
<tr>
<th>Risk Category</th>
<th>Impact</th>
<th>Likelihood</th>
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<th>Likelihood</th>
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<th>Likelihood</th>
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<tbody>
<tr>
<td>Impact 5</td>
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<td>Impact 5</td>
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<td>Impact 5</td>
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<tr>
<td>High</td>
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<tr>
<td>Medium</td>
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<td>Low</td>
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<td>Low</td>
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Objective: 14/15 - 13. Governance - ensure the CCG has robust governance arrangements in place

Residual Score: Target Score
Objective: 14/15 - 13. Governance - ensure the CCG has robust governance arrangements in place

<table>
<thead>
<tr>
<th>Risk Ref: Non financial governance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk Owner: Susanna Masters</td>
</tr>
<tr>
<td>Risk Description: Robust governance arrangements do not ensure the delivery of the CCG's statutory non-financial duties, national compliance and meet its constitutional requirements as a member’s organisation.</td>
</tr>
</tbody>
</table>

### Movement Point

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

### Causes:

a. The Governing Body does not operate within the CCG’s Constitution’s framework.

b. The Governing Body is insufficiently aware of the nature and level of risk it is willing to take to achieve its strategic objectives and ambition and of the assurances on mitigation and control.

c. The CCG does not have in place arrangements to manage effectively its corporate governance function including, Conflict of Interest, emergency planning, public sector equality duty, information strategy, information governance etc.

d. The CCG does not have in place appropriate arrangements for commissioning support services.

### Effect

- Failure to act lawfully and within the constitution
- Failure to meet non financial statutory obligations
- Loss of reputation
- Challenge from Members

### Committee

Delivery Committee

### Controls

<table>
<thead>
<tr>
<th>Controls</th>
<th>Response</th>
<th>Assurance Source</th>
<th>Assurance Given</th>
<th>Assurance Type</th>
<th>Assurance Level</th>
<th>Assurance Gaps</th>
<th>Action Required</th>
<th>Action target date</th>
<th>Residual Score</th>
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<tr>
<td>a) CCG Constitution</td>
<td>Mitigate</td>
<td>Internal Audit reports of governance processes Head of Internal Audit Opinion External Audit Reports Annual Report</td>
<td>Internal Audit of Budgetary control and scheme of delegation EA+ Internal Audit of Governance and Risk Management EA+ Head of Internal Audit Opinion April 2014 EA+</td>
<td>Independent</td>
<td>Adequate</td>
<td>The CCG does not have a process to demonstrate that it has effective member engagement. The revised CCG Constitution has not yet been ratified by NHS E (versions 2.1 &amp; 2.2) The Adult Social Care (ASC) Section 75 Agreement required updating</td>
<td>Clinical Directors, supported by SMT, are developing a Members Engagement Plan. Preparation work to be undertaken to ensure that appropriate governance arrangements are in place for primary care co-commissioning Annual Membership Engagement Event to be re-arranged ASC Section to be agreed by lawyers and signed</td>
<td>All 22st March 2015</td>
<td>3*3</td>
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<tr>
<td>a2) Terms of Reference of Committees</td>
<td>Mitigate</td>
<td>Internal Audits of governance arrangements Annual Governance Statement / Annual report</td>
<td>Internal Audit of Governance and Risk Management EA+ (NFAS) result of risk management processes 2014</td>
<td>Independent</td>
<td>Adequate</td>
<td>None identified</td>
<td>Recruit an additional independent member with financial experience to the Audit Committee</td>
<td>02/08/2015</td>
<td>3*2</td>
</tr>
</tbody>
</table>

### Risk Scoring Matrix
c. The CCG does not have in place arrangements to manage effectively its corporate governance function including, Conflict of Interest, emergency planning, public sector equality duty, information strategy, information governance etc.

### (i) Risk Management Strategy

The CCG has a Risk Management Strategy that sets out how risks are to be managed and escalated. The Board Assurance Framework describes the key risks, controls, assurance and mitigation.

- The Risk Management Group meets monthly to review the Risk Registers, the Board Assurance Framework and to oversee the risk management strategy.
- The Governing Body reviews the Board Assurance Framework.
- Audit Committee reviews the Risk Management process.

#### b. Risk Management Strategy

<table>
<thead>
<tr>
<th>Controls</th>
<th>Response</th>
<th>Assurance Source</th>
<th>Assurance Given</th>
<th>Assurance Type</th>
<th>Assurance Level</th>
<th>Assurance Gaps</th>
<th>Action Required</th>
<th>Action target date</th>
<th>Residual Score</th>
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</tbody>
</table>

### (ii) Business Continuity and Emergency Planning

CCG Business Continuity Plans (BCP) in place.

CCS BCP in place

BCP Exercises.

Accountable Emergency Officer in place

#### (2) Business Continuity and Emergency Planning

- CCG Business Continuity Plans (BCP): The CCG has a Business Continuity Plan that has been approved by the Governing Body and is regularly reviewed.
- BCP Exercises: The CCG has conducted BCP exercises to demonstrate readiness.
- Accountable Emergency Officer: An accountable emergency officer is in place.

#### (3) Information Governance


Information Governance Officer, Senior Information Risk Owner, and Caldicott Guardian in post to provide advice.

Information Governance Steering Group oversees information governance management

#### (4) Information Governance

- Information Governance Officer, Senior Information Risk Owner, and Caldicott Guardian in post.
- Information Governance Steering Group oversees information governance management.

#### (5) Conflicts of Interests

Conflict of Interest Policy and CCG Constitution.

Registers of Interests.

Declaration of Interests on agenda template for all key meetings

### (6) Conflicts of Interests

- Conflicts of Interest are managed.
- Minutes of key meetings demonstrate how conflicts of interests are managed.
- IDRs are published on the CCG website.

### (7) Be part of the NHS Improvement Change Management Framework

Update the risk management strategy and seek approval from Chief Officer

NHS Improvement Change Management Framework.

### (8) Support Unit Risk Management

- The CCG has a Risk Management Strategy that sets out how risks are to be managed and escalated.
- The Board Assurance Framework describes the key risks, controls, assurance and mitigation.
- The Risk Management Group meets monthly to review the Risk Registers, the Board Assurance Framework and to oversee the risk management strategy.
- The Governing Body reviews the Board Assurance Framework.
- Audit Committee reviews the Risk Management process.

#### (9) Support Unit Risk Management

- Update information management policies in line with recent statutory guidance.
- Ensure sufficient resources are available to implement information management policies.
- Review and update information management policies on a monthly basis.

### (10) Business Continuity and Emergency Planning

CCG Business Continuity Plans (BCP) in place.

CCS BCP in place

BCP Exercises.

Accountable Emergency Officer in place

#### (10) Business Continuity and Emergency Planning

- CCG Business Continuity Plans (BCP): The CCG has a Business Continuity Plan that has been approved by the Governing Body and is regularly reviewed.
- BCP Exercises: The CCG has conducted BCP exercises to demonstrate readiness.
- Accountable Emergency Officer: An accountable emergency officer is in place.

#### (11) Information Governance


Information Governance Officer, Senior Information Risk Owner, and Caldicott Guardian in post to provide advice.

Information Governance Steering Group oversees information governance management

#### (12) Information Governance

- Information Governance Officer, Senior Information Risk Owner, and Caldicott Guardian in post.
- Information Governance Steering Group oversees information governance management.

### (13) Conflicts of Interests

Conflict of Interest Policy and CCG Constitution.

Registers of Interests.

Declaration of Interests on agenda template for all key meetings

#### (14) Conflicts of Interests

- Conflicts of Interest are managed.
- Minutes of key meetings demonstrate how conflicts of interests are managed.
- IDRs are published on the CCG website.

### (15) Be part of the NHS Improvement Change Management Framework

Update the risk management strategy and seek approval from Chief Officer

NHS Improvement Change Management Framework.

### (16) Support Unit Risk Management

- The CCG has a Risk Management Strategy that sets out how risks are to be managed and escalated.
- The Board Assurance Framework describes the key risks, controls, assurance and mitigation.
- The Risk Management Group meets monthly to review the Risk Registers, the Board Assurance Framework and to oversee the risk management strategy.
- The Governing Body reviews the Board Assurance Framework.
- Audit Committee reviews the Risk Management process.
<table>
<thead>
<tr>
<th>Controls</th>
<th>Response</th>
<th>Assurance Source</th>
<th>Assurance Given</th>
<th>Assurance Type</th>
<th>Assurance Level</th>
<th>Assurance Gaps</th>
<th>Action Required</th>
<th>Action target date</th>
<th>Residual Score (FL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(4) Anti bribery and counter fraud</td>
<td>Accept</td>
<td>Mandatory training records</td>
<td>Counter Fraud and Anti Bribery Reports to Audit Committee</td>
<td>Management Independent</td>
<td>Adequate</td>
<td>None identified</td>
<td>None</td>
<td></td>
<td>3*1</td>
</tr>
<tr>
<td>Anti Bribery and Counter Fraud Policies</td>
<td></td>
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<tr>
<td>CCG Constitution</td>
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<td></td>
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<tr>
<td>Fraud Awareness Sessions and Bribery Awareness sessions held with all staff internally. Counter Fraud newsletters. Counter Fraud page on Intranet and Internet. Posters and payslip promotion leaflets. Counter Fraud Annual Plan. Counter Fraud Service and local counter fraud specialist appointed Mandatory training</td>
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<tr>
<td>(5) Equality and Diversity</td>
<td>Accept</td>
<td>Equality Objectives 2014/15</td>
<td>Equalities Objectives agreed at GB Oct 2013</td>
<td>Management Adequate</td>
<td>Not all Cover sheet to key committees adequately summarise the impact of the report on equalities. The CCG does not adequately demonstrate that it is leading the way on commissioning inclusive health services</td>
<td>Improve the consistency of cover sheet completion. Implement supporting development in line with the outcomes of the EDS goal 4 review - inclusive leadership.</td>
<td>March 2015</td>
<td>3*2</td>
<td></td>
</tr>
<tr>
<td>Equality objectives with owners and measures agreed at March LCCC and published. EDS Agreed. Governing Body equalities workshop on 24th January 2013 to increase awareness of equalities duties. Governing Body Agreed equalities objectives October 2013</td>
<td></td>
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<tr>
<td>(d) Commissioning support services</td>
<td>Mitigate</td>
<td>Contract and SLA documentation</td>
<td>Contract signed with CSU</td>
<td>Management External</td>
<td>Limited</td>
<td>The Services Auditors Report (SAR) identified some exceptions</td>
<td>Monitor the CSU’s action plan to address the SAR exceptions</td>
<td>On-going</td>
<td>3*1</td>
</tr>
<tr>
<td>Contract and service level agreements with the CSU</td>
<td></td>
<td>Notes of contract management meetings</td>
<td>Commissioning intentions letter to CSU July 2014</td>
<td></td>
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</tr>
</tbody>
</table>
### Controls

**Objective:** Establish open processes to facilitate a dialogue with all communities so that their views are considered at an early stage in developing commissioning plans and improving the way local services are delivered.

- **Context:**
  - The CCG does not establish open processes to facilitate a dialogue with all communities so that their views are considered at an early stage in developing commissioning plans and improving the way local services are delivered.

- **Effect:**
  - The opportunity to develop more effective plans, processes and delivery models with the public is not realised.

- **Causes:**
  - The CCG fails to deliver its Patient and Public Involvement obligations and commitments.
  - The CCG does not have the capability and/or capacity to develop and implement its CCG Public Engagement Strategy.

### Risk Scoring Matrix

<table>
<thead>
<tr>
<th>Risk Description</th>
<th>Risk Mitigation</th>
<th>Assurance Source</th>
<th>Assurance Given</th>
<th>Assurance Type</th>
<th>Assurance Level</th>
<th>Action Required</th>
<th>Action Target Date</th>
<th>Risk Score (5%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Engagement Work plan</td>
<td>Mitigate</td>
<td>Strategy reviewed and mentioned at Public Engagement Strategy Health and Wellbeing Board</td>
<td>Adequate</td>
<td>Management</td>
<td>Management</td>
<td>Public Engagement Group Chair's Reports to Strategy and Development Committee October 14 Public Engagement Group Chair's Reports to Strategy and Development Committee October 14 South East London Strategy reports related to public engagement at Strategy and Development Committee October 14 Performance of the CCG's Public Reference Group in meeting</td>
<td>Management</td>
<td>Adequate</td>
</tr>
<tr>
<td>Public Engagement Work plan</td>
<td>Mitigate</td>
<td>Strategy engagement activities reviewed and endorsed at Public Engagement Group Board, Health and Wellbeing Board</td>
<td>Adequate</td>
<td>Management</td>
<td>Management</td>
<td>Public Engagement Group Chair's Reports to Strategy and Development Committee October 14 Public Engagement Group Chair's Reports to Strategy and Development Committee October 14 South East London Strategy reports related to public engagement at Strategy and Development Committee October 14 Performance of the CCG's Public Reference Group in meeting</td>
<td>Management</td>
<td>Adequate</td>
</tr>
<tr>
<td>Public Engagement Strategy</td>
<td>Mitigate</td>
<td>Delivery Committee Operational Dashboard</td>
<td>Adequate</td>
<td>Management</td>
<td>Management</td>
<td>Operational Dashboard at Delivery Committee Sept, Oct 15</td>
<td>Management</td>
<td>Adequate</td>
</tr>
<tr>
<td>Public Engagement Strategy</td>
<td>Mitigate</td>
<td>Joint programme of work to take forward shared decision making and self management support, supplemented by a joint workforce training programme</td>
<td>Adequate</td>
<td>Management</td>
<td>Management</td>
<td>Joint programme of work to take forward shared decision making and self management support, supplemented by a joint workforce training programme</td>
<td>Management</td>
<td>Adequate</td>
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<td>Controls</td>
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</tr>
<tr>
<td>a1) Referral Support Service to improve the quality of referrals</td>
<td>Mitigate</td>
<td>Project reports to the Primary Care Strategy Group</td>
<td></td>
<td></td>
<td>Management Adequate</td>
<td>Ensuring appropriate patient feedback via Patient Focus Groups</td>
<td></td>
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</tr>
<tr>
<td>a2) Public Health Improvement Programme and NHS Health Checks</td>
<td>Mitigate</td>
<td>Reports to QIPP Scoping Group</td>
<td></td>
<td></td>
<td>Management Adequate</td>
<td>Daily Dashboard from RH v non impacts</td>
<td></td>
<td>Report on PH Programme</td>
</tr>
<tr>
<td>a3) GP Referral Support Service</td>
<td>Mitigate</td>
<td>Reports to QIPP Scoping Group</td>
<td></td>
<td></td>
<td>Management Adequate</td>
<td>Programme developed &amp; Neighbourhood visits taken place to review SEAs</td>
<td></td>
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</tr>
<tr>
<td>a4) Strategy Commissioning Framework for Primary Care Transformation in London</td>
<td>Mitigate</td>
<td>Reports to Primary Care Development Group</td>
<td></td>
<td></td>
<td>Management Adequate</td>
<td>The Commissioning Framework is in draft form and implementation of proposed incentives are ongoing</td>
<td></td>
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<tr>
<td>a5) Practice Nursing Audit / Survey and report</td>
<td>Mitigate</td>
<td>Reports to RAG and Delivery Committee</td>
<td></td>
<td></td>
<td>External Review</td>
<td>Has identified potential quality concerns in the local GP practice Nurse workforce (including a CCG led audit)</td>
<td></td>
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<tr>
<td>a6) GP clinical training</td>
<td>Mitigate</td>
<td>Practice training</td>
<td></td>
<td></td>
<td>Training Adequate</td>
<td>Training cover for teaching sessions and meetings</td>
<td></td>
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</tr>
<tr>
<td>a7) GP practices do not have the capacity to work collaboratively</td>
<td>Mitigate</td>
<td>All practices have signed up to the scheme and are implementing</td>
<td></td>
<td></td>
<td>Management Adequate</td>
<td>Site for completion of the scheme will not be available until the end of March 2015</td>
<td></td>
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<tr>
<td>a8) Development of provider vehicles</td>
<td>Mitigate</td>
<td>Primary Care Development Group</td>
<td></td>
<td></td>
<td>Management Limited</td>
<td>Collaborative working is evident but not formal provider vehicles developed</td>
<td></td>
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</tr>
<tr>
<td>a9) Clinical Engagement in Commissioning - A&amp;E Attendances</td>
<td>Mitigate</td>
<td>All practices have signed up to the scheme</td>
<td></td>
<td></td>
<td>Management Adequate</td>
<td>Site will not be available until the end of March 2015</td>
<td></td>
<td></td>
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<td>Controls</td>
<td>Response</td>
<td>Assurance Source</td>
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<tr>
<td>(2) Procurement of NHS 111 Service and ensuring that the Directory of Services is reflective of local requirements</td>
<td>Mitigate</td>
<td>Reports to QIPP Scrutiny Group</td>
<td>Procurement Strategy approved by LCCG Governing Body in November 2014</td>
<td>Management</td>
<td>Limited</td>
<td>NHS 111 will be procured for 2015/16</td>
<td>Reports to QIPP Scrutiny Group</td>
<td>Mar-15</td>
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<td></td>
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<td>Reports to Delivery Committee</td>
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<td></td>
<td>Reports to Healthier Communities Select Committee</td>
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<td>Reports to South East London Chief Officer's Group</td>
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<td>Reports to Delivery Committee</td>
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<td></td>
<td>Reports to South East London Chief Officer's Group</td>
<td></td>
</tr>
<tr>
<td>(3) Pilot of 7/7 8-8 Working in General Practice</td>
<td>Mitigate</td>
<td>Primary Care Development Group</td>
<td>Pilot stopped due to Urgent care Review and a decision to focus on In-hours 7/7 8-8 provision via the UCC and WIC and the enhanced hours DES</td>
<td>Management</td>
<td>Limited</td>
<td>UCC GP procurement WIC procurement (7/7 8-8) from 1st April 2015</td>
<td>Complete UCC and WIC procurement</td>
<td>Apr-15</td>
</tr>
</tbody>
</table>
## Objective: 14/15 - Establish neighbourhood care networks as part of Adult Integrated Care

**Risk Ref:** Neighbourhoods  
**Risk Owner:** Alison Browne

**Risk Description:** The CCG fails to reduce emergency admissions, fails to reduce the reliance on inpatient mental health beds, fails to improve the quality and patient experience of maternity services, and fails to align health services to social care to deliver care in an integrated way around the patient.

### Causes:
- a) Failure to implement neighbourhood models of integrated care
- b) Providers fail to work collaboratively to align community services with social care
- c) Failure to "risk profile" the CCG's population and it therefore does not commission appropriately to meet patients' needs
- d) The new adult mental health services model is not implemented effectively
- e) The CCG fails to implement a revised "team around the mother" maternity service specification
- f) Insufficient patients with LTCs join self-care programmes
- g) The CCG fails to deliver the objectives within the Better Care Fund plans

### Effect:
- a) Patients may get sub-optimal care as compared to other health communities where integration has taken place
- b) Planned reduction in mental health and acute admissions not realised
- c) Improvements in the quality of services, cultural changes in the workforces and value for money are not realised
- d) The CCG loses purchasing power as a result of the Better Care Fund

### Committee
- Delivery Committee

### Inherent Score

| Risk Description: The CCG fails to reduce emergency admissions, fails to reduce the reliance on inpatient mental health beds, fails to improve the quality and patient experience of maternity services, and fails to align health services to social care to deliver care in an integrated way around the patient. |
|---|---|---|---|---|---|---|---|
| Impact | Likelihood | Impact | Likelihood | Impact | Likelihood |
| High 12 | High 12 | Moderate 6 | Moderate 6 |

### Risk Scoring Matrix

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<thead>
<tr>
<th>Controls</th>
<th>Response</th>
<th>Assurance Source</th>
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<th>Assurance Gaps</th>
<th>Action Required</th>
<th>Action target date</th>
<th>Residual Score (FL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Failure to implement neighbourhood models of care</td>
<td>Mitigate</td>
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<tr>
<td>a1) The CCG has established project management support to develop each neighbourhood community team</td>
<td>Mitigate</td>
<td>Project highlights Reports to the sub groups 3 and 4 of the Integrated Care Board across health and social care</td>
<td>Sept 2014 Reports &amp; Action Plan A+ Adult Integration Programme Board has reconfigured to 5 work streams to provide more programme support with additional resources from December 2014</td>
<td>Management</td>
<td>Limited</td>
<td>There is no assurance that the right support in terms of capacity and capability is in place to support the development of the neighbourhood team</td>
<td>Action Plan (AP) to review the capacity required to deliver the neighbourhood model</td>
<td>Apr-15</td>
<td>4*2</td>
</tr>
<tr>
<td>a2) District nursing action plan has been developed which identifies where all the gaps in senior posts sit and sets a timescale for recruitment.</td>
<td>Mitigate</td>
<td>District nursing plan reports to Community Contract Group District Nurse Patient Survey</td>
<td>September Report to Community Contract Group Community Contract Group has signed off the completed action plan</td>
<td>Management</td>
<td>Adequate</td>
<td>None identified</td>
<td></td>
<td>Oct-15</td>
<td>8*2</td>
</tr>
<tr>
<td>a3) Outcomes based service specification for all community services</td>
<td>Mitigate</td>
<td>Performance and Quality Reports to Contract Management Board District Nursing Sub-Group reports to Contract Management Board &amp; escalation as required</td>
<td>None yet</td>
<td>None</td>
<td>None</td>
<td>Outcome based service specs are still in development</td>
<td>1. To review all the current check points to ensure that the information provided gives the CCG the assurances it requires and to complete the new service specifications for 2015/16 2. To ensure that the new service spec includes in reach into nursing homes for specialist advice and support</td>
<td>Apr-15</td>
<td>8*2</td>
</tr>
<tr>
<td>a4) Contract Management Sub-Group has been established as a sub-group of the Contract Management Board for the entire community contract with LTC</td>
<td>Mitigate</td>
<td>Contract Management Sub-Group reports to Contract Management Board A new quality dashboard for community services is being developed</td>
<td>Report and Minutes to Contract Management Board 31/07/14 The Contract Monitoring Sub-Group was closed in December after its work was completed and reports were sent to the Contract Monitoring Board A+</td>
<td>Management</td>
<td>Limited</td>
<td>None identified</td>
<td>None</td>
<td>Apr-15</td>
<td>4*1</td>
</tr>
<tr>
<td>Controls</td>
<td>Response</td>
<td>Assurance Source</td>
<td>Assurance Given</td>
<td>Assurance Type</td>
<td>Assurance Level</td>
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</tr>
<tr>
<td>b) Providers fail to work collaboratively to align community services with social care</td>
<td>Mitigate</td>
<td>Reports to Information Governance Steering Group</td>
<td>Verbal report to ISGG Nov 5th 2014 A joint Management Governance Group has been established for the Connect Care programme Information Sharing Agreements for the Connect Care Programme have been written and agreed in principle</td>
<td>Management</td>
<td>Adequate</td>
<td>Information Sharing Agreements are not yet signed off Common systems and single providers not yet agreed Information Sharing Agreements for the Connect Care Programme have not yet been signed off by all partners (this will happen as partners join the programme)</td>
<td>Complete the development of the Information Sharing agreements Complete the development of joint working plans Develop a Multidisciplinary User Group to determine needs As partners join the Connect Care Programme ensure that the Information sharing agreements are signed</td>
<td>31/04/2015</td>
<td>2*3</td>
</tr>
<tr>
<td>b1) Principles and Information Sharing Agreements for SLAM, LGT, LBL systems interoperability are being developed to allow IT systems to work together</td>
<td>Mitigate</td>
<td>Reports to Information Governance Steering Group</td>
<td>Verbal report to ISGG Nov 5th 2014 A joint Management Governance Group has been established for the Connect Care programme Information Sharing Agreements for the Connect Care Programme have been written and agreed in principle</td>
<td>Management</td>
<td>Adequate</td>
<td>Information Sharing Agreements are not yet signed off Common systems and single providers not yet agreed Information Sharing Agreements for the Connect Care Programme have not yet been signed off by all partners (this will happen as partners join the programme)</td>
<td>Complete the development of the Information Sharing agreements Complete the development of joint working plans Develop a Multidisciplinary User Group to determine needs As partners join the Connect Care Programme ensure that the Information sharing agreements are signed</td>
<td>31/04/2015</td>
<td>2*3</td>
</tr>
<tr>
<td>c) Failure to &quot;risk profile&quot; the CCG's population and it therefore does not commission appropriately to meet patients' needs</td>
<td>Mitigate</td>
<td>Reports to QIPP Scrutiny Panel and the Emergency Admissions Group and to Strategy and Development Committee</td>
<td>QIPP Dashboards (weekly)</td>
<td>Management</td>
<td>Limited</td>
<td>A programme to support all over 65s following risk stratification, patient segmentation and care planning is in draft business case form</td>
<td>Apex business case including: risk stratification strategy and care planning strategy</td>
<td>Mar-15</td>
<td>2*2</td>
</tr>
<tr>
<td>c1) Risk Profiling Tool used to profile risk</td>
<td>Mitigate</td>
<td>Reports to QIPP Scrutiny Panel and the Emergency Admissions Group and to Strategy and Development Committee</td>
<td>QIPP Dashboards (weekly)</td>
<td>Management</td>
<td>Limited</td>
<td>A programme to support all over 65s following risk stratification, patient segmentation and care planning is in draft business case form</td>
<td>Apex business case including: risk stratification strategy and care planning strategy</td>
<td>Mar-15</td>
<td>2*2</td>
</tr>
<tr>
<td>d) The new adult mental health services model is not implemented effectively</td>
<td>Mitigate</td>
<td>Project Highlight Reports to the sub-groups 3 and 4 of the Integrated Care Board across health and social care Regular updates on the implementation of the Adult Mental Health Model are received at the SLaM Core Contract Meeting</td>
<td>The AMH Model updates received at Core Contract Meeting</td>
<td>Management</td>
<td>Adequate</td>
<td>The local neighbourhood networks are not yet fully developed and aligned with the AMH Model</td>
<td>Continued alignment of the AMH Model with the Adult Implementation Programme</td>
<td>Mar-16</td>
<td>3*2</td>
</tr>
<tr>
<td>d1) Mental Health Executive Group established to lead the implementation</td>
<td>Mitigate</td>
<td>Project Highlight Reports to the sub-groups 3 and 4 of the Integrated Care Board across health and social care Regular updates on the implementation of the Adult Mental Health Model are received at the SLaM Core Contract Meeting</td>
<td>The AMH Model updates received at Core Contract Meeting</td>
<td>Management</td>
<td>Adequate</td>
<td>The local neighbourhood networks are not yet fully developed and aligned with the AMH Model</td>
<td>Continued alignment of the AMH Model with the Adult Implementation Programme</td>
<td>Mar-16</td>
<td>3*2</td>
</tr>
<tr>
<td>e) The CCG fails to implement a revised “team around the mother” maternity service specification</td>
<td>Mitigate</td>
<td>Notes and action plans from the maternity commissioning sub group Patient Survey Friends and Family Test</td>
<td>Minutes of the bi monthly maternity commissioning strategy meetings Patient Survey results and FFT results received at FLAG Jan 2015</td>
<td>Management</td>
<td>Adequate</td>
<td>None identified</td>
<td>Implement a new research project for high risk pre-term babies</td>
<td>Apr-17</td>
<td>3*1</td>
</tr>
<tr>
<td>e1) Revised service specification includes continuity of care for ante natal and post natal mothers, has been agreed with LGT</td>
<td>Mitigate</td>
<td>Notes and action plans from the maternity commissioning sub group Patient Survey Friends and Family Test</td>
<td>Minutes of the bi monthly maternity commissioning strategy meetings Patient Survey results and FFT results received at FLAG Jan 2015</td>
<td>Management</td>
<td>Adequate</td>
<td>None identified</td>
<td>Implement a new research project for high risk pre-term babies</td>
<td>Apr-17</td>
<td>3*1</td>
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<tr>
<td>f) Insufficient patients with LTCs join self care programmes</td>
<td>Mitigate</td>
<td>QIPP Scrutiny Group and Corporate Objectives Monitoring to Delivery Committee</td>
<td>QIPP Scrutiny Reports to Delivery Committee July, Sept, Oct, Jan JK+ Corporate Objectives Monitoring Report November and January</td>
<td>Management</td>
<td>Limited</td>
<td>Clarity of the range of self management support programmes for people with LTCs</td>
<td>Revise the draft PID to re-position the programme as part of the Adult Integrated care Programme Board</td>
<td>Apr-15</td>
<td>2*2</td>
</tr>
<tr>
<td>g) The CCG fails to deliver the objectives within the Better Care Fund plans</td>
<td>Mitigate</td>
<td>Reports to Health and Well-Being Board Risk Reports to the ACPPB Highlight reports to ACPPB</td>
<td>Better care Fund (BCF) Plan approved by NHSE Health and Well-Being Board Reports</td>
<td>Management</td>
<td>Substantial</td>
<td>Section 75 Agreement not in place Refocused Programme Structure not in place</td>
<td>Draft Section 75 Agreement for BCF Agree Section 75 Agreement for BCF</td>
<td>11/03/2015</td>
<td>3*3</td>
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<tr>
<td>g1) Adult Integrated Care Programme Board (ACPPB) Established Adult Integrated Care Programme Risk Management Process and Risk Register</td>
<td>Mitigate</td>
<td>Reports to Health and Well-Being Board Risk Reports to the ACPPB Highlight reports to ACPPB</td>
<td>Better care Fund (BCF) Plan approved by NHSE Health and Well-Being Board Reports</td>
<td>Management</td>
<td>Substantial</td>
<td>Section 75 Agreement not in place Refocused Programme Structure not in place</td>
<td>Draft Section 75 Agreement for BCF Agree Section 75 Agreement for BCF Agree additional resources to implement the ACPPB Implement the Programme</td>
<td>11/03/2015</td>
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Governing Body meeting on 12th March 2015

Report from the Chair of the Delivery Committee
Date of Meeting reported: 26 February 2015
Author: Martin Wilkinson, Chair of Delivery Committee

1. Main Issues discussed

1.1 This month the meeting was arranged into two parts; core business was conducted with a heavier than usual focus on exception reporting. This approach enabled the Committee to welcome Dr Martin Baggaley, Medical Director for South London and Maudsley (SLaM) Foundation Trust to discuss issues relating to quality and safety and staffing for SLaM services and the recent review into governance by Monitor.

The Committee heard that since the Monitor review

- There was renewed confidence in the Board structure of SLaM. A new Chair and four new Non Executive Directors have been appointed.
- The quality structures had been firmed up. A new Quality and Safety Committee includes Governors, providing additional scrutiny.
- Quality has a higher Board profile

There are challenges with workforce including recruitment, staff training and development and retention of experienced staff. A new HR Director has recently been appointed which had improved strategic human resources including looking at reducing sickness and absence, the use of agency staff and improving staff’s people skills.

There are pressures on crisis services and challenges on how to achieve strategic bed reductions whilst maintaining high quality compassionate services. There was now a senior manager on call in place and a crisis concordat.

The following questions were asked and answers provided:

- Are staffing levels on wards safe? Numbers of staff are sufficient. There are challenges in maintaining experienced staff numbers. All breaches are reported.
- In relation to patient experience are any groups less satisfied than others? MB responded that these included ethnic minorities and lesbian and gay patients. Sometimes the cultural beliefs of staff are a concern.
- What is the significance of twice as many suicides this year compared to last? SLaM will look into the specifics including any themes and trends for Lewisham patients.
- What would you improve and strengthen in relation to primary care? Joint working to improve physical health of mental health patients and working together to try and stop patients being passed between services.
- The CCG has been asking SLaM for data on safeguarding for adults for Qs1,2 &3 which has not been forthcoming. There is a committee on adult safeguarding with a new lead and the CCG will be invited to attend. Training data is provided by CAGs rather than boroughs.
The Committee thanked Dr Baggaley and are keen to maintain dialogue. In particular the Committee is keen to have assurance that the SLaM Trust Board is assured of the level of quality in SLaM, the outcomes and patient experience measures that SLaM are looking at and the performance of children's services and the transition to adult services.

1.2 Recovery actions against the below target NHS constitutional standards were discussed. These continue to concern many of the standards contained in the Top 8 report; A&E 4 hour standards, cancer 62 day waiting times, diagnostics, IAPT, dementia.

1.3 RTT
The agreed extra additional activity to improve RTT should have been completed by December and be sufficient for performance to return to standard. Some activity will be now be performed in Q4. Although the standard is being achieved overall it is not being achieved at specialty level.

1.4 A&E
Work is continuing with McKinsey and the CCG has commissioned a further 6 weeks of work to further assist a sustainable A&E performance. The Accountable Officer is attending daily Platinum Command meetings seeking to improve the flow of patients through the hospital system to discharge. Planned actions are being taken to recover the A&E performance and Committee is tracking this as a high risk in the BAF.

1.5 Health Visitors
The Committee received an update on the transfer of commissioning arrangements for children’s services from public health o the Joint Children’s and Young People Commissioning team. The target to recruit additional 72 Health Visitors remains a challenge and alternative solutions are being explored involving other children’s healthcare professionals.

1.6 Draft Operating Plan
The Committee
- Noted the CCG's Operating Plan draft submission made on 28 January and 13 February 2015
- Agreed Chair’s action to be taken to sign off the draft Operating Plan submission to NHSE on 27 February on behalf of the Governing Body.
- acknowledged that some standards would not be met in each quarter in 2015/16 including A&E target and the 62 day wait. This risk will remain on the BAF.
- Agreed dementia diagnosis rate plan to achieve 67% by February 2016, with the aim internally to meet the target by December 2015.
- Heard that the definition has changed for IAPT waiting times. It is now 6 weeks and 75% referral to treatment by the start of Q4. Currently 49% is being achieved.

1.7 Corporate Objectives 2015/16
A Governing Body workshop was held on 5 February where the work undertaken to refresh the corporate objectives and identify the priority actions for 2015/16 was discussed. The objective to deliver the neighbourhood networks require further work with partners therefore there will be a longer timescale to finalise those objectives. The neighbourhood care network’s priorities for action will be presented for approval at the March 2015 Delivery Committee. This should link to work being undertaken with partners and Optimity Matrix to develop a road map for the next five years.
The Committee agreed the draft Corporate Objectives' priorities for action for 2015/16, except the Neighbourhood Network.

2. Key achievements

2.1 The CCG remains on target to achieve its planned year-end financial surplus and reporting that it will meet its QIPP target of £9.99m.

2.2 Performance against the Better Practice payments Code has improved again. The CCG expects to deliver this duty in March.

3. Key challenges addressed

3.1 62 Day cancer referral standard: The cancer tripartite met on 25 February with the Chief Officer of Greenwich CCG representing Bexley, Greenwich and Lewisham CCGs. The Trust has been requested to provide a refreshed recovery plan and timing of when the 62 day cancer referral standard will be met.

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

4.1 Monitor has stopped the planned tariff arrangements from 2015/16. There are two options for providers;

- Enhanced tariff option – which is coming away from PbR and changes inflation and deflation and has a potential cost for NHS commissioners of £500m across the country if supported. This would be an approximate cost of £1m for the CCG which is not budgeted for.
- Default tariff rollover – which will happen if the CCG does not confirm by 4 March.

This will delay the signing of contracts.

4.2 A&E: Lewisham and Greenwich Trust has the second worst quarterly performance in London. See Performance Report

4.3 KCH A&E performance continues to be below the 4 hour standard.

5. How did the meeting promote quality and safety?

5.1 Through dialogue with the Medical Director of SLaM and the review of quality reports from FLaG and linking quality to financial and other performance metrics

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

6.1 Delivery of the NHS Constitutional standards reduces the risk of unequal access to services
A meeting of the Governing Body  
12 March 2015

Enclosure 8  
Month 10 Integrated Performance Report

RESPONSIBLE LEAD:  Tony Read, Chief Financial Officer

AUTHOR:  
Mike Hellier, Head of System Intelligence  
Tony Read, Chief Financial Officer  
Nick Brown, Head of Financial Management and Planning

RECOMMENDATIONS:

The Governing Body is asked to:

• Note the Quality Report
• Note the summary of performance challenges on the NHS Constitutional standards and note the plans for 2015/16 agreed by Delivery Committee.
• Note the Finance Report for Month 10

SUMMARY:

Quality (Appendix 1)

Responsiveness to complaints at Lewisham and Greenwich Trust (LGT) and Kings and timely resolution of complaints at LGT are improving but remain below target. The CCG is developing proposals to invest Quality Premium monies non-recurrently to improve performance at LGT.

Safe staffing levels and high vacancy rates continue to be a challenge for South London and Maudsley Foundation Trust.

Performance Indicators (Appendix 2)

Whilst the CCG is monitoring and reporting the 8 specific performance indicators identified nationally as 2014/15 priorities, all NHS Constitutional standards are important and being monitored. The CCG's corporate objectives at the start of 2014/15 included recovery of poor performance in 3 of the 8 indicators; RTT, A&E and cancer waiting times, based on 2013/14 performance.

A&E 4 hour waits is still a significant and worsening performance against the standard. £10.5m has been invested across Lewisham, Greenwich and Bexley to improve performance in 2014/15. Following the Emergency Care Intensive Support Team visit, Lewisham, Bexley and Greenwich CCGs and NHSE have commissioned Mckinsey & Co to provide a plan for sustainable improvement across Lewisham and Greenwich Trust.
Cancer Waiting times performance remains challenging. All Trusts are reporting that, while they have implemented the bulk of the IST recommendations, there is not yet an improvement to standard, and that this is now delayed until Q4 from the original recovery in Q3.

Additional activity at a value of £1.8m has been invested to deliver the RTT target by year end. This is on track in total. Capacity constraintsts in orthopaedics has prevented approximately 150 planned orthopaedic cases; which have been substituted with other specialty activity.

Diagnostic waiting time targets were met in November but missed in December.

For 2015/16 there are increased plans required for some indicators and movement towards the new waiting time standards for mental health services - specifically Improving Access to Psychological Therapies. Comments are included under the relevant performance challenges by indicator (attached).

**Financial Indicators (Appendix 3)**

At Month 10 the CCG is forecasting to deliver its planned surplus at year end.

Running cost budgets are presently reporting a £0.73m underspend.

The acute expenditure has been forecast from September data, based on historical trends, and indicates a potential overspend of £3.77m.

Following the implementation of recovery actions performance against the Better Practice payments Code is improving but remains below plan for the count.

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<th>Measure</th>
<th>Plan/Target</th>
<th>Forecast Outturn</th>
<th>Forecast Variance</th>
<th>RAG Month 10</th>
<th>RAG Forecast</th>
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<td>Planned Surplus</td>
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<td>QIPP Delivery</td>
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<td>Acute Expenditure</td>
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<td>(£3.77m)</td>
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<td>Total Expenditure</td>
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<td>£383.37m</td>
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<td>Better Practice Payments Code</td>
<td>95%</td>
<td>95%</td>
<td>NIL</td>
<td>Red</td>
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**CORPORATE AND STRATEGIC OBJECTIVES**

Delivery of the CCG’s standards for quality, outcomes, NHS constitutional commitments and expenditure plans will assist the Trust in meeting its operating plan, corporate objectives and statutory duties. The corporate objectives specifically target recovery actions to improve the underperforming top performance measures

**CONSULTATION HISTORY:**

Delivery Committee
FLAG – Quality
Governing Body – Approved budget
PUBLIC ENGAGEMENT
To be reported by exception at Governing Body in public

HEALTH INEQUALITY DUTY
The failure to achieve access standards for, in particular, RTT, A&E 4 hour waits and some cancer treatments could potentially contribute to inequitable access to healthcare and poorer or differential outcomes. Significant additional resource has been targeted to improve performance against these targets in 2014/15

PUBLIC SECTOR EQUALITY DUTY
This report does not specifically address the public sector equality duty. The CCG’s quality, outcome and financial objectives are designed to deliver the duty.

STAKEHOLDER INVOLVEMENT
To be communicated to the GP Membership

RESPONSIBLE LEAD CONTACT:
Name: Tony Read
E-Mail: tonyread@nhs.net
Telephone: 0203 049 3833

AUTHOR CONTACT:
Name: Mike Hellier
Email: Mike.Hellier@nhs.net
Telephone: 0207 206 3322
Name: Nick Brown
Email: nick.brown1@nhs.net
<table>
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<tr>
<th>Quality Indicators (To be printed in A3)</th>
<th>Latest</th>
<th>Current</th>
<th>Previous</th>
<th>Trend</th>
<th>Commentary</th>
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<td>Response time to complaints - % resolved within 25 days</td>
<td>65%</td>
<td>64.0%</td>
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<td>60%</td>
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<td>Response time to complaints - % resolved within 30 days</td>
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<td>95.7%</td>
<td>DD</td>
<td>95.7%</td>
<td>NHS England</td>
</tr>
<tr>
<td><strong>High Quality Care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Staff Engagement</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff provided as % recommended in a place to receive care</td>
<td>96%</td>
<td>95%</td>
<td>95%</td>
<td>DD</td>
<td>95%</td>
<td>NHS England</td>
</tr>
<tr>
<td>Staff provided as % recommended in a place to work</td>
<td>90%</td>
<td>89%</td>
<td>89%</td>
<td>DD</td>
<td>88%</td>
<td>NHS England</td>
</tr>
<tr>
<td><strong>High Quality Care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Registration Status</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CQC Inspection - % of inspections required</td>
<td>71%</td>
<td>71%</td>
<td>71%</td>
<td>DD</td>
<td>71%</td>
<td>CQC website</td>
</tr>
</tbody>
</table>

Note: Percentages shown are those for January, February, March, and April 2015.
NHS England has identified the Top 8 Performance indicators, which it expects to be the primary performance focus of CCGs for 2014/15. This paper identifies the summary focus and current performance issues.

A pack of performance on these issues across services and CCGs in London is presented to Chief Officers London meeting. The pack covers key issues and recovery plans.

The NHS England Top 8 and the current local issues and management are outlined below.

<table>
<thead>
<tr>
<th>Performance Area</th>
<th>Focus</th>
<th>Latest performance</th>
<th>Improved/Worsened</th>
<th>Current Issues and Management</th>
</tr>
</thead>
</table>
| A&E | 4 Hour Standard (95%) | LGT 86.4% Q4 to 22.2.15 | Same as Q3. | Lewisham and NHS Greenwich Trust has the second worst quarterly performance in London (86.4% for Q4 to 22nd February)  
The Lewisham site is on 89.7% for Q3, which compares with 93.6% for Q3 in 13/14 and is at 88.1% Q4 to 22nd February.  
The Emergency Care Intensive Support Team visited both the Queen Elizabeth and Lewisham sites in early to mid December 2014 to look at the Emergency pathway and also to look at Length of Stay (LOS). For the latter, the local system wide teams and leaders were involved. The key themes of the ECIST feedback was:  
- Early decision making around admission or admission avoidance  
- Elderly frail pathway  
- Robust discharge planning and management of medically fit patients including discharge to assess.  
- Bringing the whole activity profile of the day earlier.  
Subsequently, McKinsey & Co have been engaged to provide advice and support to the organisations across the whole system to provide a revised plan for improvement based on a single agreed version of breach analysis and in depth diagnosis – this work is still a few weeks from conclusion.  
2015-16 Planning: Before completion of this McKinsey & Co work, the standard is planned to be met for the latest CCG planning submission. It is currently on the Board Assurance
### Performance Area

<table>
<thead>
<tr>
<th>Focus</th>
<th>Latest performance</th>
<th>Improved/ Worsened</th>
<th>Current Issues and Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer waiting times</td>
<td>62 days from GP referral to treatment – standard 85%</td>
<td>71.2% Red</td>
<td>Worsened</td>
</tr>
</tbody>
</table>

The South East London group of CCGs and Trusts met on 9th January 2015 and will continue to meet monthly with the next meeting in early March 2015.

All Trusts reported that, while they have implemented the bulk of the IST recommendations, there is not yet an improvement to standard, and that this is now delayed until Q4 from the original recovery in Q3.

Kings College has been meeting the standard on a quarterly basis consistently at the Denmark Hill site. Performance at the Princess Royal site has improved significantly, so that Kings College delivered the standard from November 2014.

The joint tracker post between GSTT and Lewisham and Greenwich has been put in place focused on the Urology specialty where there have been inter-trust based breaches.

Looking forwards there is still concern among providers of sufficient endoscopy capacity across the system to meet the standard, especially with further raising of awareness in the New Year. A cross provider meeting has taken place to be reported back to the next South East London meeting.

The joint meeting also received a report that Tripartite Escalation Meetings on cancer waiting times will be beginning imminently and that South East London and Lewisham and Greenwich
<table>
<thead>
<tr>
<th>Performance Area</th>
<th>Focus</th>
<th>Latest performance</th>
<th>Improved/ Worsened</th>
<th>Current Issues and Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 Weeks Referral to Treatment times</td>
<td>There are three standards: Admitted (inpatient treatment) 90% within 18 weeks, Non admitted (outpatient treatment) 95% within 18 weeks. Incomplete treatments (the waiting list) 92% within 18 weeks. This latter standard is designed to</td>
<td></td>
<td></td>
<td>The meeting for Lewisham and Greenwich on 25&lt;sup&gt;th&lt;/sup&gt; February 2015 with Annabel Burn representing Chief Officers for Bexley, Greenwich and Lewisham and the formal minutes of this meeting are awaited. However, there are still issues in tracking patients at the Lewisham site, with a delay to the implementation of Infotex, which is the system at Queen Elizabeth site. A revision to the recovery plan and timing for meeting the 62 day standard is awaited from the Trust. There are also patients that are already at GSTT, which have already breached 62 days, so that when they are treated this will impact on performance. NHS Lewisham CCG is in the process of agreeing a two week waiting leaflet for use by GPs when referring to the process, explaining the purpose of the test and the importance of attending.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>The funded work to treat patients waiting a longer time to treatment has largely been completed. Work at BMI Blackheath has been agreed. The Trust Development Authority has written to the Trust requesting that further work to treat patients waiting a long time is conducted in Q4. This will mean that the admitted standard may not be met again until April 2015. It was met in December 2014. Since June 14 (before the planned work on the longer waiting patients) the number of longer waiting patients on the incomplete (waiting list) has fallen. By the end of December 14 patients waiting on the incomplete (waiting for treatment) over 36 weeks have fallen by 41% to 113 and over 42 weeks has fallen by half to 46 patients since June 2014. There is still 1 Lewisham person waiting longer than 52 weeks in December 2014 at Kings College Hospital. There were 12 people doing so in June 2014. December figures are slightly higher than November’s. However, the non admitted standard has not been met for the last three months, largely because of challenges in patients being treated for dermatology at Lewisham and Greenwich NHS Trust. The improvement in January 2015 has continued, so the standard is now being met. Looking forwards to future challenges, the number of incomplete pathways overall (the waiting list) continues to be higher than previous years for NHS Lewisham CCG and across the NHS. As a result the time for activity to treat the patients on this list is now rising beyond the level recommended by the 18 weeks Intensive Support Team. An exercise to validate this incomplete list is underway, supported by the 18 weeks Intensive Support Team.</td>
</tr>
<tr>
<td>Performance Area</td>
<td>Focus</td>
<td>Latest performance</td>
<td>Improved/ Worsened</td>
<td>Current Issues and Management</td>
</tr>
<tr>
<td>------------------</td>
<td>-------</td>
<td>--------------------</td>
<td>--------------------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>6 week waits (99% of diagnostic waiting list within this standard)</td>
<td>98.3% Amber December</td>
<td>Worse</td>
<td>Lewisham and Greenwich met the standard for Lewisham people at 99.9% in December data. However, the Trust has notified the CCG that there may be a dip in performance in January data with further people identified as needing to be diagnosed. There were significant challenges at both Kings and GSTT, with only 94.5% of Lewisham people being diagnosed within 6 weeks.</td>
</tr>
<tr>
<td>Health visitors</td>
<td>Increased Numbers of health visitors.</td>
<td></td>
<td></td>
<td>NHS England is currently the commissioner. There is a plan to transfer this to the London Borough of Lewisham in October 2015. There are currently 52.4 whole time equivalents which compares to a plan of 72 by March 2015. The LGT service is aiming to recruit a number of people completing training. There has been an agreed service model in development between the Local Authority and the CCG to utilise this expanded workforce.</td>
</tr>
<tr>
<td>Improved Access to Psychological Therapies (IAPT)</td>
<td>15 % of need entering treatment by Q4 (i.e. 3.75%) Recovery rate i.e. the percentage of people entering treatment</td>
<td>3.1% Amber v. plan Q3 36% Red Q3</td>
<td>Improved/ Worse</td>
<td>A plan to improve the percentage people entering treatment compared to need based on group work, especially for those with long term conditions, is beginning to be delivered in for Q4. January 2015 was the first month and this was at 1.4% of need for the month (or a 4.2% quarterly run rate). The recovery rate was 42% in January. Delivery Committee has considered the service and its model in January 2015. Lewisham CCG is on monthly reporting to NHS England on the two existing indicators. The service and the CCG have engaged the IAPT Intensive Support Team to ensure that the data understood by the service is being accurately reported for both the service and the CCG, with the data being sent and reported by the Health and Social Care Information Centre – a small number of Lewisham people using the service refuse to have their data uploaded. The next</td>
</tr>
<tr>
<td>Performance Area</td>
<td>Focus</td>
<td>Latest performance</td>
<td>Improved/ Worsened</td>
<td>Current Issues and Management</td>
</tr>
<tr>
<td>------------------</td>
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<td>--------------------</td>
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<td>------------------------------</td>
</tr>
<tr>
<td></td>
<td>who are at a level of recovery - 40%+ for 14/15. Recovery rate require for 2015/16 50% There is a further standard for April 2016 that “75% of people referred to the IAPT programme will be treated within 6 weeks of referral (E.H.1. A1), and 95% will be treated within 18 weeks of</td>
<td>48% Q3 for 6 weeks 98% for 18 weeks</td>
<td>meeting is in early March 2015. Delivery Committee agreed that while the percentage of need standard will be met for 2015-16, the Recovery Rate is planned to improve gradually from 40% to the 50% standard by Q4.. The waiting time standards are met for 18 weeks, but short of the standard for 6 weeks. Both are due in April 2016, so the plan for 6 weeks moves towards the standard and is planned to be met in Q4 2015-16.</td>
<td></td>
</tr>
<tr>
<td>Performance Area</td>
<td>Focus</td>
<td>Latest performance</td>
<td>Improved/Worsened</td>
<td>Current Issues and Management</td>
</tr>
<tr>
<td>------------------</td>
<td>-------</td>
<td>---------------------</td>
<td>-------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>Dementia</td>
<td>Diagnosis rate of prevalence to 58% (NHS England expect 67% in 2015/16 which was promised in the last planning round).</td>
<td>53% Red</td>
<td>Same</td>
<td></td>
</tr>
</tbody>
</table>

In 2014/15 the diagnosis rate has been flat at c53% across the months, while overall London CCG performance has improved especially in the last three months and is now at 58.5% for December 2014. Lambeth and Southwark CCGs are now both over 60%. The latest figures for January 2015 indicated that London is now over 60% and Lewisham’s like CCGs are at 61%. Lewisham is now 7% adrift of London and 8% adrift of our like CCGs, as Lewisham’s figures have not moved.

The plan includes a coding audit and a communication on the coding audit with the majority being completed in March 2015.

Lewisham is on monthly reporting to NHS England for dementia diagnosis.

There are plans in 2015 with the following strands:

![Dementia Diagnosis Rate of Prevalence 2014-15](image-url)

In 2014/15 the diagnosis rate has been flat at c53% across the months, while overall London CCG performance has improved especially in the last three months and is now at 58.5% for December 2014. Lambeth and Southwark CCGs are now both over 60%. The latest figures for January 2015 indicated that London is now over 60% and Lewisham’s like CCGs are at 61%. Lewisham is now 7% adrift of London and 8% adrift of our like CCGs, as Lewisham’s figures have not moved.

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Lewisham is on monthly reporting to NHS England for dementia diagnosis.

There are plans in 2015 with the following strands:
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Forming a Dementia Action Alliance with the local authority and professionals and the voluntary sector
- Having a Dementia Awareness Day
- Presentations to neighbourhood meetings on the above.
- Memory Service Referral Process
- Further presentations to professional groups.

The Memory Service has waits of 13 weeks for assessment to begin. The assessment process can take between 2 to 6 weeks dependent on whether an MRI scan is required. Further funding has been agreed for the service in Q4 given increases in referrals. There is further improvement planned in 2015-16.

Given the effort required in the plan above the diagnosis rate for 2015-16 agreed by Delivery Committee is to move from the CCG planned rate of 58% in March 2015 to the diagnosis rate of 67% by February 2016.

Winterbourne View

- Focus on people still in specialist services, especially those in services outside Lewisham to bring them to more locally based services.

| Winterbourne View |                   | At the end of Q2, there were 6 CCG funded people who were in specialist services on the 1st April 2014. All 6 have been reviewed in the last 6 months. The two patients planned to transfer in Q4 have been transferred. Independent reviews with the involvement of NHS England are planned for three patients to ensure that they are in the appropriate setting with a plan for change if agreed. The CCG may, of course, have some new patients into this cohort in the next quarter. |
Outcomes

The Outcomes for Healthcare Acquired Infections (HCAIs) are reported as follows from April to September 2014:
- There have been five MRSA infections above the zero tolerance level.
- There have been 41 CDifficile infections which is in excess of the annual maximum of 33. The action plan for improvement on CDifficile has been reviewed by Delivery Committee. The planning assumption for CDifficile, published on the NHS England website, for 2015/16 is 53 CDifficile infections, which is one infection less than the current run rate.

Other Constitutional Standards

London Ambulance – LAS -performance on the 8 minute standard for reaching patients with life threatening conditions is currently red rated against the 75% standard and this is putting the two rolling year indicators at risk. This is true at a London level. There has been a recovery plan agreed by London commissioners and the Trust, which includes recruitment by LAS and other changes with the due date for recovery in February 2015. Furthermore, LAS is piloting a change to Red 1 and Red 2 reporting in order to focus meeting 8 minutes for the most life threatened patients at Red 1. However, it is very unlikely that the Red 1 8 minute standard will be delivered for the year and this will reduce the CCG’s Quality Premium for 15/16 by a quarter.
Finance Report
Month 10, period to 31st January 2015, and full year forecast.

1. Summary

At Month 10 the CCG is forecasting to deliver its planned surplus at year end.

Table 1: Financial Headline Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Plan/Target</th>
<th>Forecast Outturn</th>
<th>Forecast Variance</th>
<th>RAG Month 10</th>
<th>RAG Forecast</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Surplus</td>
<td>£7.60m</td>
<td>£7.60m</td>
<td>NIL</td>
<td>Green</td>
<td>Green</td>
</tr>
<tr>
<td>QIPP Delivery</td>
<td>£9.99m</td>
<td>£9.99m</td>
<td>NIL</td>
<td>Green</td>
<td>Green</td>
</tr>
<tr>
<td>Acute Expenditure</td>
<td>£215.65m</td>
<td>£219.42m</td>
<td>(£3.77m)</td>
<td>Amber</td>
<td>Amber</td>
</tr>
<tr>
<td>Total Expenditure</td>
<td>£383.37m</td>
<td>£383.37m</td>
<td>NIL</td>
<td>Green</td>
<td>Green</td>
</tr>
<tr>
<td>Better Practice Payments Code</td>
<td>95%</td>
<td>95%</td>
<td>NIL</td>
<td>Red</td>
<td>Amber</td>
</tr>
</tbody>
</table>

2. Revenue Resource Limit and Start Budget

2.1. At Month 10 the CCG's combined Revenue Resource Limits total £390.97m. This includes £7.68m for its running cost allowance (RCA).

2.2. In Month 10 there has been four confirmed allocation adjustments;

- £0.27m allocation relating to tranche 2 of the RTT funding
- £1.50m adjustment for Market Forces Factor
- £1.76m Specialist adjustment
- £4.1m adjustment Risk Pool Correction

The Quality Premium allocation received in Month 9 has also been reclassified as a Running Cost allocation. This is in line with national reporting.

2.3. Table 2 shows the confirmed allocations categorised by Running and Programme Costs. Details of allocation adjustments for the year to date are provided as appendix 1.

Table 2: Revenue Resource Limits

<table>
<thead>
<tr>
<th>Programme</th>
<th>Running</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>£m</td>
<td>£m</td>
<td>£m</td>
</tr>
<tr>
<td>Notified Allocation at Month 9</td>
<td>386.87</td>
<td>7.67</td>
</tr>
<tr>
<td>Month 10 Allocations</td>
<td>(3.57)</td>
<td>7.67</td>
</tr>
<tr>
<td>Notified Allocation at Month 10</td>
<td>383.30</td>
<td>7.67</td>
</tr>
</tbody>
</table>
2.4. The CCG is anticipating no further adjustments to the CCG allocations for 2014/15. The LAS Resilience funding, reported as an anticipated allocation in month 9, will be invoiced in February and will be reported as expenditure.

3  Cash and Maximum Cash Drawdown

3.1 The CCG’s advised maximum cash drawdown is £386.36m for the year. As at Month 10 the CCG has drawn down £310.21m (80.3%).

4  Headline Financial Performance

4.1 At Month 10 the CCG is reporting an overall underspend of £4.17m against its issued budgets. This is in line with planned surplus.

4.2 Programme budgets are forecast to be under-spent at year end by £6.73m and Running Cost budgets are forecast to be under-spent by £0.87m. This is summarised in Table 3 below:

Table 3: Headline Financial Performance

<table>
<thead>
<tr>
<th>Overall CCG Budget</th>
<th>Year to Date</th>
<th>Annual</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Budget £m</td>
<td>Actual £m</td>
<td>Variance £m</td>
</tr>
<tr>
<td>Acute Contracts</td>
<td>177.42</td>
<td>178.49</td>
<td>(1.07)</td>
</tr>
<tr>
<td>Community Services</td>
<td>24.87</td>
<td>24.65</td>
<td>0.22</td>
</tr>
<tr>
<td>Joint Commissioning Adults</td>
<td>66.60</td>
<td>66.01</td>
<td>0.59</td>
</tr>
<tr>
<td>Joint Commissioning Children</td>
<td>1.46</td>
<td>1.31</td>
<td>0.15</td>
</tr>
<tr>
<td>Primary Care Budgets</td>
<td>30.17</td>
<td>29.86</td>
<td>0.31</td>
</tr>
<tr>
<td>Corporate Budgets</td>
<td>6.96</td>
<td>6.15</td>
<td>0.81</td>
</tr>
<tr>
<td>Other, Reserves and Financing</td>
<td>7.24</td>
<td>7.24</td>
<td>0.00</td>
</tr>
<tr>
<td>Planned Surplus</td>
<td>4.17</td>
<td>0.00</td>
<td>4.17</td>
</tr>
<tr>
<td><strong>Total CCG Budget</strong></td>
<td><strong>317.89</strong></td>
<td><strong>313.72</strong></td>
<td><strong>4.17</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Programme/ Running Cost Split</th>
<th>Budget £m</th>
<th>Actual £m</th>
<th>Variance £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Programme Budgets</td>
<td>311.84</td>
<td>308.40</td>
<td>3.45</td>
</tr>
<tr>
<td>Running Cost Budget</td>
<td>6.05</td>
<td>5.32</td>
<td>0.73</td>
</tr>
<tr>
<td><strong>Total CCG Budget</strong></td>
<td><strong>317.89</strong></td>
<td><strong>313.72</strong></td>
<td><strong>4.17</strong></td>
</tr>
</tbody>
</table>

4.3 The CCG is forecasting to deliver its planned surplus of £7.60m at year end.

5  Acute Budgets

5.1 The Year to Date (YTD) and forecast year end position for the CCG’s acute budgets is set out below in Table 4:
Table 4: Acute Financial Performance

<table>
<thead>
<tr>
<th>Local Acute Service Agreements</th>
<th>Year to Date</th>
<th>Annual</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Budget £m</td>
<td>Actual £m</td>
</tr>
<tr>
<td>Lewisham and Greenwich NHS Trust</td>
<td>99.69</td>
<td>101.67</td>
</tr>
<tr>
<td>Guy's and St Thomas' NHS Foundation Trust</td>
<td>25.14</td>
<td>25.94</td>
</tr>
<tr>
<td>King's College Hospital NHS Foundation Trust</td>
<td>26.03</td>
<td>26.80</td>
</tr>
<tr>
<td><strong>Total Local Acute Service Agreements</strong></td>
<td><strong>150.86</strong></td>
<td><strong>154.41</strong></td>
</tr>
<tr>
<td>External Service Agreements</td>
<td>19.77</td>
<td>20.39</td>
</tr>
<tr>
<td>Non Contracted</td>
<td>2.67</td>
<td>3.08</td>
</tr>
<tr>
<td>Other Acute</td>
<td>4.13</td>
<td>0.61</td>
</tr>
<tr>
<td><strong>Total Acute Contracts</strong></td>
<td><strong>177.42</strong></td>
<td><strong>178.49</strong></td>
</tr>
</tbody>
</table>

5.2 The year to date (YTD) position is based on Month 9 flex information, with a year-end forecast provided by the CSU Acute Contracting team based on expenditure profiles seen in previous years.

5.3 Lewisham and Greenwich Trust (£1.98m) – The position worsened in month with particularly high levels of emergency (£0.54m swing in FOT in month). Under-performance remains in maternity (£0.43m favourable), and critical care (£0.37m favourable), although pressures still exist within outpatients (£1.26m adverse) and A&E (£0.54m adverse)

5.4 King’s College Hospital (£0.77m) – The Kings position has improved in month. This is due to reductions in over performance in elective (£0.16m) and outpatient (£0.01m) PODs. Although emergency activity remains under plan the overall underperformance has reduced in month.

5.5 Guy’s and St Thomas’ (£0.80m) – This variance is mainly caused by Critical Care (£0.35m adverse) and Drugs and Devices (£0.49m adverse) expenditure above plan.

6 Corporate Budgets

6.1 Expenditure against the CCG corporate budgets continues in line with last year. As at Month 10 the CCG is forecasting to underspend its corporate budgets by £0.86m (and the running cost element by £0.87m).

6.2 Once the non-recurrent expenditure relating to the Quality Premium is excluded, this equates to forecast running cost expenditure of £21.76 per head of population. This places the CCG in a good position to manage within the £22.50 per head maximum from April 2015.
The forecast £0.87m RCA underspend is being used in 2014/15 for patient treatments and care.

7 Prescribing and Other Primary Care Budgets

7.1 The prescribing position is based on Month 8 data from the NHS Prescription Service. The expected impact of the 2014/15 community pharmacy arrangements hasn’t materialised as expected and has therefore been removed from the forecast outturn.

8 Adult Joint Commissioning Budgets

8.1 The Adult joint commissioning budgets continues to underspend across all services, a forecast £0.84m favourable variance at the year end.

9 Other, Reserves and Financing

9.1 To allow the CCG to achieve its reported surplus it has released £5.24m of its reserves into the forecast year end position.

10 Other Budget Headings

9.1 All other budget headings are on or close to target.

11 Quality, Innovation, Productivity and Prevention (QIPP) Position

11.1 The CCG’s agreed budget includes required net savings totalling £9.99m, from risk assessed QIPP schemes.

11.2 At Month 10 the CCG is forecasting to be £0.08m worse than its planned position. The YTD slippage is mainly caused by revisions to the implementation plan for the Outpatient Referral Management Service (RMS). It is expected that the slippage will be recovered in-year and the year-end forecast is to deliver in line with plan.

11.3 In line with the acute position above the Month 10 position for schemes relating to Lewisham and Greenwich have been based on Month 9 data.

11.4 Table 5 summarises the net financial position of the 2014/15 QIPP programme.
Table 5: 2014/15 QIPP Summary

<table>
<thead>
<tr>
<th>Month 10 QIPP</th>
<th>201415 Plan</th>
<th>YTD Plan</th>
<th>YTD Actual</th>
<th>Forecast Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£’000s</td>
<td>£’000s</td>
<td>£’000s</td>
<td>£’000s</td>
</tr>
<tr>
<td><strong>Integrated Care (Emergency Admissions)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Diabetes</td>
<td>451</td>
<td>376</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>- Heart Failure</td>
<td>259</td>
<td>216</td>
<td>104</td>
<td>125</td>
</tr>
<tr>
<td>- COPD</td>
<td>446</td>
<td>372</td>
<td>266</td>
<td>319</td>
</tr>
<tr>
<td>- Asthma</td>
<td>50</td>
<td>42</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>- Other Emergency Admissions</td>
<td>33</td>
<td>28</td>
<td>1,639</td>
<td>2,082</td>
</tr>
<tr>
<td><strong>Total Integrated Care</strong></td>
<td>1,239</td>
<td>1,033</td>
<td>2,009</td>
<td>2,526</td>
</tr>
<tr>
<td><strong>Primary and Planned Care Programme</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Outpatient Referrals</td>
<td>1,517</td>
<td>1,014</td>
<td>551</td>
<td>1,000</td>
</tr>
<tr>
<td>- Physiotherapy - Local Tariff Adjustment</td>
<td>279</td>
<td>233</td>
<td>233</td>
<td>279</td>
</tr>
<tr>
<td>- A&amp;E (Reviewing the current configuration of urgent and emergency care)</td>
<td>300</td>
<td>250</td>
<td>50</td>
<td>150</td>
</tr>
<tr>
<td>- Contract Metrics</td>
<td>823</td>
<td>686</td>
<td>686</td>
<td>823</td>
</tr>
<tr>
<td><strong>Total Primary and Planned Care Programme</strong></td>
<td>2,919</td>
<td>2,182</td>
<td>1,519</td>
<td>2,252</td>
</tr>
<tr>
<td><strong>Mental Health</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Shifting focus to Community Care</td>
<td>1,000</td>
<td>833</td>
<td>833</td>
<td>1,000</td>
</tr>
<tr>
<td><strong>Total Mental Health</strong></td>
<td>1,000</td>
<td>833</td>
<td>833</td>
<td>1,000</td>
</tr>
<tr>
<td><strong>Older Adults</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Reduction in Emergency Admissions</td>
<td>520</td>
<td>325</td>
<td>(22)</td>
<td>(26)</td>
</tr>
<tr>
<td>- AQP Continuing Care</td>
<td>480</td>
<td>400</td>
<td>400</td>
<td>480</td>
</tr>
<tr>
<td><strong>Total Older Adults</strong></td>
<td>1,000</td>
<td>725</td>
<td>378</td>
<td>454</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Maternity</td>
<td>858</td>
<td>715</td>
<td>715</td>
<td>858</td>
</tr>
<tr>
<td>- Anti Coagulation</td>
<td>74</td>
<td>49</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>- Improving prescribing and patient concordance</td>
<td>2,300</td>
<td>1,917</td>
<td>1,917</td>
<td>2,300</td>
</tr>
<tr>
<td>- Other Trust Guarantee</td>
<td>600</td>
<td>500</td>
<td>500</td>
<td>600</td>
</tr>
<tr>
<td><strong>Total Other</strong></td>
<td>3,832</td>
<td>3,181</td>
<td>3,132</td>
<td>3,758</td>
</tr>
<tr>
<td><strong>Month 9 QIPP Performance</strong></td>
<td>9,990</td>
<td>7,954</td>
<td>7,871</td>
<td>9,990</td>
</tr>
</tbody>
</table>
12 Creditors and Debtors

12.1 Table 6 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. Performance to Month 10 is below required standard. Remedial action has been taken to speed up the processing of invoice payments. Current month and cumulative performance are shown and demonstrate a month on month improvement in performance since Month 6.

Table 6: Better Practice Payments Code

<table>
<thead>
<tr>
<th></th>
<th>Jan-15</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>93.80%</td>
<td>97.95%</td>
</tr>
<tr>
<td>% of Invoices Paid within Target (Value)</td>
<td>99.56%</td>
<td>98.99%</td>
</tr>
</tbody>
</table>

![Total Invoice Count Graph](image-url)
12.2 Table 7 below outlines the aged debt position for 31st January 2015.

Table 7: Aged Debt

<table>
<thead>
<tr>
<th></th>
<th>£m</th>
</tr>
</thead>
<tbody>
<tr>
<td>AR not yet due</td>
<td>0.040</td>
</tr>
<tr>
<td>AR overdue 1-30</td>
<td>0.112</td>
</tr>
<tr>
<td>AR overdue 31-60</td>
<td>0.000</td>
</tr>
<tr>
<td>AR overdue 61-90</td>
<td>0.026</td>
</tr>
<tr>
<td>AR overdue 91-120</td>
<td>0.071</td>
</tr>
<tr>
<td>AR overdue 121-180</td>
<td>0.085</td>
</tr>
<tr>
<td>AR overdue 181-360</td>
<td>0.004</td>
</tr>
</tbody>
</table>

**Aged Debt Summary**

AR = accounts receivable

12.3 As at 4 March 2015 the value of debts over 60 days is £52k compared with £186k at end January 2015. There are no debts overdue by more than 180 days.

Tony Read  
Chief Financial Officer  
4 March 2015
## Appendix 1: Revenue Resource Limit

<table>
<thead>
<tr>
<th></th>
<th>Admin £000s</th>
<th>Programme £000s</th>
<th>Total £000s</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Opening Allocations</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2014-15 Opening Baseline</td>
<td>7.23</td>
<td>370.31</td>
<td>377.54</td>
</tr>
<tr>
<td>2013-14 Surplus Carry Forward</td>
<td></td>
<td>3.70</td>
<td>3.70</td>
</tr>
<tr>
<td><strong>Board Approved Budget</strong></td>
<td>7.23</td>
<td>374.01</td>
<td>381.24</td>
</tr>
<tr>
<td><strong>In Year Allocation</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2013-14 Change in Surplus</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td><strong>Total Allocation at Month 2</strong></td>
<td>7.23</td>
<td>374.01</td>
<td>381.24</td>
</tr>
<tr>
<td><strong>GP IT</strong></td>
<td>0.76</td>
<td>0.79</td>
<td></td>
</tr>
<tr>
<td><strong>Specialised Commissioning</strong></td>
<td>0.22</td>
<td>0.22</td>
<td></td>
</tr>
<tr>
<td><strong>Total Allocation at Month 3</strong></td>
<td>7.23</td>
<td>374.99</td>
<td>382.23</td>
</tr>
<tr>
<td><strong>No adjustments Month 4</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Allocation at Month 4</strong></td>
<td>7.23</td>
<td>374.99</td>
<td>382.23</td>
</tr>
<tr>
<td>1415 Referral to Treatment Funding</td>
<td>1.54</td>
<td>1.54</td>
<td></td>
</tr>
<tr>
<td><strong>Total Allocation at Month 5</strong></td>
<td>7.23</td>
<td>376.53</td>
<td>383.76</td>
</tr>
<tr>
<td>2014-15 CEOV and non rechargeable services</td>
<td>1.43</td>
<td>1.43</td>
<td></td>
</tr>
<tr>
<td><strong>Total Allocation at Month 6</strong></td>
<td>7.23</td>
<td>377.96</td>
<td>385.19</td>
</tr>
<tr>
<td>System Resilience Funding</td>
<td>2.01</td>
<td>2.01</td>
<td></td>
</tr>
<tr>
<td>System Resilience Funding (2\textsuperscript{nd} Tranche)</td>
<td>6.74</td>
<td>6.74</td>
<td></td>
</tr>
<tr>
<td><strong>Rounding</strong></td>
<td>0.01</td>
<td>0.01</td>
<td></td>
</tr>
<tr>
<td><strong>Total Allocation at Month 7</strong></td>
<td>7.23</td>
<td>386.72</td>
<td>393.95</td>
</tr>
<tr>
<td><strong>No adjustments in Month 8</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Allocation at Month 8</strong></td>
<td>7.23</td>
<td>386.72</td>
<td>393.95</td>
</tr>
<tr>
<td>Specialised Mental Health</td>
<td>(0.20)</td>
<td>(0.20)</td>
<td></td>
</tr>
<tr>
<td>Quality Premium 2013-14</td>
<td>0.45</td>
<td>0.45</td>
<td></td>
</tr>
<tr>
<td>Mental Health Resilience</td>
<td>0.17</td>
<td>0.17</td>
<td></td>
</tr>
<tr>
<td><strong>Total Allocation at Month 10</strong></td>
<td>7.67</td>
<td>387.27</td>
<td>394.55</td>
</tr>
<tr>
<td>2014-15 Referral to Treatment Funding</td>
<td>0.27</td>
<td>0.27</td>
<td></td>
</tr>
<tr>
<td>South East London Market Forces Factor</td>
<td>(1.50)</td>
<td>(1.50)</td>
<td></td>
</tr>
<tr>
<td>Specialised Commissioning misattributions</td>
<td>1.76</td>
<td>1.76</td>
<td></td>
</tr>
<tr>
<td>South East London Risk Pool adjustment</td>
<td>(4.10)</td>
<td>(4.10)</td>
<td></td>
</tr>
<tr>
<td><strong>Total Allocation at Month 10</strong></td>
<td>7.67</td>
<td>383.30</td>
<td>390.97</td>
</tr>
</tbody>
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A meeting of the Governing Body  
12<sup>th</sup> March 2015

<table>
<thead>
<tr>
<th>ENCLOSURE 9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Engagement: Quality Summit Next Steps</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>GOVERNING BODY LEAD:</th>
<th>Diana Robbins</th>
<th>Post Lay Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>AUTHOR:</td>
<td>Charles Malcolm-Smith</td>
<td>Post Deputy Director (Strategy &amp; Organisational Development)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RECOMMENDATIONS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Governing Body is asked to:</td>
</tr>
<tr>
<td>• Note updates to Quality Summit Report Summary, organisational responses and proposed next steps</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SUMMARY:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Governing Body will receive a presentation at the meeting that will summarise the main content areas of the report.</td>
</tr>
</tbody>
</table>

The event ‘Quality in Health and Social Care: A People’s Summit’ was held on 29<sup>th</sup> March 2014. Almost 100 people attended the Summit, giving up their time to help us understand the kind of health and social care services they need and want.

A full report has been written and reviewed by PEG and will shortly be available for publication via the partner organisation websites.

The summary report contains organisational responses.

A follow-up event is being considered, and the aims, scheduling, content and format of that is subject to further development.

<table>
<thead>
<tr>
<th>KEY ISSUES:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The summary report includes:</td>
</tr>
<tr>
<td>• The main findings from the summit:</td>
</tr>
<tr>
<td>o Themes</td>
</tr>
<tr>
<td>o Meaning of Quality</td>
</tr>
<tr>
<td>o Practical Recommendations</td>
</tr>
<tr>
<td>• Work with partners</td>
</tr>
<tr>
<td>• Organisational responses</td>
</tr>
</tbody>
</table>

| CORPORATE AND STRATEGIC OBJECTIVES |
Supports the objectives that public engagement is intrinsic to all commissioning activities, High Quality Care - commission high quality care services today

**CONSULTATION HISTORY INCLUDING MEMBERS ENGAGEMENT:**
- Governing Body workshop 5\textsuperscript{th} February 2015
- Membership Forum 11\textsuperscript{th} February 2015
- Delivery Committee 26\textsuperscript{th} February 2015

**PUBLIC ENGAGEMENT**
- The Quality Summit engaged members of the local population in order to understand their concerns and expectations regarding quality of health and care services

**HEALTH INEQUALITY DUTY & PUBLIC SECTOR EQUALITY DUTY**
Further engagement will be undertaken with population groups and communities in the planning and decision-making of the CCG.

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

**AUTHOR CONTACT:**
Name: Charles Malcolm-Smith  
E-Mail: charles.malcolm-smith@nhs.net
Governing Body
12th March 2015

Report from the Chair of the Strategy & Development Committee
Date of Meeting(s) reported: 5th February 2015
Author: Dr David Abraham

1. Summary

The committee received its regular report from the Public Engagement Group (PEG) and Joint Public Engagement Group (JPEG), a summary the initial outcomes of the public engagement on the Joint Integrated Commissioning Intentions, a report from the Primary Care Development Group, a report from the Maternity Commissioning Steering Group, the updated CCG strategic framework, the proposal for the Five Year Forward View new models of care programme.

2. Main Issues Discussed

2.1 Outcomes of Engagement on Commissioning Intentions

The committee reviewed the preliminary outcomes of the public engagement on the Joint Integrated Commissioning Intentions that indicated that people are generally supportive of the identified commissioning priorities; there was also a strong emphasis on mental health.

2.2 Primary Care Development Group

The report highlighted the CQC Intelligence Report which was also sent to the For Learning and Action Group (FLAG), primary care access, primary care improvement scheme, corporate objectives for 2015/16 which will feed into the February Governing Body Workshop.

2.3 Maternity Commissioning Steering Group

The report covered the maternity service specification, development of the preterm birth project, the Clinical Leadership Group developing the SEL 5 year strategy, arrangements for maternity commissioning.

2.4 CCG Strategy

The Committee agreed changes to the CCG strategic framework to be taken to the Governing Body for approval. This will support implementation of the CCG’s strategic priorities, particularly their alignment with the Our Healthier South East London programme whole system and local care network models.

2.5 Five Year Forward View

Proposal to register an interest to join the new models of care programme. The Committee supported the bid in terms of strategic direction, and it was agreed that the PACS model built on the vertical integration already taking place between the acute and community. As a provider led bid, the issue for commissioners is having a clear statement of the “commissioning ask” and to develop the market to deliver efficiencies, better outcomes and joined up care.
ENCLOSURE 11
CCG STRATEGY

CLINICAL LEAD: Dr David Abraham
MANAGERIAL LEAD: Susanna Masters

AUTHOR: Charles Malcolm-Smith

RECOMMENDATIONS:
The Governing Body is asked to:

- Agree the CCG 5 Year Strategic Framework

SUMMARY:
The CCG’s commissioning strategy was approved by the Governing Body in October 2013 and updates reviewed by the Strategy & Development Committee in June, September and December 2014. The Strategic Framework attached in Appendix 1 was agreed by the Strategy & Development Committee in February 2015.

The strategy includes the CCG’s vision and ambition, population health needs, public and members’ feedback, context and priority areas.

Developments include the presentation of the measures for our ambitions for better health and best care, and the vision for best care.

KEY ISSUES:

Better Health
To reduce the gap in key health outcomes between Lewisham and England by 10% over the five year period

We will continue to determine our success in improving the health of Lewisham people through measures of life expectancy, rates of premature mortality from the three biggest causes of death in Lewisham (cancer, respiratory diseases and cardiovascular disease), infant mortality, patient experience and end of life care. These are shown in charts that show current trends and agreed targets.
Best Care
High quality care for everyone - Care should be provided at the simplest level and ‘at the right place’; that is, so that it is least restrictive to patients and carers, localised where possible, and at the most appropriate setting.

Charts show key outcome measures, again with trends and agreed targets.

Best Value
To commissioning more effectively with the most efficient use of resources

We will continue measure our success by operating within our commissioning budget and demonstrating that we have used the budget effectively, delivering value for money. The change is illustrated to show current the breakdown of provider expenditure and expected shift in resources.

Population Health
Overall the health of Lewisham residents has improved but the key health challenges have not changed since last year’s strategic plan. Lewisham residents die at an earlier age compared to the rest of London.

Public Feedback
We have heard some common views expressed by many local residents about the improvements that are most important to them:

• People’s experience of care is very variable and should be made better;
• Service users want personalised care, which is provided by staff who are courteous and compassionate and listen to the user’s and the carer’s view;
• Users want their care to be joined up between different services;
• Public want to be supported to stay healthy and well and are willing to do more self-management;
• Public want improved access on data on local services’ performance

CCG Members Feedback
Engagement with our members has identified themes for the challenges and developments that can be built in the priority commissioning areas of primary care development and planned care, maternity and children’s care in hospital, adult integrated care, and urgent care there were consistent t identified for both on for the future.

Priorities & Objectives
Our priority areas have informed our objectives for 2014-15, and are closely aligned with national, London-wide and south east London strategy and policy development. The model of delivery for Lewisham and across south east London is based on networks of services at neighbourhood or local level.
### Next Steps
- Further development and monitoring of measures and outcomes for our ambitions
- Regular engagement with our whole membership and at neighbourhood level
- Establish an on-going dialogue to gain feedback from our local population
- Monitor the impact on equalities and health inequalities
- Continue to assess the viability of our plans against different financial scenarios

### CORPORATE AND STRATEGIC OBJECTIVES
The medium term strategic vision and context inform the one and two year corporate objectives and commissioning priorities within the organisational planning framework.

### CONSULTATION HISTORY:
- The CCG Governing Body approved the first version of the strategy in October 2013.
- The CCG membership was involved in a review of the priority areas in March 2014.
- A joint meeting of the Clinical Directors committee and management team in September 2014 reviewed the ‘best care’ and ‘best value’ aspects of the strategic vision.
- A workshop for the CCG Governing Body in October 2014 reviewed the strategic vision and those factors that may impact on its success.

### PUBLIC ENGAGEMENT
- There has been extensive public engagement since the previous draft strategy and on the priorities arising from the finalised version. A section on public engagement is included in the draft strategy document.

### HEALTH INEQUALITY DUTY
Health inequalities are included in the population health needs analysis and their reduction is integral to the CCG strategic vision and ambition.

### PUBLIC SECTOR EQUALITY DUTY
An equalities analysis was completed on the strategic priorities and objectives and has been reviewed to consider the updated version of the strategy. Both analyses have concluded that the strategy will contribute to reducing inequalities, and highlights potential positive outcomes for disadvantaged groups and for those that share protected characteristics. A full report was included in the first version of the strategy and will be available as an on-line reference to support the updated version.

### RESPONSIBLE MANAGERIAL LEAD CONTACT:
Name: Susanna Master  
E-Mail: susanna.masters@nhs.net
<table>
<thead>
<tr>
<th>Telephone:</th>
<th>020 3049 3126</th>
</tr>
</thead>
</table>

**AUTHOR CONTACT:**

Name: Charles Malcolm-Smith  
E-Mail: Charles.malcolm-smith@nhs.net  
Telephone: 020 7206 3246
<table>
<thead>
<tr>
<th>Contents</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
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<td>Who we are</td>
<td>3-4</td>
</tr>
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<td>Partnership working</td>
<td>5-6</td>
</tr>
<tr>
<td>Vision &amp; Ambition</td>
<td>7</td>
</tr>
<tr>
<td>Better Health Ambitions</td>
<td>8-11</td>
</tr>
<tr>
<td>Best Care Ambitions</td>
<td>12-17</td>
</tr>
<tr>
<td>Best Value &amp; context, provider landscape, challenges, shifting resources</td>
<td>18-22</td>
</tr>
<tr>
<td>Population health</td>
<td>23-26</td>
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<tr>
<td>Lewisham Neighbourhoods</td>
<td>27</td>
</tr>
<tr>
<td>Public feedback</td>
<td>28-29</td>
</tr>
<tr>
<td>CCG members feedback</td>
<td>30</td>
</tr>
<tr>
<td>Case for change summary</td>
<td>31</td>
</tr>
<tr>
<td>Transforming local services</td>
<td>32</td>
</tr>
<tr>
<td>Strategic priorities and objectives</td>
<td>33</td>
</tr>
<tr>
<td>Neighbourhood Networks</td>
<td>34</td>
</tr>
<tr>
<td>Our Healthier South East London Whole System Model</td>
<td>35</td>
</tr>
<tr>
<td>Equalities analysis</td>
<td>36</td>
</tr>
<tr>
<td>Summary &amp; next steps</td>
<td>37</td>
</tr>
</tbody>
</table>
Who we are

Lewisham CCG took over full responsibility for commissioning (planning, buying and monitoring) most of the healthcare services for Lewisham residents on 1st April 2013. These services include:

- Hospital care
- Rehabilitation care
- Urgent and emergency care
- Most community health services
- Mental health

Our aim is to secure the best possible health and care services for Lewisham residents in order to reduce health inequalities and improve health outcomes. We will do this by using findings about the health needs of our population (see http://www.lewishamjsna.org.uk/ for more information) to identify priorities and to make plans for how healthcare can be provided. We have contracts with a range of health service providers that includes NHS and private hospitals and voluntary sector organisations. We monitor how well the services are being delivered to ensure that they are meeting the needs of our patients, that they are safe and of high quality, and that they are providing value for money.

We are overseen by NHS England which makes sure that we have the capacity and capability to commission services successfully and to meet our financial responsibilities.

As a membership organisation, our GP member practices work closely in local or neighbourhood groupings, to discuss common problems that are arising, and to see how local services can be improved and co-ordinated better.
Who we are

The GPs in Lewisham have elected seven representatives, including the CCG Chair Dr Marc Rowland, to lead clinical commissioning in Lewisham. As well as spending time on commissioning as members of our Governing Body, these GPs are still practising clinicians and they work closely with other doctors to share information about the services that people need.

They are members of the CCG’s Governing Body, along with two lay members, a nurse and a hospital doctor as well as two senior managers (the CCG’s Chief Officer and Chief Finance Officer). The Governing Body has responsibility for agreeing commissioning plans, ensuring public funds are spent correctly and for assuring the quality and safety of services the CCG commissions.

As a membership organisation, our GP member practices work closely in local or neighbourhood groupings, to discuss common problems that are arising, and to see how local services can be improved and co-ordinated better.
Partnership working

We work in partnership with the public and other commissioners to meet our goals and to ensure efficient and effective working.

Lewisham Health & Wellbeing Board

The Health & Wellbeing Board is a statutory committee of the London Borough of Lewisham (LBL). Its key function is to support the development of greater integration to improve health and wellbeing of the area, and to prepare a joint strategic needs assessment (JSNA) so that the Council and CCG can develop strategies to meet identified needs. The CCG Chair is a member and vice chair of the Health and Wellbeing Board.

The Board has established the Adult Integrated Care Programme to provide joined up health and care services and support healthy living across the adult population in Lewisham. The programme is aligned to the Better Care Fund (BCF) and is jointly led by LBL and the CCG.

Borough Joint Commissioning

The CCG works closely with Lewisham Council to jointly commission services for children and young people, learning disability, mental health, physical disabilities and emerging client groups, and older adults services. These arrangements have been established under Section 75 agreements. These joint commissioning arrangements sit within the management structures of LBL. The LBL Executive Director of Community Services is a co-opted advisory member of our Governing Body.

Public Health

Lewisham Public Health functions and staff transferred to LBL in April 2013. The CCG has a strong working relationship with and the Director of Public Health is also a co-opted advisory member of our Governing Body. The Public Health team are responsible for co-ordinating the JSNA on behalf of the Health and Wellbeing Board. The JSNA brings together in one place a wealth of information on the health and social care needs of Lewisham’s citizens, complemented by information on the social, environmental and population trends that are likely to impact on people’s health and well-being.
Partnership working –
South East London Clinical Commissioning Groups

Where some strategic change will need to be delivered across CCGs, the six CCGs in south east London are working together and with NHS England commissioners (specialised services and primary care), on the elements of the strategy that cannot be addressed at CCG level alone, or where there is common agreement that there is added value in working collectively, as well as developing their individual plans and strategies. While each CCG is accountable for developing a Strategic, Operational and Financial plan, they have joined with neighbouring CCGs in a larger ‘strategic planning group’ to aggregate plans, ensure that the strategies align in a holistic way and maximise the value for money from the planning resources and support at their disposal. This programme is known as ‘Our Healthier South East London’.

In south east London we spend £2.3billion in the NHS. Over the next five years we aim to achieve much better outcomes than we do now by:

- Supporting people to be more in control of their health and have a greater say in their own care
- Helping people to live independently and know what to do when things go wrong
- Closing the inequalities gap between worst health outcomes and our best
- Making sure primary care services are consistently excellent and with an increased focus on prevention
- Reducing variation in healthcare outcomes by raising the standards in our health services to match the best
- Developing joined up care so that people receive the support they need when they need it
- Delivering services that meet the same high quality standards whenever and wherever care is provided
- Spending our money wisely, to deliver better outcomes and avoid waste.

Further details of these plans can be found at: www.ourhealthiersel.nhs.uk/
Vision & Ambitions

Better Health
To improve the health outcomes for the Lewisham population by commissioning a wide range of advice, support and care to make choosing healthy living easier, for people to keep fit and healthy and to reduce preventable ill health and health inequalities

Best Care
To ensure that all commissioned services are of high quality – safe, evidence based and provides a positive patient experience, and also to shift the focus of support and care to prevention, self-care and planned care in the community

Best Value
To commission services which are integrated and sustainable so delivering high quality, effectiveness and value for money

Working together with Lewisham people is at the centre of everything we do.

Our overall vision and ambition, which was supported by the public, has not changed since last year – as set out in the next section on Better Health, Best Care and Best Value.
Better Health

To reduce the gap in key health outcomes between Lewisham and England by 10% over the five year period

We will continue to determine our success in improving the health of Lewisham people through measures of life expectancy, rates of premature mortality from the three biggest causes of death in Lewisham (cancer, respiratory diseases and cardiovascular disease), infant mortality, patient experience and end of life care.

Using National Health & Social Care Information Centre data, Lewisham Public Health have identified target levels for these key measures through which we will monitor progress towards achieving our vision.
Improving measures of life expectancy for the Lewisham population
Causes of Death: decreasing the rates of premature mortality from the three biggest causes of death in Lewisham
Better Health: our ambitions for 2018/19

Decreasing the rate of infant mortality

Ensuring patient experience continues to improve

*Target not determined; rates subject to year-on-year variability due to natural variation
High quality care for everyone - Care should be provided at the simplest level and ‘at the right place’; that is, so that it is least restrictive to patients and carers, localised where possible, and at the most appropriate setting.

We will focus on the core elements of quality:

- Patient Safety
- Patient experience
- Clinical effectiveness
## Best Care: statements of principle to support elements of quality

<table>
<thead>
<tr>
<th>Principles and Processes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Principles:</strong></td>
</tr>
<tr>
<td>• Have care in place that is personalised and centred around the whole needs of the individual patient</td>
</tr>
<tr>
<td>• Work for continually improving patient experience</td>
</tr>
<tr>
<td>• Ensure patients are informed about their care and are encouraged to live well, stay healthy and be independent longer</td>
</tr>
<tr>
<td>• Get it right first time by Integrated and co-ordinated service provision – reducing re-admissions</td>
</tr>
<tr>
<td>• Ensure staff are skilled and competent to provide care with dignity, respect and humanity</td>
</tr>
<tr>
<td>• Develop and improve services with the best evidence and using clinical audits</td>
</tr>
<tr>
<td><strong>Processes:</strong></td>
</tr>
<tr>
<td>• Ensure robust quality assurance processes are in place</td>
</tr>
<tr>
<td>• Monitoring and acting on quality alerts</td>
</tr>
<tr>
<td>• Seek to acquire real-time, constant feedback</td>
</tr>
<tr>
<td>• Ensure transparent information is available to the public about the performance of services and outcomes</td>
</tr>
</tbody>
</table>
Best Care: our ambitions for 2018/19

Reducing the amount of time children and young people spend avoidably in hospital

Unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s

Emergency admissions for children with lower respiratory tract infections

Rate per 100,000 pop
Best Care: our ambitions for 2018/19

Reducing the amount of time Adults spend avoidably in hospital

Emergency admissions for acute conditions that should not usually require hospital admission

<table>
<thead>
<tr>
<th>Year</th>
<th>Rate per 100,000 pop</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010/11</td>
<td>1147.8</td>
</tr>
<tr>
<td>2011/12</td>
<td>1155.8</td>
</tr>
<tr>
<td>2012/13</td>
<td>1324.8</td>
</tr>
<tr>
<td>2013-18</td>
<td>1324.8</td>
</tr>
<tr>
<td>2018-19</td>
<td>1332</td>
</tr>
</tbody>
</table>

Trend: rising

Target: 1332

91 day stays after admission – proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation service*

<table>
<thead>
<tr>
<th>Proportion</th>
<th>Baseline (2013/14)</th>
<th>Planned 14/15</th>
<th>Planned 15/16</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>86.9</td>
<td>88.0</td>
<td>88.0</td>
</tr>
</tbody>
</table>

* Under development, target for 2018/19 not yet determined

Rate per 100,000 pop

Baseline

Planned

Planned 15/16
Improving end-of-life care for Lewisham’s residents by increasing the proportion who die in their preferred place.

*Proxy measures in the absence of a single measure for preferred place of death.
Best Care: our ambitions for 2018/19

Ensuring a positive experience of care

<table>
<thead>
<tr>
<th>Composite indicator comprised of (i) GP services, (ii) GP Out of Hours – poor scores. (2012)</th>
<th>Current Score</th>
<th>Target Score 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6.7</td>
<td>6.3</td>
</tr>
</tbody>
</table>

No data trend is available
Best value

To commissioning more effectively with the most efficient use of resources

We will continue measure our success by operating within our commissioning budget and demonstrating that we have used the budget effectively, delivering value for money.

We will use benchmarking information, such as NHS England’s Commissioning for Value tool, to identify opportunities to improve outcomes and increase value for our local populations. The information will help to ensure that we prioritise those areas for change to make improvements in healthcare quality, outcomes and efficiency.
Best Value: Financial Context

If Lewisham CCG continues to commission in the same way as today it will result in the CCG facing a funding gap between projected spending requirements and resources available of around £41 million between 2015/16 and 2018/19. This estimate is made taking into account current expected productivity improvements and the expected annual out-turn expenditure in line with contracts, and notified tariff assumptions and allocation changes. Year on year challenge assumes spending each year is within budget (e.g. no acute overperformance), and that QIPP will increase by any in year overspend.

We expect to receive (2015/16) around £401.5m to commission most of the healthcare services in Lewisham which we allocate as follows:

### Commissioning Plan 2015/16

<table>
<thead>
<tr>
<th>Service</th>
<th>2015/16 (£'000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>217,420</td>
</tr>
<tr>
<td>Mental Health - Inpatients</td>
<td>33,550</td>
</tr>
<tr>
<td>Mental Health - Outpatients</td>
<td>28,880</td>
</tr>
<tr>
<td>Community</td>
<td>45,132</td>
</tr>
<tr>
<td>Continuing Care</td>
<td>11,377</td>
</tr>
<tr>
<td>Primary Care</td>
<td>40,071</td>
</tr>
<tr>
<td>Other Programme</td>
<td>17,346</td>
</tr>
</tbody>
</table>

**Note:** The percentages in the pie chart correspond to the following services:
- Acute: 55.3%
- Mental Health: 10.2%
- Community: 12.0%
- Continuing Care: 16.4%
- Primary Care: 2.8%
- Other Programme: 3.3%
Our main providers of secondary care services are Lewisham & Greenwich NHS Trust (LGT), King’s College Hospital NHS Foundation Trust (KCH), and Guy’s and St Thomas’s NHS Foundation Trust (GSTT). Their approximate share of activity is as follows:

![Secondary Care Providers % Activity 2013-14](chart)

- LGT: 58%
- KCH: 17%
- GSTT: 13%
- Others: 12%

Our community services provider is also the Lewisham & Greenwich Trust, and mental health services are provided by the South London and Maudsley NHS Foundation Trust (SLAM).

All our health service providers, public, voluntary and privately owned organisations, are facing challenges to secure sustainable primary, community and acute services.
Best Value: Provider Challenges

Health service providers face increasing demand because:

- Health demand overall is increasing – rising rate of people with one or more long-term conditions and an ageing population
- Public expectations - patients using services 24/7 and seeking treatment for minor conditions rather than healthy living and self management
  - Medical advances are helping people to live longer but, in line with this, more people can expect to live for some time with a care and support need. The NHS can now treat conditions that previously went undiagnosed or were simply untreatable.

Health services providers face increasing difficulty in providing/supplying services:

- Increasing costs - the cost of providing care is getting more expensive. The NHS now provides a much more extensive and sophisticated range of treatments and procedures
- Increased focus on quality – safety, patient experience and effectiveness
- Limited financial resources to buy health services - the broad consensus is that for the next decade, the NHS can expect its budget to remain flat in real terms, or to increase with overall GDP growth at best. This represents a dramatic slow-down in spending growth for the NHS.
Best Value: Shifting Resources

We plan to shift resources and change the balance of expenditure to commission more services in the community.
Population Health

This section explains why we need to work differently with you: the public, other commissioners and providers of care. The challenges outlined provide the ‘case for change’. No change will not deliver our vision for better health, best care and best value.

Overall the health of Lewisham residents has improved but the key health challenges have not changed since last year’s strategic plan. Lewisham residents die at an earlier age compared to the rest of London.

A population health profile is available on our website [http://www.lewishamccg.nhs.uk/about-us/our-plans/Pages/default.aspx](http://www.lewishamccg.nhs.uk/about-us/our-plans/Pages/default.aspx) its main findings are summarised below, which has been informed by Lewisham’s Joint Strategic Needs Assessment (JSNA) ([http://www.lewishamjsna.org.uk/](http://www.lewishamjsna.org.uk/)).

### SUMMARY – OUR POPULATION PROFILE & HEALTH CHALLENGES

| Population | The Lewisham population is projected to grow across all age groups over the next five years. For this period the largest increase in numbers is in the 20-64 year old age group. Over the next fifteen years the greatest percentage increase will be in the 65+ age group.
|           | The population of children, in particular those aged 5 to 14 will continue to rise for the foreseeable future because of the previous rise in births.
|           | Lewisham is a very ethnically diverse borough. Black and Ethnic Minority (BAME) groups make up 49.3% of the population, the two largest groups are Black African (12%) and Black Caribbean (11%). In the school population 77% are from BAME. The ethnic profile of the older population, which has been predominately white will change. |
### Inequalities

| There have been improvements in the health of Lewisham residents. However, Lewisham experiences significantly worse health outcomes than London and England. Lewisham has a 17% excess mortality rate compared to England. |
| Health outcomes are variable across Lewisham. Recent data indicate that Life Expectancy for males in New Cross, Sydenham and Lewisham Central wards is 75 years; five years lower than for males living in Crofton Park. Female Life Expectancy in New Cross is 77 years, nine years lower than for females living in Crofton Park. |
| The premature mortality rate for Lewisham is significantly higher than that of London and England. There are higher rates of in the more deprived areas of the borough. |
| In addition to deprivation impacting on inequalities in health outcomes, other populations such as those with mental health problems, homeless people, asylum seekers and Black and minority ethnic groups experience health inequalities. |

### Cause of Death

| Cancer is now the main cause of death (28.3%), followed by circulatory disease (28.1%), respiratory disease (13.8%) and dementia (9%). |

### Health Risks

| More people smoke in Lewisham than the national average, reducing the number of people who smoke would make a major impact on the key causes of premature death. Obesity rates in children are high compared to England although similar to rates in London. Reducing levels of obesity, alcohol intake and inactivity would also contribute to improving health outcomes. |
## Population Health

<table>
<thead>
<tr>
<th>Long-Term Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>There will be increasing numbers of people who have long-term conditions and this will further increase with the ageing population, particularly the likelihood of having more than two conditions.</td>
</tr>
<tr>
<td>Lewisham’s Black and Minority Ethnic communities are also at greater risk from health conditions such as diabetes, hypertension and stroke.</td>
</tr>
<tr>
<td>Identifying those with disease early and treating them optimally will be essential to managing this increasing demand.</td>
</tr>
<tr>
<td>Dementia - with the increasing age of the population the number of dementia cases will rise; prevalence increases particularly in the population older than 65.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevalence of mental illness is high in Lewisham both for Common Mental Illnesses and Severe Mental Illness. Poor mental health is more prevalent in disadvantaged communities in Lewisham. Demand for services is high</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sexual Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lewisham has very high rates of abortion, teenage pregnancy and Sexually transmitted infections. HIV rates are high and over half of all cases are diagnosed 'late'.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Birth weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>The percentage of low birthweight babies has increased in the last two years. Early access to antenatal care, careful management of high risk pregnancies and smoking cessation can significantly improve neonatal and maternal outcomes including low birthweight.</td>
</tr>
<tr>
<td>Population Health</td>
</tr>
<tr>
<td>-------------------</td>
</tr>
<tr>
<td><strong>Children</strong></td>
</tr>
<tr>
<td><strong>Young People</strong></td>
</tr>
<tr>
<td><strong>Adults</strong></td>
</tr>
<tr>
<td><strong>Older people</strong></td>
</tr>
</tbody>
</table>
Lewisham Neighbourhoods

The total registered population of the forty-one GP practices in Lewisham is 300,736 higher than the resident population of 288,004.

Lewisham is divided into 4 geographical areas for administrative reasons and collaborative working between practices.

The size of the population, ethnicity and socio-economic profile of each neighbourhood varies. Some parts of Lewisham are more deprived than others, however, every neighbourhood has at least one very deprived ward. The age profiles of the neighbourhoods are very similar to Lewisham as a whole, although N1 has a younger population than Lewisham.

There is variation in health outcomes within all neighbourhoods.
Public Feedback

Over a number of phases we have been building our understanding of what our local population thinks about local services, their experiences and their feedback on our plans for the future. Since 2012 we have collected patient and public feedback from a number of sources, including questionnaires and surveys, the PALS service and complaints, and face-to-face meetings and events with local organisations and with the wider public (there are more details available on our website http://www.lewishamccg.nhs.uk/about-us/our-plans/Pages/default.aspx).

2012-13 Pre-authorisation: Establishing the CCG
- ‘Have Your Say’ patient survey
- ‘Shaping Your Health Services’ Event January 2013

2013 Developing a Local Strategy for Lewisham
- Lewisham Peoples Day July 2013
- ‘We are up for the challenge’ September-October 2013

2013-14 Building on & Refreshing Our Strategy
- Commissioning Intentions Engagement from January 2014
- ‘Quality in Health and Social Care: A Peoples Summit’ March 2014
- Commissioning Intentions Engagement from January 2015
Feedback on our Strategic Priorities

Over the past year, we have asked Lewisham people about our strategic priorities and what is important about health services. Overall the Lewisham public supported the focus on our priority areas.

We have heard some common views expressed by many local residents about the improvements that are most important to them:

- People’s experience of care is very variable and should be made better;
- Service users want personalised care, which is provided by staff who are courteous and compassionate and listen to the user’s and the carer’s view;
- Users want their care to be joined up between different services;
- Public want to be supported to stay healthy and well and are willing to do more self-management;
- Public want improved access on data on local services’ performance

Healthwatch Lewisham were asked to consider the feedback we have received from the public, and to explore if these views from the perspective of information they have received in their more recent interactions with the public. The Healthwatch response is:

In general, the public feedback provided to the CCG reflects local priorities and concerns gathered by Healthwatch in recent months.

- Primary Care access continues to be challenging for many patients
- Mental Health services and access to MH, CAMHS and transition is a higher priority now than one year ago
- Young people want to engage with health dialogues to influence services and make sure their needs are understood
- Better communication needed for 111 and SELDOC – to fill public knowledge gap
- Discharge processes need to be improved for vulnerable groups i.e. hostel residents, MH patients
- Carers (unpaid) and family members want better inclusion in care planning process
- Strong support for ‘every contact counts’ ethos; with strong desire for improved interpersonal skills across all services
- There are emerging concerns from some specific groups about equity and equality (LGBT, HIV, Substance Misusers, Vietnamese speakers and parents of children with complex needs)
CCG Members Feedback

Our members, the GP practices in Lewisham, are integral to decision-making and prioritising. Their elected representatives chair and are members of our governing body, and we hold monthly membership and neighbourhood meetings through which we have reviewed our strategic priorities and commissioning intentions.

Additionally, in March 2014 we held an event open to everyone from our member practices. Around 80 participants reviewed our strategic priority areas and the challenges that will need to be addressed in our commissioning plans.

Through review of the priority commissioning areas of primary care development and planned care, maternity and children’s care in hospital, adult integrated care, and urgent care there were consistent themes identified for both challenges and existing features or developments that can be built on for the future.

- **Building & Developing**
  - Successful multi-disciplinary working was identified in links with children’s centres, collaborative primary care networks, between midwives and practice teams, and when piloted in adult integrated care
  - The potential of a care co-ordinator or key worker role to support integrated working and provide an individualised, holistic approach to care
  - Clear, innovative information campaigns such as the ‘yellow man’ series (winter 2013-14) can have an impact on patient education/self-care

- **Challenges**
  - Capacity in primary care to meet the demands of both planned and urgent care, and the expectations of acute services
  - Access to shared records and information, ensuring continuity of care
  - Patient information and education to enable self-management and understanding of appropriate services
  - Access to services out of hours, for instance maternity
  - Ensuring quality of care of community-based care
Case for Change Summary

• We need to improve our health outcomes
• We need to improve quality and accessibility of local services to all
• The changing health needs of the Lewisham population will increase demand on services
• We need to shift the balance of care from emergency responses to care that is proactive and planned
• The current configuration of health services is not likely to be sustainable
• There will be gap in finances, between resources available and expenditure
• We need to develop advice, care and support services that empower people to want to take control and be responsible for their health and wellbeing
Transforming Local Services

This section describes the changes we plan to make to our commissioning to achieve our vision.

Our commissioning strategy does not sit alone, and we will be working in partnership with other South East London clinical commissioning groups and in particular as members of the Lewisham Health & Wellbeing Board to meet the health needs identified in the JSNA.
We have identified nine strategic priorities, and additional cross-cutting ‘enablers’, which we will focus on to transform services. Our strategic priorities are translated into annual delivery objectives:

<table>
<thead>
<tr>
<th>Strategic Themes</th>
<th>Strategic Priorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy Living for All – helped to live healthy lifestyles, make healthy choices and reduce health inequalities</td>
<td>Health promotion and prevention</td>
</tr>
<tr>
<td></td>
<td>Maternity and children's care in hospital</td>
</tr>
<tr>
<td>Frail and Vulnerable People - supported and cared for with dignity and respect</td>
<td>Vulnerable and frail older people including end of life care</td>
</tr>
<tr>
<td>Long Term Conditions – empowering people with greater choice to manage their condition</td>
<td>Long Term Conditions pathways – eg COPD, diabetes, CVD, dementia</td>
</tr>
<tr>
<td></td>
<td>Mental Health care</td>
</tr>
<tr>
<td>Local Care/Neighbourhood Networks</td>
<td>Community based advice, support and care</td>
</tr>
<tr>
<td></td>
<td>Integrated neighbourhood community teams based in each of the four localities</td>
</tr>
<tr>
<td></td>
<td>Primary care development and planned care</td>
</tr>
<tr>
<td></td>
<td>Urgent Care</td>
</tr>
<tr>
<td>Cross Cutting Areas – enabling high quality and integrated care</td>
<td>High quality care, Public engagement, Research and innovation, Better outcomes, Governance arrangements, Partnership working, CCG leadership</td>
</tr>
</tbody>
</table>

The model of delivery for Lewisham and across south east London is based on networks of services at neighbourhood or local level
Neighbourhood Networks (also known as Local Care Networks) are the foundation of the whole system model providing person centred services to populations.

**Strong confident communities**

**Self care**
- Health coaching
- Self management tool kits
- Social prescribing
- Optimising neighbourhood assets

**Managed care**
- Anticipatory care planning
- Active case management
- Disease management
- Public health programmes

**Specialist input** shared between LCNs:
- Pulled into care delivery from outside the network:
  - Virtual clinics
  - Specialist nurses
  - Consultants
  - Geriatricians
  - End of Life expertise
  - Specialist rehab

**Wider community infrastructure:**
- Police
- Fire service
- Schools
- Housing

**Affordable high quality outcomes**

**Neighbourhood Networks**

**Population needs and budget**

**Diagnostics**

**GP practice**

**Family/social network**

**Local Care Network**

**Person**

**Care Co-ordination**

**Urgent and emergency**
Local Care Networks will operate beyond usual GP hours in order to reduce referrals to emergency care.
Our Healthier South East London health and care whole system model

- This is our integrated system model.
- Local Care Networks are the foundation of the whole system model providing person centred services to populations.
- The petals are the pathways providing services to cohorts of people and drawing on specialised services.
- The orange circles represent key features of the model.

Mums-to-be will receive a personalised service, continuity of care and a range of birthing options.

Children and young people will be able to access more specialised services through children’s integrated community teams.

A rapid response team will make sure patients who need urgent and emergency care will receive the treatment they need in the right place at the right time and will support patients to return home and move back to local health and care services.

Improve patient outcomes through prevention and early detection and diagnosis of cancer; stronger support for people living with and beyond cancer.

Strong confident communities are a critical part of the foundation of the model. Initiatives will seek to build community resilience so that they support local people to be physically and mentally healthy and take care of peoples social needs.

Patients who need planned care across SEL will receive consistent quality and outcomes regardless of the setting.
Equalities Analysis

An initial equalities analysis of the draft strategic aims and priorities was undertaken by Lewisham Public Health in August 2013.

A full assessment of the Lewisham population in relation to the nine statutory protected characteristics (age, disability, sex and gender, pregnancy and maternity, race, religion or belief, gender reassignment, sexual orientation, marriage and civil partnership), plus deprivation was formed part of an Equality Impact Assessment of the Lewisham Health and Wellbeing Board’s Strategy for the next decade, and was used as the principal source of information on Lewisham’s population for the equalities analysis. The analysis examined the CCG strategic priority areas and for each one identified potential positive, negative and neutral outcomes.

A further equalities analysis was carried out in August 2014 by the Equality & Diversity Lead from South London Commissioning Support Unit. It looked at the proposed strategic priorities and themes and assessed their likely positive or negative impacts.

Both analyses concluded that overall the strategy will contribute to reducing inequalities, and highlights potential positive outcomes for disadvantaged groups and for those that share protected characteristics. The more recent analysis also highlighted the feedback and concerns that were included in the public feedback especially where they relate to patient experience and communication issues.

Further work on equality impact assessment is being undertaken as part of the development of the CCG’s plans.

The equalities analyses are both available on our website http://www.lewishamccg.nhs.uk/about-us/our-plans/Pages/default.aspx
Summary & Next Steps

Summary
- We have refined our vision and ambitions for Better Health, Best Care and Best Value
- We have reviewed our case for change
- We have reaffirmed our strategic priorities
- Our approach is supported by the NHS Five Year Forward View and Better Health for London
- CCG and Our Healthier South East London are aligned in their goals, case for change summaries, priority areas and transformation through neighbourhood, or local care, networks

Next Steps
- Further development and monitoring of measures and outcomes for our ambitions
- Regular engagement with our whole membership and at neighbourhood level
- Establish an on-going dialogue to gain feedback from our local population
- Monitor the impact on equalities and health inequalities
- Continue to assess the viability of our plans against different financial scenarios
- Annual planning and delivery of commissioning intentions, operating plan and corporate objectives to meet our strategic priorities
### Enc12

**Proposed constitutional amendments for Primary Care Co-Commissioning and other technical amendments**

<table>
<thead>
<tr>
<th>CLINICAL LEAD: Marc Rowland</th>
<th>Managerial Lead: Susanna Masters</th>
</tr>
</thead>
</table>

**AUTHORS:**

- Graham Hewett
- Head of Integrated Governance

**RECOMMENDATIONS:**

Governing Body is asked to

- Approve the proposed changes to the CCG’s Constitution.

**KEY ISSUES:**

There are five sets of changes proposed to the CCG’s Constitution:

1. to enable joint commissioning and joint decision making arrangements with other CCGs and with NHS England
2. to change the rule for quoracy in the Governing Body Terms of Reference
3. to change the Audit Committee Terms of Reference to allow additional independent lay members with financial and accounting expertise
4. to remove duplication within the constitution and CCG policy on the management of conflicts of interest
5. Other amendments

**CORPORATE AND STRATEGIC OBJECTIVES**

Governance

**CONSULTATION HISTORY:**

1. **Proposed constitutional amendments to enable joint commissioning and joint decision making arrangements with other CCGs and with NHS England**
   - Formally launched engagement programme with members in November through distributing a detailed information pack on Co-commissioning. This has been supported by meetings at the four Neighbourhoods during November and December, in addition to
discussions at a recently held Protected Learning Time event for GP Practices and at our monthly Membership Forum.

- On 4th December 2014 LCCG held a workshop on Co-commissioning with its Governing Body, which included representation from neighbourhoods.
  - Governing Body supported the recommendations for Co-commissioning at its meeting on the 8th January
  - Approved by Membership Forum 11th February 2015

2. Proposed constitutional amendments to change the rule for quoracy in the Governing Body Terms of Reference

- Recommended by the Governing Body at its meeting on 13th November 2014
- Minor amendment and approved by Membership Forum 11th February 2015

3. Proposed constitutional amendments to change the Audit Committee Terms of Reference to allow an additional independent lay member with financial and accounting expertise

- Recommended by Audit Committee at its meeting on 6th January 2015
- Supported by Governing Body at its meeting on 8th January
- Approved by Membership Forum 11th February 2015

4. Proposed constitutional amendments to remove duplication within the constitution and CCG policy on the management of conflicts of interest

- Technical amendment in common with six CCGs in South East London following legal advice received by NHS Greenwich CCG
- Approved by Membership Forum 11th February 2015

5. Other Amendments

- Technical changes
- Approved by Membership Forum 11th February 2015

PUBLIC ENGAGEMENT

No public engagement has taken place.

HEALTH INEQUALITY DUTY

No impact

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

No impact

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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Name: Susanna Masters</td>
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<tbody>
<tr>
<td>Graham Hewett</td>
</tr>
<tr>
<td>E-Mail: <a href="mailto:graham.hewett@nhs.net">graham.hewett@nhs.net</a></td>
</tr>
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Proposed changes to the NHS Lewisham Clinical Commissioning Group Constitution.
Version 2.2
January 2015

1. Proposed constitutional amendments to enable joint commissioning and joint decision making arrangements with other CCGs and with NHS England

Amendment 1
Insert new clauses at:

6.6 Joint commissioning and decision making arrangements with other Clinical Commissioning Groups

6.6.1 The clinical commissioning group (CCG) may wish to work together with other CCGs in the exercise of its commissioning functions.

6.6.2 The CCG may make arrangements with one or more CCG in respect of:

6.6.2.1 delegating any of the CCG’s commissioning functions to another CCG;

6.6.2.2 exercising any of the commissioning functions of another CCG; or

6.6.2.3 exercising jointly the commissioning functions of the CCG and another CCG

6.6.3 For the purposes of the arrangements described at paragraph 6.6.2, the CCG may:

6.6.3.1 make payments to another CCG;

6.6.3.2 receive payments from another CCG;

6.6.3.3 make the services of its employees or any other resources available to another CCG; or

6.6.3.4 receive the services of the employees or the resources available to another CCG.

6.6.4 Where the CCG makes arrangements which involve all the CCGs exercising any of their commissioning functions jointly, a joint committee or committee(s) in common may be established to exercise those functions.

6.6.5 For the purposes of the arrangements described at paragraph 6.6.2 above, the CCG may establish and maintain a pooled fund made up of contributions by any of the CCGs working together pursuant to paragraph 6.6.2.3 above. Any such pooled fund may be used to make payments towards expenditure incurred in the discharge of any of the commissioning functions in respect of which the arrangements are made.
Annex A

6.6.6 Where the CCG makes arrangements with another CCG as described at paragraph [6.6.2] above, the CCG shall develop and agree with that CCG an agreement setting out the arrangements for joint working, including details of:

- How the parties will work together to carry out their commissioning functions;
- The duties and responsibilities of the parties;
- How risk will be managed and apportioned between the parties;
- Financial arrangements, including, if applicable, payments towards a pooled fund and management of that fund;
- Contributions from the parties, including details around assets, employees and equipment to be used under the joint working arrangements.

6.6.7 The liability of the CCG to carry out its functions will not be affected where the CCG enters into arrangements pursuant to paragraph [6.6.2] above.

6.6.8 The CCG will act in accordance with any further guidance issued by NHS England on co-commissioning.

6.6.9 Only arrangements that are safe and in the interests of patients registered with member practices will be approved by the governing body.

6.6.10 The governing body of the CCG shall require, in all joint commissioning and decision making arrangements, that the lead clinician and lead manager of the lead CCG make a quarterly written report to the governing body and hold at least annual engagement events to review aims, objectives, strategy and progress and publish an annual report on progress made against objectives.

6.6.11 Should a joint commissioning or decision making arrangement prove to be unsatisfactory the governing body of the CCG can decide to withdraw from the arrangement, but has to give six months’ notice to partners, with new arrangements starting from the beginning of the next new financial year.

6.7 Joint commissioning arrangements with NHS England for the exercise of CCG functions

6.7.1 The CCG may wish to work together with NHS England in the exercise of its commissioning functions.

6.7.2 The CCG and NHS England may make arrangements to exercise any of the CCG’s commissioning functions jointly.

6.7.3 The arrangements referred to in paragraph 6.7.2 above may include other CCGs.

6.7.4 Where joint commissioning arrangements pursuant to 6.7.2 above are entered into, the parties may establish a joint committee or committee(s) in common to exercise the commissioning functions in question.
Annex A

6.7.5 Arrangements made pursuant to 6.7.2 above may be on such terms and conditions (including terms as to payment) as may be agreed between NHS England and the CCG.

6.7.6 Where the CCG makes arrangements with NHS England (and another CCG if relevant) as described at paragraph 6.7.2 above, the CCG shall develop and agree with NHS England a framework setting out the arrangements for joint working, including details of:

- How the parties will work together to carry out their commissioning functions;
- The duties and responsibilities of the parties;
- How risk will be managed and apportioned between the parties;
- Financial arrangements, including, if applicable, payments towards a pooled fund and management of that fund;
- Contributions from the parties, including details around assets, employees and equipment to be used under the joint working arrangements; and

6.7.7 The liability of the CCG to carry out its functions will not be affected where the CCG enters into arrangements pursuant to paragraph 6.7.2 above.

6.7.8 The CCG will act in accordance with any further guidance issued by NHS England on co-commissioning.

6.7.9 Only arrangements that are safe and in the interests of patients registered with member practices will be approved by the governing body.

6.7.10 The governing body of the CCG shall require, in all joint commissioning arrangements that the Chief Officer of the CCG make a quarterly written report to the governing body and hold at least annual engagement events to review aims, objectives, strategy and progress and publish an annual report on progress made against objectives.

6.7.11 Should a joint commissioning arrangement prove to be unsatisfactory the governing body of the CCG can decide to withdraw from the arrangement, but has to give six months’ notice to partners, with new arrangements starting from the beginning of the next new financial year after the expiration of the six months’ notice period.

6.8 Joint commissioning arrangements with NHS England for the exercise of NHS England’s functions

6.8.1 The CCG may wish to work with NHS England and, where applicable, other CCGs, to exercise specified NHS England functions.

6.8.2 The CCG may enter into arrangements with NHS England and, where applicable, other CCGs to:

- Exercise such functions as specified by NHS England under delegated arrangements;
Jointly exercise such functions as specified with NHS England.

6.8.3 Where arrangements are made for the CCG and, where applicable, other CCGs to exercise functions jointly with NHS England a joint committee or committee(s) in common may be established to exercise the functions in question.

6.8.4 Arrangements made between NHS England and the CCG may be on such terms and conditions (including terms as to payment) as may be agreed between the parties.

6.8.5 For the purposes of the arrangements described at paragraph [3.2] above, NHS England and the CCG may establish and maintain a pooled fund made up of contributions by the parties working together. Any such pooled fund may be used to make payments towards expenditure incurred in the discharge of any of the commissioning functions in respect of which the arrangements are made.

6.8.6 Where the CCG enters into arrangements with NHS England as described at paragraph [3.2] above, the parties will develop and agree a framework setting out the arrangements for joint working, including details of:

- How the parties will work together to carry out their commissioning functions;
- The duties and responsibilities of the parties;
- How risk will be managed and apportioned between the parties;
- Financial arrangements, including payments towards a pooled fund and management of that fund;
- Contributions from the parties, including details around assets, employees and equipment to be used under the joint working arrangements.

6.8.7 The liability of NHS England to carry out its functions will not be affected where it and the CCG enter into arrangements pursuant to paragraph 6.8.2 above.

6.8.8 The CCG will act in accordance with any further guidance issued by NHS England on co-commissioning.

6.8.9 Only arrangements that are safe and in the interests of patients registered with member practices will be approved by the governing body.

6.8.10 The governing body of the CCG shall require, in all joint commissioning arrangements that the Chief Officer of the CCG make a quarterly written report to the governing body and hold at least annual engagement events to review aims, objectives, strategy and progress and publish an annual report on progress made against objectives.

6.8.11 Should a joint commissioning arrangement prove to be unsatisfactory the governing body of the CCG can decide to withdraw from the arrangement, but has to give six months’ notice to partners, with new arrangements starting from the beginning of the next new financial year after the expiration of the six months’ notice period.

Amendment 2
Annex A

Renumber clause 6.6 to 6.9
Renumber clause 6.7 to 6.10

Amendment 3
Insert a new column to the Scheme of Delegation
“Delegated to the primary care commissioning committee”
Insert a new row to the Scheme of Delegation as set out below and tick the column
“Delegated to the primary care commissioning committee”

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<td>Partnership working</td>
<td>• Approval of the arrangements for discharging the CCG’s responsibilities and duties associated with its primary care commissioning functions, including but not limited to promoting the involvement of each patient, patient choice, reducing inequalities, improvement in the quality of services, obtaining appropriate advice and public engagement and consultation.</td>
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<td>Reserved to the membership forum</td>
<td>Reserved to the Clinical Directors Committee</td>
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<tr>
<td>Partnership working</td>
<td>• Approval of the arrangements for discharging the CCG’s responsibilities and duties associated with its primary care commissioning functions, including but not limited to promoting the involvement of each patient, patient choice, reducing inequalities, improvement in the quality of services, obtaining appropriate advice and public engagement and consultation.</td>
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Amendment 4
Insert the words “committees in common” to Clause 6.3.2

6.3.2 When discharging their delegated functions, committees, sub-committees, committees in common and joint committees must also operate in accordance with their approved terms of reference.

Date: 30/01/2015.  Author: Graham Hewett.  Page: 5 of 9
2. Proposed constitutional amendments to change the rule for quoracy in the Governing Body Terms of Reference

Amendment 1
Amend Appendix 3 Standing Orders Clause 3.6.1

3.6 Quorum

3.6.1 The Governing Body will be deemed quorate when a minimum of 7 members, 4 of which must be GP representatives, including the Chair and/or Deputy Chair, is present. A member who is present at the Board but is conflicted out of a particular agenda item will not contribute to the quoracy of the Board for the duration of that agenda item.

To

3.6 Quorum

3.6.1 The Governing Body will be deemed quorate when a minimum of 7 members is present, 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 or Secondary Care Doctor or Registered Nurse). A member who is present at the Board but is conflicted out of a particular agenda item will not contribute to the quoracy of the Board for the duration of that agenda item.
3. **Proposed constitutional amendments to change the Audit Committee Terms of Reference to allow an additional independent lay member with financial and accounting expertise**

**Amendment 1**
Amend clause 6.6.3 (now renumbered as 6.9.3 – assuming the above changes are approved)

**From**

6.9.3  **Committees of the Governing Body** - the Governing Body has appointed the following committees and sub-committees:

a) **Audit Committee** — the Audit Committee is accountable to the Governing Body:

*Function* - it provides the Group’s Governing Body with an independent and objective view of the group’s financial systems, financial information and compliance with laws, regulations and directions governing the group in so far as they relate to finance. The Governing Body has approved and keeps under review the terms of reference for the Audit Committee.

*Terms of Reference* – accessible and available at: [www.lewishamccg.nhs.uk](http://www.lewishamccg.nhs.uk) or on request in writing to: NHS Lewisham, Cantilever House, Eltham Road, London, SE12 8RN

- **Composition** – it comprises the following people:
  - Chair – the lay member (audit, governance [conflicts of interests] and remuneration) of the governing body who was has qualifications, expertise or experience in financial management and audit matters;
  - The lay member of the governing body appointed as lead on patient and public participation matters, Senior Clinical Director with lead for quality,
  - Secondary Care Consultant.
  - Registered Nurse
  - Individuals in attendance but without voting rights may include: the Chief Financial Officer and representatives from internal and external audit services and from the Local Counter Fraud Specialist.

**To**

6.9.3  **Committees of the Governing Body** - the Governing Body has appointed the following committees and sub-committees:

b) **Audit Committee** — the Audit Committee is accountable to the Governing Body:

*Function* - it provides the Group’s Governing Body with an independent and objective view of the group’s financial systems, financial information and compliance with laws, regulations and directions governing the group in so far as they relate to finance. The Governing Body has approved and keeps under review the terms of reference for the Audit Committee.

*Terms of Reference* – accessible and available at: [www.lewishamccg.nhs.uk](http://www.lewishamccg.nhs.uk) or on request in writing to: NHS Lewisham, Cantilever House, Eltham Road, London, SE12 8RN

- **Composition** – it comprises the following people:
  - Chair – the lay member (audit, governance [conflicts of interests] and remuneration) of the governing body who was has qualifications, expertise or experience in financial management and audit matters;
  - The lay member of the governing body appointed as lead on patient and public participation matters, Senior Clinical Director with lead for quality,
  - Secondary Care Consultant.
  - Registered Nurse

Date: 30/01/2015. Author: Graham Hewett. Page: 7 of 9
• The Audit Committee may appoint additional independent members with financial management experience who are not members of the CCG’s Governing Body and who are not employed by an NHS Lewisham CCG Member Practice and who are not employees of the CCG.

• Individuals in attendance but without voting rights may include: the Chief Financial Officer and representatives from internal and external audit services and from the Local Counter Fraud Specialist.
4. Proposed constitutional amendments to remove duplication within the constitution and CCG policy on the management of conflicts of interest

Amendment 1
Delete clause 8.2.2
Delete clause 8.2.3
Delete clause 8.2.4
Delete clause 8.3
Delete clause 8.4
Delete clause 8.5
Delete clause 8.6

Renumber current clause (and sub clauses) 8.7 to 8.3

Amendment 2
Insert new clause at 8.2.2

8.2.2 The Clinical Commissioning Group arrangements for managing conflicts of interest will be set out in policy. The NHS Lewisham CCG Conflict of Interest Policy will be available on the Clinical Commissioning Group’s website at: http://www.lewishamccg.nhs.uk/news-publications/Policies/Pages/default.aspx

5 Other amendments

Amendment 1
Insert the words “section 256” at clause 6.5.2

6.5.2 The group has joint partnership agreements with the following local authority:
a) London Borough of Lewisham (section 75 and section 256) for formalising Joint Commissioning arrangements.

Amendment 2
Appendix 3 Standing Orders Clause 2.1.1 Delete the words “meets monthly” each time they appear in the chart

Appendix 3 Standing Orders Clause 3.1.2 Delete the words “once per month, with” and insert the words “in public.”

From
3.1.2 The CCG Governing Body will meet once per month, with a minimum of six times per annum.
To
3.1.2 The CCG Governing Body will meet in public a minimum of six times per annum.

[Ends.]
## ENCLOSURE 13
NHS Lewisham CCG Conflicts of Interest Policy

<table>
<thead>
<tr>
<th>CLINICAL LEAD:</th>
<th>Dr Marc Rowland</th>
<th>Post Chair</th>
</tr>
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<tbody>
<tr>
<td>MANAGERIAL LEAD:</td>
<td>Susanna Masters</td>
<td>Post Corporate Director</td>
</tr>
<tr>
<td>AUTHOR:</td>
<td>Graham Hewett</td>
<td>Post Head of Integrated Governance</td>
</tr>
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## RECOMMENDATIONS:

The Governing Body is asked to:

1. Note the consultation process that has taken place to strengthen the Conflicts of Interest Policy
2. Approve the new version of the Conflicts of Interest Policy

## Summary:

- New statutory guidance for managing conflicts of interest was issued by NHS England in December 2014.
- The guidance was published to coincide with the moves towards the co-commissioning of primary care but strengthens the management of conflicts of interest and potential conflicts of interest in all the CCG’s areas of work.
- The new Conflict of Interest Policy will have affect as if incorporated into the CCG’s Constitution.

## Key Issues:

1. NHS England issued new Managing Conflicts of Interest: Statutory Guidance for CCGs in December 2014 to coincide and support the moves towards joint and delegated commissioning of Primary Medical Services.
2. As well as establishing policy for the commissioning of Primary Medical Services the new guidance clarifies and strengthens the arrangements in all areas of the CCG’s work.
3. The new guidance is, for the first time, statutory requirements for CCGs.
4. A review of the CCG’s Conflict of Interest Policy found that it was not compliant with the new guidance in a number of areas and therefore has been subject to a major
5. Following legal advice received by NHS Greenwich the clauses within the CCG’s constitution setting out how the CCG will manage conflicts of interest have been removed and this new policy will have affect as if it was incorporated within the constitution.

6. The new policy:
   a. clarifies who should make a declaration of interests, when and how frequently. A new declaration form is included
   b. includes a new requirement for potential bidders for contracts with the CCG to make a declaration of interests
   c. includes a new requirement for applicants to the CCG as an employee or as a member of the Governing Body (and other committees) to make a declaration of interests
   d. clarifies how conflicts of interests should be managed by individuals and when the CCG conducts its business during meetings and in other settings
   e. includes a new process for resolving disputes which will be led by the lay member of the Governing Body with responsibility for governance and ratified by the Governing Body
   f. includes new systems and processes to follow when the CCG is procuring services
   g. requires the CCG to publish a register of all procurement decisions taken and how conflicts of interest have been managed
   h. requires the CCG to publish a register of all contracts entered into including the contract value
   i. clarifies how conflicts of interest should be managed when commissioning Primary Medical Services either jointly with NHS England or under full delegation.
   j. requires the CCG to support member practices publish on their websites the mean net earnings of GPs in their practice (from March 2016)
   k. requires the Chair of the Audit Committee and the Chief Officer to provide direct formal attestation to NHS England that the CCG has complied with NHS England statutory guidance on an annual basis.

7. The draft revised policy has been considered by:
   a. CCG Directors
   b. The lay member of the Governing Body with responsibility for governance
   c. The Membership Forum

CORPORATE AND STRATEGIC OBJECTIVES
Robust governance

CONSULTATION HISTORY INCLUDING MEMBERS ENGAGEMENT:
• Discussed at Membership Forum 11th March 2015

PUBLIC ENGAGEMENT

• A communications programme to explain to the public how conflicts of interest will be managed by the CCG, given its increased responsibilities for commissioning primary care, is being planned with support from HealthWatch Lewisham.

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 Conflict of Interest Policy ensures NHS Lewisham CCG will carry out its business in a culture of openness and transparency, ensuring trust and confidence in the organisation and enabling strategic, planning and commissioning decisions to be made that are in the best interests of all taxpayers and all of the local population.

RESPONSIBLE MANAGERIAL LEAD CONTACT:

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E-Mail: Susanna.masters@nhs.net 020 3049 3237

AUTHOR CONTACT:

Name: Graham Hewett
E-Mail: graham.hewett@nhs.net 020 3049 3352
# Conflicts of Interest Policy

## Document control

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<th>Ratified by:</th>
<th>Name of originator/author:</th>
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<th>Review date:</th>
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<td>Charles Malcolm-Smith, Head of Organisational Development</td>
<td>11th July 2012</td>
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## Change History

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Date: 04/03/2015. Version: 3.4. Author: Charles Malcolm-Smith. – This revision – Graham Hewett Status: Draft. Approvals: none
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Aims of the Conflict of Interest Policy

1. This policy sets out how the CCG will manage conflicts of interest and will have affect as if it was incorporated into the CCG’s constitution.

2. The policy reflects the Nolan seven principles of public life:
   a. Selflessness
   b. Integrity
   c. Objectivity
   d. Accountability
   e. Openness
   f. Honesty
   g. Leadership

3. The Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry 2013 (The Francis Report) recommended that the NHS and all who work for it must adopt and demonstrate a shared culture in which the patient is the priority in everything done. This requires:
   a. “A common set of core values and standards shared throughout the system; … and …
   b. A system which recognises and applies the values of transparency, honesty and candour;”

4. The aims of the Conflicts of Interest Policy are to:
   a. enable the CCG and clinicians in commissioning roles to demonstrate that they are acting fairly and transparently and in the best interest of their patients and local populations;
   b. ensure that the CCG operates within the legal framework, but without being bound by over-prescriptive rules that risk stifling innovation;
   c. safeguard clinically led commissioning, whilst ensuring objective investment decisions;

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d. provide the public, providers, Parliament and regulators with confidence in the probity, integrity and fairness of commissioners’ decisions; and

e. uphold the confidence and trust between patients and GP, in the recognition that individual commissioners want to behave ethically but may need support and training to understand when conflicts (whether actual or potential) may arise and how to manage them if they do.

5. NHS Lewisham CCG will carry out its business in a culture of openness and transparency, ensuring trust and confidence in the organisation and enabling strategic, planning and commissioning decisions to be made that are in the best interests of taxpayers and the local population.

6. Governing Body members, members of the CCG, committee members, subcommittee and working group members and employees of NHS Lewisham Clinical Commission Group will transact the CCG’s business in line with Section 8 (Standards of Business Conduct) of the CCG’s constitution and in line with this policy.

7. Members of the CCG, members of the Governing Body, members of the CCG’s committees or sub-committees or committees or subcommittees of the Governing Body and employees are required to:

   a. Ensure that the interests of patients and members of the public remain paramount at all times

   b. Be impartial and honest in the conduct of their official business

   c. Use public funds entrusted to them to the best advantage of the service, always ensuring value for money

   d. Ensure that they do not abuse their official position for personal gain or to the benefit of their family or friends

   e. Ensure that they do not seek to advantage or further, private or other interests, in the course of their official duties.

   f. Make a declaration of interests and keep this up to date
What are Conflicts of Interest?

8. A conflict of interest occurs where an individual's ability to exercise judgement, or act in a role, is or could be impaired or otherwise influenced by his or her involvement in another role or relationship. The individual does not need to exploit his or her position or obtain an actual benefit, financial or otherwise, for a conflict of interest to occur.

9. “For the purposes of Regulation 6 [National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 20132, a conflict will arise where an individual’s ability to exercise judgement or act in their role in the commissioning of services is impaired or influenced by their interests in the provision of those services.”

10. The Royal College of General Practice and the NHS Confederation and NHS England Guidance identify four types of potential conflict of interest:

   a. direct financial;
   b. indirect financial (for example a spouse has a financial interest in a provider);
   c. non-financial (i.e. reputation) and;
   d. loyalty (i.e. to professional bodies)

11. As well as direct financial interests, conflicts can arise from an indirect financial interest (e.g. payment to a spouse) or a non-financial interest (e.g. reputation). Conflicts of loyalty may arise (e.g. in respect of an organisation of which the individual is a member or with which they have an affiliation). Conflicts can arise from personal or professional relationships with others, e.g. where the role or interest of a family member, friend or acquaintance may influence an individual’s judgement or actions, or could be perceived to do so. Depending upon the individual circumstances, these factors can all give rise to potential or actual conflicts of interest.

12. For a commissioner, a conflict of interest may therefore arise when their judgment as a commissioner could be, or be perceived to be, influenced and impaired by their own concerns and obligations as a provider. It is recognised by the CCG that with its planned increased responsibility for commissioning primary care, a conflict of

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2 Monitor - Substantive guidance on the Procurement, Patient Choice and Competition Regulations (December 2013)
interest may arise more often. In the case of a GP involved in commissioning, an
obvious example is the award of a new contract to a provider in which the individual
GP has a financial stake. However, the same considerations, and the approaches
set out in this guidance, apply when deciding whether to extend a contract
Policy Statement

Legislative Framework

14. The starting point for the CCGs is section 14O of the Act\(^3\). This sets out the minimum requirements in terms of what the CCG must do in terms of managing conflicts of interest.

15. This means that the CCG will:

   a. Maintain appropriate registers of interests;
   
   b. Publish or make arrangements for the public to access those registers;
   
   c. Make arrangements requiring the prompt declaration of interests by the persons specified (members and employees) and ensure that these interests are entered into the relevant register;
   
   d. Make arrangements for managing conflicts and potential conflicts of interest (e.g. developing appropriate policies and procedures); and
   
   e. Have regard to guidance published by NHS England and Monitor in relation to conflicts of interest.

General requirements

16. Where an individual, i.e. members of the CCG, members of the Governing Body, members of the CCG’s committees or sub-committees or committees or sub-committees of the Governing Body or an employee has an interest, or becomes aware of an interest which could lead to a conflict of interests in the event of the CCG considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provisions of this policy.

17. The lay member of the governing body with particular responsibility for governance will make themselves available to provide advice to any individual who believes they have, or may have, a conflict of interest. Support for this role will be provided by the Corporate Director.

18. The CCG will provide clear guidance to members and employees on what might constitute a conflict of interest, providing examples of situations that may arise. Pertinent issues include:

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\(^3\) National Health Service Act (2006) (as amended by the Health and Social Care Act (2012))
a) a perception of wrongdoing, impaired judgement or undue influence can be as detrimental as any of them actually occurring

b) if in doubt, it is better to assume the existence of a conflict of interest and manage it appropriately rather than ignore it; and

c) for a conflict of interest to exist, financial gain is not necessary

Appointing Governing Body or committee members
19. The CCG will consider whether conflicts of interest should exclude individuals from being appointed to the governing body or to a committee or sub-committee of the CCG or governing body. These will be considered on a case-by-case basis with reference to the CCG’s general principles as set out in the CCG’s constitution.

20. The CCG will assess the materiality of the interest, in particular whether the individual (or a family member or business partner) could benefit from any decision the governing body might make. This will be particularly relevant for any profit sharing member of any organisation but should also be considered for all employees and especially those operating at senior or governing body level.

21. The CCG will determine the extent of the interest. If it is related to an area of business significant enough that the individual would be unable to make a full and proper contribution to the governing body, that individual will not become a member of the governing body.

22. Any individual who has a material interest in an organisation which provides, or is likely to provide, substantial services to a CCG (either as a provider of healthcare or commissioning support services) should not be a member of the governing body if the nature of their interest is such that they are likely to need to exclude themselves from decision-making on so regular a basis that it significantly limits their ability to effectively operate as a governing body member.

Declaring and Registering Interests
23. Members of the CCG, members of the Governing Body, members of the CCG’s committees or sub-committees or committees or subcommittees of the Governing Body and employees of NHS Lewisham Clinical Commissioning Group will complete a declaration of interests using the declaration form at Annex A of this policy.
24. Individuals are required to declare any interest that they have, in relation to a decision to be made in the exercise of the commissioning functions of the CCG, in writing to the governing body by completing a declaration of interests form, as soon as they are aware of it and in any event no later than 28 days after becoming aware.

25. The CCG will ensure that, when members declare interests, this includes the interests of all relevant individuals within their own organisations (e.g. partners in a GP practice), who have a relationship with the CCG and who would potentially be in a position to benefit from the CCG’s decisions.

26. When entering an interest on its register of interests, the CCG will ensure that it includes sufficient information about the nature of the interest and the details of those holding the interest.

27. The CCG will ensure that, as a matter of course, declarations of interest are made and regularly confirmed or updated. This includes the following circumstances:

   On appointment:
   a. Applicants for any appointment to the CCG or its governing body will be asked to declare any relevant interests. When an appointment is made, a formal declaration of interests will again be made and recorded.

   At meetings:
   b. All attendees will be asked to declare any interest they have in any agenda item before it is discussed or as soon as it becomes apparent. Even if an interest is declared in the register of interests, it should be declared in meetings where matters relating to that interest are discussed. Declarations of interest will be recorded in minutes of meetings.

   Quarterly:
   c. The CCG will establish systems to satisfy itself on a quarterly basis that the register of interests is accurate and up to date.

   On changing role or responsibility:
   d. Where an individual changes role or responsibility within the CCG or the Governing Body, any change to the individual’s interests should be declared.

   On any other change of circumstances:
e. Wherever an individual’s circumstances change in a way that affects the individual’s interests (e.g. where an individual takes on a new role outside the CCG or sets up a new business or relationship), a further declaration should be made to reflect the change in circumstances. This could involve a conflict of interest ceasing to exist or a new one materialising.

28. In keeping with the regulations, individuals who have a conflict should declare this as soon as they become aware of it, and in any event not later than 28 days after becoming aware.

29. Whenever interests are declared, they should be reported to the person designated with responsibility for the register of interests (the Head of Integrated Governance), who should then update the register accordingly.

30. Where an individual is unable to provide a declaration in writing, for example, if a conflict becomes apparent in the course of a meeting, they will make an oral declaration before witnesses, and provide a written declaration as soon as possible thereafter to the governing body.

31. The Chair of the governing body will take such steps as deemed appropriate, and request information deemed appropriate from individuals, to ensure that all conflicts of interest and potential conflicts of interest are declared.

32. Information provided by Governing Body members, members of the CCG, committee, subcommittee and working group members and employees of NHS Lewisham Clinical Commission Group in their declarations of interests will be processed in accordance with the Data Protection Act (1998) and other relevant legislation. The information provided will not be used for any other purposes than those set out in this policy.

33. The CCG will maintain registers of the interests of:

   a. the members of the CCG;
   b. the members of its governing body;

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4 The members of the group will include member practice’s partners (GPs and others), salaried GPs, and any other employee if they conduct business on behalf of the CCG or who might benefit from the CCG’s decisions.
c. the members of its committees or sub-committees and the committees or sub-committees of its governing body; and

d. its employees.

34. The CCG will update the registers of interests whenever a new or revised interest is declared.

35. The registers will be published on the CCG’s website at www.lewishamccg.nhs.uk or made available upon request in writing to: NHS Lewisham CCG, Cantilever House, Eltham Road, London, SE12 8RN.

36. The register of Governing Body Member’s interests will also be published in the CCG’s Annual Report and Accounts.

Resolving disputes

37. Members of the CCG, members of the Governing Body, members of the CCG’s committees or sub-committees or committees or subcommittees of the Governing Body and employees of NHS Lewisham Clinical Commission Group who dispute that they have a conflict of interest will be invited to discuss the matter with the lay member of the governing body with responsibility for governance.

38. The lay member of the governing body with responsibility for governance will review the case and make recommendations on whether there is a conflict of interest and how it will be managed that will have immediate effect until ratified by the Governing Body.

39. The lay member of the governing body with responsibility for governance will present his/her recommendation at the next meeting of the Governing Body (in private) for agreement. Members of the CCG, members of the Governing Body, members of the CCG’s committees or sub-committees or committees or subcommittees of the Governing Body and employees in dispute will be given an opportunity to present their case to the Governing Body at this same meeting as a form of appeal.

The Governing Body’s decision will be final.
40. Members of the CCG, members of the Governing Body, members of the CCG’s committees or sub-committees or committees or subcommittees of the Governing Body and employees of NHS Lewisham Clinical Commission Group should also refer to their respective professional codes of conduct relating to the declaration of conflicts of interest.

41. The CCG will view instances where this policy is not followed as serious and may take appropriate disciplinary action against individuals, which may result in dismissal.

42. Any disciplinary action will be taken following the policy and procedures set out in the NHS Lewisham CCG Disciplinary Policy and Procedures and the CCG’s Constitution. Where Fraud, Bribery or Corruption is suspected the matter will be passed to the CCG’s Local Counter Fraud Specialist (LCFS) for investigation in line with the NHS Lewisham CCG Policy in relation to Fraud and Fraud Response Plan and the CCG’s Anti-Bribery Policy. This may lead to the individual being prosecuted through the Criminal Courts.

Managing Conflicts of Interest:

43. The following arrangements will be put in place to manage conflicts of interest and potential conflicts of interest in such a way to ensure that the integrity of the CCG’s decision making is not or does not appear to be affected.

44. The Chair of the governing body will ensure that for every interest declared, either in writing or by oral declaration, arrangements are in place to manage the conflict of interests or potential conflict of interests, to ensure the integrity of the CCG’s decision-making processes. Arrangements for the governing body and other committees, sub-committees and working groups are set out below.

45. Where an interest has been declared, either in writing or by oral declaration, the declarer will ensure that before participating in any activity connected with the CCG’s exercise of its commissioning functions, they have received confirmation of the arrangements to manage the conflict of interest or potential conflict of interest from the governing body.

46. Arrangements for the management of conflicts of interest are to be determined by the Chair of the governing body and will include the requirement to put in writing to
the relevant individual arrangements for managing the conflict of interests or potential conflicts of interests, within a week of declaration.

47. The arrangements will confirm the following:

a. when an individual should withdraw from specified activity, on a temporary or permanent basis;

b. monitoring of the specified activity undertaken by the individual, either by a line manager, colleague or other designated individual.

Managing Conflicts of Interest: Governing Body, committees, sub-committees and working groups

48. 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.

49. 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.

50. 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.

51. 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).

52. 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.

53. 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.

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

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

   a. an individual GP or a non-GP partner from a member practice who is not
      conflicted

   b. a member of the Lewisham Health and Wellbeing Board;

   c. If quorum cannot be achieved by a) or b) (above) a member of a governing
      body of another clinical commissioning group.

56. These arrangements will be recorded in the minutes.
Managing Conflicts of Interest: Contractors
57. Anyone seeking information in relation to a procurement process or participating in procurement, or otherwise engaging with the clinical commissioning group in relation to the potential provision of services or facilities to the CCG, will be required to make a declaration of interest using the declaration form for bidders/contractors at Appendix B.

58. Anyone contracted to provide services or facilities directly to the clinical commissioning group will be subject to the same provisions of this policy in relation to managing conflicts of interests. This requirement will be set out in the contract for their services.

Procuring Services – legislative framework
59. The CCG recognises the importance in making decisions about the services it procures in a way that does not call into question the integrity of the procurement decision that has been made. The CCG will procure services in a manner that is equal treatment, non-discriminatory and transparent to all potential providers; follow the three main principles of procurement law.

60. Section 14O of the 2006 Act is supplemented by the procurement specific requirements set out in the National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013. In particular, regulation 6 requires the following:
   a. CCGs must not award a contract for the provision of NHS health care services where conflicts, or potential conflicts, between the interests involved in commissioning such services and the interests involved in providing them affect, or appear to affect, the integrity of the award of that contract; and
   b. The CCG will keep a record of how it managed any such conflict in relation to NHS commissioning contracts it enters into.

The CCG’s Procurement Policy
61. The CCG will publish a Procurement Policy approved by its governing body which will ensure that:
   a. relevant clinicians (not just members of the CCG) and potential providers, together with local members of the public, are engaged in confirming the
design of service specifications will meet patient needs and decision-making processes used to procure services;

b. service redesign and procurement processes are conducted in an open, transparent, non-discriminatory and fair way;

c. commissioners seek, as far as possible, to specify the outcomes that they wish to see delivered through a new service, rather than the process by which these outcomes are to be achieved.

62. The CCG will not award a contract for the provision of NHS health care services where conflicts, or potential conflicts, between the interests involved in commissioning such services and the interests involved in providing them affect, or appear to affect, the integrity of the award of that contract.

63. The CCG will keep a record of how it managed any such conflict in relation to NHS commissioning contracts it enters into. All such records will be published on the CCG’s website.

64. CCGs will ensure it has systems in place for managing conflicts of interest on an ongoing basis, for instance, by monitoring a contract that has been awarded to a provider in which an individual commissioner has a vested interest.

65. The CCG recognises that it is imperative that all CCG staff engaged in any procurement process are fully conversant with and understand the implications of the Bribery Act (2010) to ensure that they maintain professional standards of conduct and ensure that the process is fair, open and transparent, free from any undue influence. We will seek to ensure that through appropriate guidance and training, that staff are familiar and confident in identifying any breaches.

66. Should it become apparent that an individual involved in making a procurement decision was conflicted after a contract has been let; the governing body will review the extent of the conflict and determine whether the contract should be terminated and a new procurement process started.

67. The CCG will follow the guidance from NHS England⁵ “Code of Conduct: Managing conflicts of interests where GP practices are potential providers of CCG-commissioned services” (not including primary medical services – see below) and

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complete the template Annex C when commissioning services where GPs are potential providers. This will include:

a. services that a CCG is proposing to commission through competitive tender where GP practices are likely to bid;

b. services that a CCG is proposing to commission through an Any Qualified Provider' (AQP) approach, where GP practices are likely to be among the qualified providers that offer to provide the service; and

c. services that a CCG is proposing to commission through single tender from GP practices.

68. Use of the template will provide assurance:

a. that the CCG is seeking and encouraging scrutiny of its decision-making process;

b. to Health and Wellbeing Boards, HealthWatch Lewisham and to local communities that the proposed service meets local needs and priorities; it will enable them to raise questions if they have concerns about the approach being taken;

c. to the audit committee and, where necessary, external auditors, that a robust process has been followed in deciding to commission the service, in selecting the appropriate procurement route, and in addressing potential conflicts; and

d. to NHS England

69. Copies of this Procurement Policy will be available on the group’s website at www.lewishamccg.nhs.uk and is also available upon request in writing to: NHS Lewisham CCG, Cantilever House, Eltham Road, London, SE12 8RN.

Commissioning and Procuring Primary Medical Care Services

70. If or when the CCG seeks to take on delegated or joint commissioning responsibilities for commissioning and procuring Primary Medical Services the Audit Committee Chair and the Chief Officer will provide direct formal attestation to NHS England that the CCG has complied with NHS England statutory guidance on

\[\text{NHS England Managing Conflicts of Interest: Statutory guidance for CCGs (December 2014)}\]
managing conflicts of interest. Subsequently, this attestation will form part of an annual certification as required by NHS England.

71. Procurement decisions related to the commissioning of primary medical services will be made by a committee of the CCG’s Governing Body.

72. The committee of the Governing Body responsible for primary care commissioning will be constituted to ensure that lay and executive members hold the majority. These arrangements will be set out in the Committee’s terms of reference and will be approved by the Governing Body.

73. The committee of the Governing Body responsible for primary care commissioning will meet in public and HealthWatch Lewisham and a representative from the Lewisham Health and Well-Being Board will be invited to attend.

74. As a general rule, meetings of these committees, including the decision making and the deliberations leading up to the decision, should be held in public (unless the CCG has concluded it is appropriate to exclude the public).

75. The committee of the Governing Body responsible for primary care commissioning will ensure that from March 2016 GP member practices publish on their websites the mean net earnings of GPs in their practice.

76. The arrangements for primary medical care decision making do not preclude GP participation in strategic discussions on primary care issues, subject to appropriate management of conflicts of interest. They apply to decision-making on procurement issues and the deliberations leading up to the decision.

Register of Procurement Decisions

77. The CCG will maintain a record of all procurement decisions taken, which will include:

a. The details of the decision

b. Who was involved in making the decision

c. A summary of any conflicts in relation to the decision and how this was managed
78. The Register of Procurement Decisions will be updated whenever a procurement decision is taken and will be published on the CCG’s website at www.lewishamccg.nhs.uk and is also available upon request in writing to: NHS Lewisham CCG, Cantilever House, Eltham Road, London, SE12 8RN.

79. The Register of Procurement Decisions will be included in the CCG’s Annual Report and Accounts

Register of Contracts

80. The CCG will keep a Register of Contracts entered into, including the contract value, which will be updated whenever a new contract is entered into.

81. The Register of Contracts will be published on the CCG’s website at www.lewishamccg.nhs.uk and is also available upon request in writing to: NHS Lewisham CCG, Cantilever House, Eltham Road, London, SE12 8RN.

82. The Register of Contracts will be included in the CCG’s Annual Report and Accounts

Commissioning and Procurement Support

83. The CCG will assure itself that all of its providers of commissioning support services have robust business practices that enable the CCG to meet its statutory duties and policy commitments in relation to procurement including the management of conflicts of interests.

84. The CCG will seek assurance of the robustness of its commissioning support services providers’ business practices through its contract monitoring processes.

Scope

85. This policy applies to all members of the CCG, members of the Governing Body, members of the CCG’s committees or sub-committees or committees or subcommittees of the Governing Body and employees of NHS Lewisham CCG.

Responsibilities
86. Individuals including employees

a. The primary responsibility for declaring and guarding against conflicts of interests lies with individual members of the CCG, members of the Governing Body, members of the CCG’s committees or sub-committees or committees or subcommittees of the Governing Body and employees.

b. Members of the CCG, members of the Governing Body, members of the CCG’s committees or sub-committees or committees or subcommittees of the Governing Body and employees:
   
   i. will familiarise themselves with this policy and comply with the provisions set out in it.
   
   ii. will take proactive action to seek advice if there is any doubt about whether to include any information in the Register of Interests and or how to manage a potential conflict of interest.

c. In any transaction undertaken in support of the clinical commissioning group’s exercise of its commissioning functions (including conversations between two or more individuals, e-mails, correspondence and other communications), individuals must ensure, where they are aware of an interest that they conform to the arrangements confirmed for the management of that interest. Where an individual has not had confirmation of arrangements for managing the interest, they must declare their interest at the earliest possible opportunity in the course of that transaction, and declare that interest as soon as possible thereafter. The individual must also inform either their line manager (in the case of employees), or the governing body, of the transaction.

87. Governing Body

a. It is the responsibility of the Governing Body to ensure that the register of interests is reviewed regularly, and updated as necessary; and to ensure that all conflicts of interest or potential conflicts of interest are declared.

b. It is the responsibility of the Governing Body to ensure that for every interest declared, either in writing or by oral declaration, arrangements are in place to manage the conflict of interests or potential conflict of interests.

c. It is the responsibility of the Governing Body to determine arrangements for the management of conflicts of interest including to put in writing to the relevant individual arrangements for managing the conflict of interests or...
potential conflicts of interests, within a week of declaration. The arrangements will confirm the following

i. when an individual should withdraw from specified activity, on a temporary or permanent basis

ii. monitoring of the specified activity undertaken by the individual, either by a line manager, colleague or other designated individual

88. Chair of the Governing Body, chairs of the CCG’s committees or sub-committees or committees or subcommittees of the Governing Body (chairs of meetings)

a. It is the responsibility of the chairs of meetings to ensure that the Register of Interests is reviewed at the start of every meeting and updated as necessary

b. It is the responsibility of the chairs of meetings to take such steps as deemed appropriate, and request information deemed appropriate from individuals, to ensure that all conflicts of interest and potential conflicts of interest are declared.

89. Chief Officer

a. The Chief Officer has overall responsibility for ensuring NHS Lewisham CCG has appropriate governance policies and procedures in place to ensure the CCG works to best practice and complies with all relevant legislation.

90. Lay Member for Governance

a. The lay member with responsibility for governance is responsible for reviewing the Register of Interests against the agenda for the Governing Body meetings.

b. The lay member with responsibility for governance will review the Register of Interests against the agenda for all other committees and working groups supported by the corporate governance team.

c. The lay member will make himself/herself available to provide advice to any individual who believes they have, or may have, a conflict of interest.

d. The lay member will develop a body of ‘case law’ as a source of guidance, which may be reviewed, when providing advice.
e. The lay member (with the support of an appropriate director) will review cases where an individual disputes that they have a conflict of interest and will make a recommendation to be approved by the Governing Body.

91. Directors

a. The Corporate Director is responsible for ensuring NHS Lewisham CCG applies the principles of this policy and that there are suitable resources to support its implementation.

b. The Chief Financial Officer is responsible for seeking assurance that all of its providers of commissioning support services have robust business practices that enable the CCG to meet its statutory duties and policy commitments in relation to procurement including the management of conflicts of interests.

c. The Corporate Director is normally responsible for reviewing register entries on a regular basis and taking any action necessary as highlighted by the review.

d. The Corporate Director is responsible for reviewing any suspected and actual breaches of the policy and for reporting lessons learned to the lay member of the governing body with responsibility for governance and to the audit committee.

92. Commissioning Director

a. The Commissioning Director will ensure that the Register of Contracts and the register of Procurement Decisions are published on the CCG’s website and are available to view on request.

93. Head of Integrated Governance supported by the Corporate Governance Team

a. The Head of Integrated Governance is responsible for maintaining the Registers of Interests and ensuring this is produced for the chairs of meetings at every Governing Body and Committee Meeting.

b. The Head of Integrated Governance will ensure that the Register of Interests is a standard agenda item for all committee, sub-committee and working group meetings.
c. In the event of withdrawal of a conflicted member, the Head of Integrated Governance will ensure that the chairs of meetings are supported and advised to monitor quorum appropriately.

d. The Head of Integrated Governance will hold details of each query in regard to conflicts of interests to provide an audit trail on each query and the action taken. These records may be used, in liaison with the lay member with responsibility for governance, to compile a body of “case law” for use by the Governing Body lay member when providing advice.

e. The Head of Integrated Governance will ensure that the Registers of Interests are published on the CCG’s website or made available to the public on request.

f. The Head of Integrated Governance will ensure that refresher training is provided for all Governing Body members, members of the CCG, committee, subcommittee and working group members and employees on an annual basis.

Implementation Plan

94. Newly appointed employees, members of the CCG, Governing Body members, committee, subcommittee and working group members will be advised of this policy and supported to make a declaration of interests as part of their formal induction.

95. When recruiting new employees, members of the CCG, Governing Body members, committee, subcommittee and working group members a declaration of interests will be requested from all the candidates.

96. NHS Lewisham CCG will ensure that all members of the CCG, members of the Governing Body, members of the CCG’s committees or sub-committees or committees or subcommittees of the Governing Body and employees are aware of the existence of this policy. The following will be undertaken to ensure awareness:

a. Annual reminder of the existence and importance of the policy via internal communication methods.

b. Quarterly reminder to update declaration forms sent to all members of the CCG, members of the Governing Body, members of the CCG’s committees or sub-committees or committees or subcommittees of the Governing Body and employees.
c. Refresher training will be provided for all members of the CCG, members of the Governing Body, members of the CCG’s committees or sub-committees or committees or subcommittees of the Governing Body and employees members on an annual basis.

Monitoring Compliance and Effectiveness of the Policy

97. The implementation of the policy will be reviewed annually by the Governing Body.

98. The Audit Committee will scrutinise the systems and processes for managing conflicts of interest.

99. The Corporate Director will review register entries on a regular basis and take any action necessary as highlighted by the review.

100. An appropriate Director will review any suspected and actual breaches of the policy and will report lessons learned to the lay member of the governing body with responsibility for conflicts of interests and to the audit committee.

Definition of terms

101. “Relevant and material interests” are defined as:
   a. Roles and responsibilities held within member practices
   b. Directorships, including non-executive directorships held in private companies or public limited companies (with the exception of those of dormant companies)
   c. Ownership or part ownership of companies, businesses or consultancies which may seek to do business with the CCG
   d. Any shareholdings of companies in the field of health and social care;
   e. Membership of or a position of authority or trust in an organisation (eg, charity, professional body or voluntary organisation) in the field of health and social care;
f. Any connection with a voluntary or other organisation contracting for NHS services

g. Research funding/grants that may be received by the individual or any organisation they have an interest or role in

h. Interests in pooled funds that are under separate management (any relevant company included in this fund that has a potential relationship with the CCG must be declared)

i. Formal interest with a position of influence in a political party or organisation

j. Current contracts with NHS England/NHS Lewisham CCG in which the individual has a beneficial interest

k. Any other employment, business involvement or relationship or those of a spouse or partner that conflicts, or may potentially conflict with the interests of NHS Lewisham CCG.

l. Personal healthcare needs or those of a spouse or partner that conflicts, or may potentially conflict with the interests of NHS Lewisham CCG.

m. Media appearances where members appear in the capacity of a health professional.

Other Related Policies and Guidance

a) NHS Lewisham CCG Constitution

b) NHS Lewisham CCG Procurement Policy

c) NHS Lewisham CCG Gifts and Hospitality Policy

d) NHS Lewisham CCG Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions

e) NHS England Managing Conflicts of Interest: Statutory guidance for CCGs (December 2014)

f) NHS England Code of Conduct: Managing conflicts of interests where GP practices are potential providers of CCG-commissioned services (October 2012)

g) National Health Service Act (2006) (as amended by the Health and Social Care Act (2012))
h) National Health Service (Procurement, Patient Choice and Competition) (No 2) Regulations 2013.

i) Monitor – Substantive guidance on the Procurement, Patient Choice and Competition Regulations (December 2013)

j) NHS Clinical Commissioners, Royal College of General Practitioners and British Medical Association – Shared principles on conflicts of interests when CCGs are commissioning from member practices


m) The Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry 2013

n) General Medical Council (2006) Good Medical Practice

o) NHS Lewisham CCG Disciplinary Policy and Procedures

p) NHS Lewisham CCG Policy in relation to fraud and Fraud Response Plan

q) NHS Lewisham CCG Anti-Bribery Policy
Annex A: Declaration of interests for members / employees template

NHS Lewisham Clinical Commissioning Group
Member / employee/ governing body member / committee or sub-committee member (including committees and sub-committees of the governing body) [delete as appropriate] declaration form: financial and other interests

This form is required to be completed in accordance with the CCG’s Constitution and section 14O of The National Health Service Act 2006, the NHS (Procurement, Patient Choice and Competition) regulations 2013 and the Substantive guidance on the Procurement, Patient Choice and Competition Regulations

Notes:

- Each CCG must make arrangements to ensure that the persons mentioned above declare any interest which may lead to a conflict with the interests of the CCG and/or NHS England and the public for whom they commission services in relation to a decision to be made by the CCG and/or NHS England or which may affect or appear to affect the integrity of the award of any contract by the CCG and/or NHS England.

- A declaration must be made of any interest likely to lead to a conflict or potential conflict as soon as the individual becomes aware of it, and within 28 days.

- If any assistance is required in order to complete this form, then the individual should contact [specify].

- The completed form should be sent by both email and signed hard copy to [specify].

- Any changes to interests declared must also be registered within 28 days by completing and submitting a new declaration form.

- The register will be published [specify how, or how otherwise made available to the public and whether there will be any circumstances where information will be redacted].

- Any individual – and in particular members and employees of the CCG and/or NHS England- must provide sufficient detail of the interest, and the potential for conflict with the interests of the CCG and/or NHS England and the public for whom they commission services, to enable a lay person to understand the implications and why the interest needs to be registered.

Date: 07/10/2014. Author: Graham Hewett. Page: 1 of 10
If there is any doubt as to whether or not a conflict of interests could arise, a declaration of the interest must be made.

Interests that must be declared (whether such interests are those of the individual themselves or of a family member, close friend or other acquaintance of the individual) include:

- roles and responsibilities held within member practices;
- directorships, including non-executive directorships, held in private companies or PLCs;
- ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the CCG and/or with NHS England
- shareholdings (more than 5%) of companies in the field of health and social care;
- a position of authority in an organisation (e.g. charity or voluntary organisation) in the field of health and social care;
- any connection with a voluntary or other organisation (public or private) contracting for NHS services;
- research funding/grants that may be received by the individual or any organisation in which they have an interest or role;
- any other role or relationship which the public could perceive would impair or otherwise influence the individual’s judgment or actions in their role within the CCG.

If there is any doubt as to whether or not an interest is relevant, a declaration of the interest must be made.
## Declaration

| Name: | 
| --- | --- |
| **Position within or relationship with, the CCG or NHS England:** | 

### Interests

<table>
<thead>
<tr>
<th>Type of Interest</th>
<th>Details</th>
<th>Personal interest or that of a family member, close friend or other acquaintance?</th>
</tr>
</thead>
</table>

#### Roles and responsibilities held within member practices

#### Directorships, including non-executive directorships, held in private companies or PLCs

#### Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the CCG and/or with NHS England

#### Shareholdings (more than 5%) of companies in the field of health and social care

#### Positions of authority in an organisation (e.g. charity or voluntary)

**Date:** 07/10/2014  
**Author:** Graham Hewett
<table>
<thead>
<tr>
<th>Organisation in the field of health and social care</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Any connection with a voluntary or other organisation contracting for NHS services</td>
<td></td>
</tr>
<tr>
<td>Research funding/grants that may be received by the individual or any organisation they have an interest or role in</td>
<td></td>
</tr>
<tr>
<td>[Other specific interests?]</td>
<td></td>
</tr>
<tr>
<td>Any other role or relationship which the public could perceive would impair or otherwise influence the individual’s judgment or actions in their role within the CCG and/or with NHS England.</td>
<td></td>
</tr>
</tbody>
</table>

To the best of my knowledge and belief, the above information is complete and correct. I undertake to update as necessary the information provided and to review the accuracy of the information provided regularly and no longer than annually. I give my consent for the information to be used for the purposes described in the CCG’s Constitution and published accordingly.

Signed:

Date: 07/10/2014. Author: Graham Hewett. Page: 4 of 10
Annex B: Declaration of conflict of interests for bidders/contractors template

NHS Lewisham Clinical Commissioning Group
Bidders/potential contractors/service providers declaration form: financial and other interests

This form is required to be completed in accordance with the CCG’s Constitution, and s140 of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) and the NHS (Procurement, Patient Choice and Competition) (No2) Regulations 2013 and related guidance

Notes:

• All potential bidders/contractors/service providers, including sub-contractors, members of a consortium, advisers or other associated parties (Relevant Organisation) are required to identify any potential conflicts of interest that could arise if the Relevant Organisation were to take part in any procurement process and/or provide services under, or otherwise enter into any contract with, the CCG, or with NHS England in circumstances where the CCG is jointly commissioning the service with, or acting under a delegation from, NHS England. If any assistance is required in order to complete this form, then the Relevant Organisation should contact [specify].

• The completed form should be sent to [specify].

• Any changes to interests declared either during the procurement process or during the term of any contract subsequently entered into by the Relevant Organisation and the CCG must notified to the CCG by completing a new declaration form and submitting it to [specify].

• Relevant Organisations completing this declaration form must provide sufficient detail of each interest so that the CCG, NHS England and also a member of the public would be able to understand clearly the sort of financial or other interest the person concerned has and the circumstances in which a conflict of interest with the business or running of the CCG or NHS England (including the award of a contract) might arise.

• If in doubt as to whether a conflict of interests could arise, a declaration of the interest should be made.

Interests that must be declared (whether such interests are those of the Relevant Person themselves or of a family member, close friend or other acquaintance of the Relevant Person), include the following:

Date: 07/10/2014. Author: Graham Hewett. Page: 5 of 10
• the Relevant Organisation or any person employed or engaged by or otherwise connected with a Relevant Organisation (Relevant Person) has provided or is providing services or other work for the CCG or NHS England;

• a Relevant Organisation or Relevant Person is providing services or other work for any other potential bidder in respect of this project or procurement process;

• the Relevant Organisation or any Relevant Person has any other connection with the CCG or NHS England, whether personal or professional, which the public could perceive may impair or otherwise influence the CCG’s or any of its members’ or employees’ judgements, decisions or actions.
### Declarations

<table>
<thead>
<tr>
<th>Name of Relevant Organisation:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Interests</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of Interest</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provision of services or other work for the CCG or NHS England</td>
<td></td>
</tr>
<tr>
<td>Provision of services or other work for any other potential bidder in respect of this project or procurement process</td>
<td></td>
</tr>
<tr>
<td>Any other connection with the CCG or NHS England, whether personal or professional, which the public could perceive may impair or otherwise influence the CCG’s or any of its members’ or employees’ judgements, decisions or actions</td>
<td></td>
</tr>
</tbody>
</table>

**Date:** 07/10/2014.  **Author:** Graham Hewett.  **Page:** 7 of 10
<table>
<thead>
<tr>
<th>Name of Relevant Person</th>
<th>(Complete for all Relevant Persons)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Interests</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Type of Interest</strong></td>
<td><strong>Details</strong></td>
</tr>
<tr>
<td>Provision of services or other work for the CCG or NHS England</td>
<td></td>
</tr>
<tr>
<td>Provision of services or other work for any other potential bidder in respect of this project or procurement process</td>
<td></td>
</tr>
<tr>
<td>Any other connection with the CCG or NHS England, whether personal or professional, which the public could perceive may impair or otherwise influence the CCG’s or any of its members’ or employees’ judgements, decisions or actions</td>
<td></td>
</tr>
</tbody>
</table>

To the best of my knowledge and belief, the above information is complete and correct. I undertake to update as necessary the information.

Signed:

On behalf of:

Date:

Date: 07/10/2014. Author: Graham Hewett. Page: 8 of 10
### ANNEX C

**TEMPLATE**

TO BE USED WHEN COMMISSIONING SERVICES FROM GP PRACTICES, INCLUDING PROVIDER CONSORTIA, OR ORGANISATIONS IN WHICH GPS HAVE A FINANCIAL INTEREST

### NHS Lewisham

**Clinical Commissioning Group**

<table>
<thead>
<tr>
<th>Service:</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Question</th>
<th>Comment/Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Questions for all three procurement routes</strong></td>
<td></td>
</tr>
<tr>
<td>How does the proposal deliver good or improved outcomes and value for money – what are the estimated costs and the estimated benefits? How does it reflect the CCG’s proposed commissioning priorities?</td>
<td></td>
</tr>
<tr>
<td>How have you involved the public in the decision to commission this service?</td>
<td></td>
</tr>
<tr>
<td>What range of health professionals have been involved in designing the proposed service?</td>
<td></td>
</tr>
<tr>
<td>What range of potential providers have been involved in considering the proposals?</td>
<td></td>
</tr>
<tr>
<td>How have you involved your Health and Wellbeing Board(s)? How does the proposal support the priorities in the relevant joint health and wellbeing strategy (or strategies)?</td>
<td></td>
</tr>
<tr>
<td>What are the proposals for monitoring the quality of the service?</td>
<td></td>
</tr>
<tr>
<td>What systems will there be to monitor and publish data on referral patterns?</td>
<td></td>
</tr>
<tr>
<td>Have all conflicts and potential conflicts of interests been appropriately declared and entered in registers which are publicly available?</td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Answer</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>Why have you chosen this procurement route?</td>
<td></td>
</tr>
<tr>
<td>What additional external involvement will there be in scrutinising the proposed decisions?</td>
<td></td>
</tr>
<tr>
<td>How will the CCG make its final commissioning decision in ways that preserve the integrity of the decision-making process?</td>
<td></td>
</tr>
<tr>
<td>Additional question for AQP or single tender (for services where national tariffs do not apply)</td>
<td></td>
</tr>
<tr>
<td>How have you determined a fair price for the service?</td>
<td></td>
</tr>
<tr>
<td>Additional questions for AQP only (where GP practices are likely to be qualified providers)</td>
<td></td>
</tr>
<tr>
<td>How will you ensure that patients are aware of the full range of qualified providers from whom they can choose?</td>
<td></td>
</tr>
<tr>
<td>Additional questions for single tenders from GP providers</td>
<td></td>
</tr>
<tr>
<td>What steps have been taken to demonstrate that there are no other providers that could deliver this service?</td>
<td></td>
</tr>
<tr>
<td>In what ways does the proposed service go above and beyond what GP practices should be expected to provide under the GP contract?</td>
<td></td>
</tr>
<tr>
<td>What assurances will there be that a GP practice is providing high-quality services under the GP contract before it has the opportunity to provide any new services?</td>
<td></td>
</tr>
</tbody>
</table>

1 Taking into account all relevant regulations (e.g. the NHS (Procurement, patient choice and competition) (No 2) Regulations 2013 and guidance (e.g. that of Monitor).
ENCLOSURE 14

CCG’s OPERATING PLAN 2015/16

LEAD: Martin Wilkinson  
Post: Chief Officer

MANAGERIAL LEAD: Susanna Masters  
Post: Corporate Director
Tony Read  
Chief Finance Officer

AUTHOR: Susanna Masters  
Post: Corporate Director

RECOMMENDATIONS:

The Governing Body is asked to:

- note the national planning guidance, revised timetable and updates which are informing the CCG’s Operating Plan 2015/16
- agree to delegate to the Delivery Committee the responsibility to sign off the submission on 7th April 2015 of the CCG Operating Plan to NHS England
- endorse the approach to complete the CCG’s Operating Plan for 2015/16
- endorse the proposed corporate objectives and the high level priority actions for 2015/16

SUMMARY

This report summarises the national guidance for the CCG’s Operating Plan and sets out the approach, local timetable and governance arrangements to develop and agree Lewisham CCG’s Operating Plan and Corporate Objectives for 2015/16.

1. Background

1.1 NHS England’s Operating Plan requirements for 2015/16

All CCGs are required to update the second year of their current Operating plan for 2014/15 and 2015/16. CCGs also are required to ensure that their Operating Plan is informed by national planning guidance and financial parameters, as well as local priorities.

This year the national planning guidance is set out in the ‘Forward view into action: Planning for 2015/16’ issued in December 2014. The link to the annual planning guidance for 2015/16 and CCG allocations can be found at: http://www.england.nhs.uk/2014/12/19/forward-view/
The key national planning requirements are to:

- Refresh Operational Plans for 2015/16 - one year only
- Deliver the NHS Constitutional Standards
- Focus on prevention of ill-health, empowering patients and engaging communities - all essential components of creating a sustainable NHS
- Accelerate the design of local sustainable solutions which are local sustainability using different models of care – multispéciality community providers (MCPs) and integrated primary and acute systems (PACS):
- Ensure patients receive high quality, timely care today - especially patient safety related to tackling sepsis and acute kidney injury, improving antibiotic prescribing in primary and secondary care and meeting the clinical standards for seven day working
- Achieve parity for mental health (with new access targets)
- Transform the care of people with learning disabilities

From a financial perspective the key aspects to note are:

- Revised allocation of an extra £1.83bn to NHS England, with a further reallocation of £150m from NHS England resources; total new money available nationally of £1.98bn
- Specific funding:
  - to improve access to general practice
  - to fund the infrastructure; to support the creation of new care
- Mental health investment for Improving Access to Psychological Therapies (IAPT) and liaison psychiatry
- No additional funding for resilience or performance in year

1.2 National Issues

There have been a number of difficulties in taking forward this year’s Operating Plan on a national basis:

- **National Tariff** - the outcome of the consultation on the National tariff payment system 2015/16 concluded that as ‘75% of relevant providers, by share of supply, objected to the proposed method for determining national prices for NHS services the National Tariff cannot be introduced in its current form at this stage and its implementation will be delayed’. NHS England and Monitor have proposed alternative tariff options for providers to choose from – the Enhanced Tariff Option and the Default Tariff Rollover. Providers and commissioners are assessing the potential financial implications of these different options.

- **2015/16 NHS Standard Contract** and associated documentation including CQUINs, sanctions and Quality Premiums - was planned to be available in January. The NHS England website states it will be available from March 2015.

- **Transfer of Specialised Services** – following the consultation on the transfer of
specialist services, NHS England has concluded that a transfer date of 1 April 2015 is not feasible for a safe and effective transfer of commissioning responsibilities for renal dialysis and morbid obesity surgery services to the CCGs, due to widespread concern. It is now planned that the transfer of morbid obesity surgery services will be postponed until April 2016 and the transfer of renal dialysis services will be further considered.

1.3 National Operating Plan Timetable

CCGs has been advised by NHS England that work is being undertaken to revise the national planning and contracting timetable to ensure commissioners and providers have sufficient time to reflect decisions on the tariff options for 2015/16 in their planning processes. We are expecting the revised joint planning timetable, shown below, to be formally confirmed imminently in the CCG bulletin.

<table>
<thead>
<tr>
<th>National Timetable item (applicable to all bodies unless specifically referenced)</th>
<th>Original timetable</th>
<th>Revised timetable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contract negotiations</td>
<td>Jan – 11 Mar</td>
<td>Jan – 31 Mar</td>
</tr>
<tr>
<td>Contract tracker to be submitted each Thursday</td>
<td>From 29 Jan</td>
<td>From 29 Jan</td>
</tr>
<tr>
<td>Submission of draft activity plan data (NHS Trusts, NHS FTs (except distressed NHS FTs))</td>
<td>n/a</td>
<td>27 Feb</td>
</tr>
<tr>
<td>Submission of draft finance and activity plan data (CCGs, NHS England and distressed NHS FTs)</td>
<td>n/a</td>
<td>27 Feb</td>
</tr>
<tr>
<td>Confirmation by providers of chosen tariff option - ETO or DTR</td>
<td>n/a</td>
<td>4 Mar, 6pm</td>
</tr>
<tr>
<td>Checkpoint for progress with planning measures and trajectories (CCGs, NHS England)</td>
<td>13 Feb</td>
<td>20 Mar</td>
</tr>
<tr>
<td>National contract stocktake – to check the status of contracts</td>
<td>20 Feb</td>
<td>27 Mar</td>
</tr>
<tr>
<td>Contract Signature Deadline</td>
<td>11 Mar</td>
<td>31 Mar</td>
</tr>
<tr>
<td>Full commissioner plans approved by Governing Bodies of CCGs</td>
<td>n/a</td>
<td>By 31 Mar</td>
</tr>
<tr>
<td>Draft plans approved by NHS Trusts and NHS FTs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-contract signature deadline: where contracts not signed, local decisions to enter mediation*</td>
<td>25 Feb</td>
<td>1 Apr</td>
</tr>
<tr>
<td>Submission of full commissioner plans (CCGs, NHS England)</td>
<td>27 Feb, noon</td>
<td>7 Apr, (noon</td>
</tr>
<tr>
<td>Submission of draft plans (NHS Trusts &amp; NHS FTs)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assurance of most recent plan submissions by national bodies</td>
<td>27 Feb – 30 Mar</td>
<td>7 Apr – 13 May</td>
</tr>
<tr>
<td>Event Description</td>
<td>Date Range</td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------</td>
<td></td>
</tr>
<tr>
<td>Checkpoint for progress with planning measures and trajectories (CCGs, NHS England)</td>
<td>6 Mar – 14 Apr</td>
<td></td>
</tr>
<tr>
<td>Contracts signed post-mediation</td>
<td>11 Mar, noon – 17 Apr, noon</td>
<td></td>
</tr>
<tr>
<td>Entry into arbitration where contracts not signed; and submission of Dispute Resolution Process paperwork*</td>
<td>11 Mar, noon – 17 Apr, noon</td>
<td></td>
</tr>
<tr>
<td>Contract arbitration panels and / or hearings*</td>
<td>13 – 24 Mar – 20 – 29 Apr</td>
<td></td>
</tr>
<tr>
<td>Arbitration outcomes notified to commissioners and providers*</td>
<td>By 25 Mar – By 30 Apr</td>
<td></td>
</tr>
<tr>
<td>Plans approved by Boards of NHS Trusts and FTs</td>
<td>By 31 Mar – By early May</td>
<td></td>
</tr>
<tr>
<td>Contract and schedule revisions reflecting arbitration findings completed and signed by both parties*</td>
<td>By 31 Mar – By 7 May</td>
<td></td>
</tr>
<tr>
<td>Submission of final plans (NHS Trusts &amp; FTs) Commissioner plan refresh if required (CCGs and NHS England)</td>
<td>10 Apr, noon – 14 May, noon</td>
<td></td>
</tr>
<tr>
<td>Assurance and reconciliation of operational plans</td>
<td>From 10 Apr – From 14 May</td>
<td></td>
</tr>
</tbody>
</table>

*The dispute resolution process is non-mandatory for FTs

The Governing Body is asked to note the above national planning guidance, revised timetable and updates which are informing the CCG’s Operating Plan for 2015/16.

2. Lewisham CCG’s Operating Plan 2015/16

2.1 Lewisham CCG’s governance arrangements

The Governing Body agreed at its meeting on 8th January 2015 that the Delivery Committee would oversee the coordination of the Operating Plan.

The Governing Body is asked to delegate to the Delivery Committee the responsibility to sign off the Operating Plans submission on 7th April 2015 to NHS England at its next meeting on 26th March 2015.

It is planned that the Governing Body will agree the final Operating Plan at its next meeting on 14th May, in line with the revised national planning timetable.

The Governing Body is asked to agree to delegate to the Delivery Committee the responsibility to sign off the submission on 7th April 2015 of the CCG Operating Plan to NHS England.

2.2 Lewisham CCG’s approach to developing the Operating Plan

The CCG’s approach to developing the 2015/16 Operating plan has been to refresh last year’s Operating Plan by reviewing the delivery of our Corporate Objectives for 2014/15 and
reflecting on the public feedback to our consultation on the Joint Commissioning Intentions for Integrated Care. Using this approach the key priority actions to be delivered during 2015/16 have been identified.

The CCG submitted initial draft performance trajectories on 28th January 2015 and draft performance measures and trajectories on 13th February 2015 in line with NHS England’s requirements.

More detailed information was submitted on 27th February, using national templates on activity, finance and performance projections, including a focus on dementia and IAPT targets. Also a draft narrative was submitted summarising the process of developing Lewisham CCG’s Operating Plan. A summary of proposed trajectories, key exceptions and recovery actions for 2015-16 is summarised in the Integrated Performance Report under the relevant NHS Constitutional standard.

It is planned that we publish our Operating Plan 2015/16, following final consideration and agreement by the Governing Body at its next meeting in May 2015.

The Governing Body are asked to endorse the approach to complete the CCG’s Operating Plan for 2015/16

2.3 Lewisham CCG’s approach to developing the Corporate Objectives

Work has been undertaken to refresh the five corporate objectives for 2015/16 and to identify the priority actions required to deliver this objective, the outputs, the measures to use to monitor and the associated risk. This collective work was presented at the Governing Body’s workshop on 5th February, discussed and challenged.

The Governing Body’s workshop concluded that further work was required to:

- Improve the description of the priority actions so that they are SMART
- Ensure success criteria measures are clear – including how progress will be monitored in year
- Develop investment plans to support the implementation of some priorities for action
- Align CCG’s capacity and capabilities to deliver the priorities for action

A summary of the draft Corporate Objectives and high level priority actions are shown at Appendix 1 – 5. It should be noted that at present the priority actions for Equalities are included within the Governance objective which is being considered further.

The Governing Body recognised specifically that further joint work with partners was required to be clearer of the vision and road map to deliver the local neighbourhood networks. Given this involves further collaborative work and is interdependent with the work being undertaken to support local providers, to determine the most appropriate delivery model of care, a longer timescale will be required to finalise these objectives.

The corporate objectives will be used to inform staff objective setting during April and May
2015, in line with the CCG’s staff appraisal process.

The Governing Body is asked to endorse the proposed corporate objectives and the high level priority actions for 2015/16

**APPENDICES**

Appendix 1 - Quality  
Appendix 2 - Governance  
Appendix 3 - Public Engagement  
Appendix 4 - Primary Care  
Appendix 5 - Neighbourhood care networks

**CORPORATE AND STRATEGIC OBJECTIVES**

The development of the Operating Plan will be informed by the CCG’s strategic objectives and Joint Commissioning Intentions for Integrated Care.

The Operating Plan for 2015/16 will be the basis of the Corporate Objectives for 2015/16

**CONSULTATION HISTORY:**

**Membership Forum on 11th February 2015** – summary presentation of the emerging priorities for action for 2015/16, focusing on the developmental corporate objectives, for members consideration.

**Governing Body Workshop on 5th February 2015** - a presentation and discussion of the collective work which had been undertaken to refresh the corporate objectives and to identify the priority actions for 2015/16.

**Delivery Committee meeting on 22nd January 2015** - noted the national planning guidance and timetable for CCGs Operating Plan 2015/16; supported the recommendation that the Governing Body delegates to the Delivery Committee the responsibility to sign off the full draft CCG’s Operating Plan and the final submission to NHS England; agreed that Chair’s action be taken to agree the submissions on 28th January 2015 and the planning activity and finance measures and trajectories for the Operating Plan to be submitted on 13th February 2015; agreed the approach to develop the CCG’s Operating Plan for 2015-16.

**Governing Body meeting on 8th January 2015** – Chief Officer’s report provided an outline of the national requirements for the 2015/16 Operating Plan.

**Delivery Committee meeting on 18th December 2014** – received an outline timeline for the development of the Operating Plan
### PUBLIC ENGAGEMENT

- The ten week public engagement programme on the Joint Commissioning Intentions for Integrated Care finished at the end of January 2015.
- The preliminary analysis of the outcome of this public engagement exercise was considered by the Joint Public Engagement Group (JPEG) on 29th January 2015.
- A full analysis of the responses received is being undertaken and will be reviewed at Adult Joint Strategic Commissioning Group on 12th March 2015 and will be assured by JPEG on 30th April 2015.

### 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 Operating Plan will set out the CCG’s plans to promote equality and tackle inequalities during 2015/16.

### RESPONSIBLE MANAGERIAL LEAD CONTACT:

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

Name: Tony Read  
E-Mail: tonyread@nhs.net

### AUTHOR CONTACT:

Name: Susanna Masters  
E-Mail: susanna.masters@nhs.net
<table>
<thead>
<tr>
<th>AREA</th>
<th>Priorities for Action to work towards achieving objective (SMART)</th>
</tr>
</thead>
</table>
| 1. Build on processes for assuring quality | Further develop Quality Assurance processes with regular review of the quality and safety within Care Homes.  
Further develop oversight and assurance over community health services covering both adults and Children &Young People.  
Work with NHSE to develop oversight and assurance over GP Practices.  
Update CCG safeguarding assurance processes in view of Care Act for Adult Safeguarding.  
Maintain safeguarding practices by ensuring CCG has systems in place for Safeguarding children looked after Children business case, FGM and Prevention. |
Appropriate 7 day services and progress towards London Quality Standards.  
Met new Mental Health access standards against agreed trajectory. |
Operating Plan 2015/2016 – Governance

Core Corporate Objective – ensure that robust governance arrangements are in place

<table>
<thead>
<tr>
<th>AREA</th>
<th>Priority Action towards achieving objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Financial grip - plans, controls, risk management, delivery of duties and assurance frameworks to achieve financial balance.</td>
<td>2015/16 Budgets are agreed by GB and delegated to budget holders for sign off. Monthly integrated report is available on the CCG web site for the public and Governing Body members. Annual Report and Accounts are completed. BCF’s section 75 governance and risk sharing arrangements and resource allocation ‘rules’ are agreed.</td>
</tr>
<tr>
<td>2. Statutory functions are discharged in accordance with the agreed CCG’s Constitution</td>
<td>Implement the governance arrangements to enable primary care commissioning at level 2 to be undertaken effectively. Develop and implement plan to support the CCG to move towards level 3 for primary care co-commissioning. Strengthen membership engagement.</td>
</tr>
<tr>
<td>3. Governing Body is focused on the strategic agenda</td>
<td>2015/16 BAF to include strategic risks. Development of long and medium term evidenced based financial modelling to underpin the CCG’s strategic framework.</td>
</tr>
<tr>
<td>4. CCG’s Information Management and Technology (IM&amp;T)</td>
<td>CCG’s Information Strategy is developed, agreed and implemented to support: • effective decision making by GPs and commissioning staff • provision of accurate and transparent information to the public • sharing information between professionals To deliver the highest Information Governance standards through a risk management approach</td>
</tr>
<tr>
<td>5. Equalities is embedded within</td>
<td>A CCG Equalities Group is established to steer, advise and oversee the delivery of the CCG equality priorities including:</td>
</tr>
<tr>
<td>AREA</td>
<td>Priority Action towards achieving objective</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>the CCG</td>
<td>• Using EDS2 as set out in the guidance published by NHS England, and to act on its results</td>
</tr>
<tr>
<td></td>
<td>• Undertaking and publishing Equality Analyses of its policies, reviews and intentions whenever appropriate</td>
</tr>
<tr>
<td></td>
<td>• ensuring the approach to public engagement is inclusive of the diverse communities of Lewisham, and that feedback from engagement events can be disaggregated by protected characteristics</td>
</tr>
<tr>
<td></td>
<td>• ensuring that its public-facing publications are accessible and made available in different formats and languages whenever appropriate</td>
</tr>
<tr>
<td></td>
<td>• supporting the Public Health Department of the local authority to improve the equality content of the JSNA</td>
</tr>
<tr>
<td>6. The CCG secures the best range of</td>
<td>Current CSU support services are monitored effectively using KPIs.</td>
</tr>
<tr>
<td>commissioning support services</td>
<td>Reviews options to commissioning services from lead provider framework – September 2014</td>
</tr>
<tr>
<td>7. The Organisational Development Plan</td>
<td>Agree shared set of values and behaviours with the Governing Body</td>
</tr>
<tr>
<td>ensures that the CCG’s full potential is achieved</td>
<td>OD issues identified in the Governing Body self-assessment are addressed</td>
</tr>
<tr>
<td></td>
<td>Develop strong leadership at every level throughout the organisation</td>
</tr>
<tr>
<td></td>
<td>Develop good employer and healthy work status</td>
</tr>
</tbody>
</table>
### Operating Plan 2015/2016 – Public Engagement

**Core Corporate Objective – Public engagement is intrinsic to all commissioning activities**

<table>
<thead>
<tr>
<th>AREA</th>
<th>Priority Action towards achieving objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>CCG public reference group</td>
</tr>
<tr>
<td></td>
<td>Members of the CCG public reference group are recruited, and development plan is implemented</td>
</tr>
<tr>
<td></td>
<td>Work plan for the CCG public reference group developed and agreed</td>
</tr>
<tr>
<td></td>
<td>Evaluation of the impact and effectiveness of the group</td>
</tr>
<tr>
<td>2.</td>
<td>Public participation at every stage of the commissioning cycle</td>
</tr>
<tr>
<td></td>
<td>Immediate review the commissioning cycle to ensure that there is public participation built in on an ongoing basis for each the key stages: policy/service development, procurement, evaluation ….TBC</td>
</tr>
<tr>
<td></td>
<td>Systematic framework developed: collecting and analysing feedback, reporting, measuring impact, assessing involvement</td>
</tr>
<tr>
<td>3.</td>
<td>CCG’s strategic and key developmental work</td>
</tr>
<tr>
<td></td>
<td>Develop and implement an engagement plan to support primary care development</td>
</tr>
<tr>
<td></td>
<td>Implement local aspects of engagement plan for our Healthier SEL programme</td>
</tr>
<tr>
<td></td>
<td>Implement AICP engagement plan including recruitment of programme resource for engagement</td>
</tr>
<tr>
<td>4.</td>
<td>Better public information’</td>
</tr>
<tr>
<td></td>
<td>Reviewing current public communication, including publications, social media, GB pre-meet and meetings</td>
</tr>
<tr>
<td></td>
<td>Identify gap analysis of local population that are not being reached</td>
</tr>
<tr>
<td></td>
<td>Develop options for real time patient experience feedback access (eg ‘I want great care’)</td>
</tr>
<tr>
<td></td>
<td>Review the communications &amp; engagement functions</td>
</tr>
</tbody>
</table>
Corporate Objectives 2015-2016 – Primary Care

Developmental Corporate Objective: Stronger Primary Care working within in local care networks delivering improved patient experience and outcomes

<table>
<thead>
<tr>
<th>AREA</th>
<th>Priorities for Action to work towards achieving objective (SMART)</th>
</tr>
</thead>
</table>
| 1. Implement core components of year 2 of the CCG Primary Care Strategy (access/co-ordinated care and early diagnosis and preventative) | (a) Implementation of Co-ordinated Care Improvement scheme  
(b) Maximising in-hours – specifically focusing on improving access via the phone for patients |
| 2. Support the establishment of formal GP provider vehicle(s) at a neighbourhood level with a CCG provider development ‘offer’ | (a) Develop and commission ‘offer’ to GP provider vehicles  
(b) The development of a commissioning framework (the ‘ask’) for neighbourhood providers to enable population based commissioning |
| 3. Ensure that primary care providers are working as an integral part of the neighbourhood teams and networks, underpinned by supporting ‘enablers’; | (a) Produce workforce development plan in partnership with provider vehicles and SEL  
(b) ICT Strategy & Stakeholder/User Group for GP practices/CCG ICT Resource as part of the Integrated Care Programme  
(c) Commission resource to scope collective estates audit/plan to support delivery of the Local Care Network as part of the Integrated Care Programme |
| 4. Maximising the benefits of co-commissioning for joint commissioning and planning for delegation in 2016/17 | (a) Working with SEL to consider; (i) operational processes for committee in common; and (ii) resources to support across CCGs with NHS England  
(b) Develop local CCG resource plan to support delegation  
(c) Develop strategic commissioning intentions for ‘core’ GP services |
| 5. Implementation of Year 2 of the Referral Support Service (RSS) | (a) Rollout 2nd year of pilot  
(b) Identify community alternatives and education needs for GP practices  
(c) Evaluation and review of procurement options for 2016/17 |
### Corporate Objectives 2015-2016

**DRAFT Developmental Corporate Area: Establish Neighbourhood Networks**

<table>
<thead>
<tr>
<th>AREA</th>
<th>Priorities for Action to work towards achieving objective (SMART)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Neighbourhood teams and networks</td>
<td>Embed neighbourhood teams and networks, supported with shared approach to care management across health and social care</td>
</tr>
<tr>
<td>2. Enhanced advice, support and care</td>
<td>Lead the refocus and redesign the current provision of enhanced care to support people to continue to live at home, to prevent people requiring a hospital admission and to ensure effective structured discharge</td>
</tr>
<tr>
<td>3. Prevention and Early intervention</td>
<td>Promote the development of stronger communities and encourage people to improve their health and wellbeing and stay well</td>
</tr>
<tr>
<td>4. Supporting Enablers</td>
<td>Develop the underpinning support enablers – workforce development; information management and technology and estates</td>
</tr>
<tr>
<td>5. Provider models of Care</td>
<td>Work collaboratively with current and future providers to develop the local market and to identify the most appropriate provider model of care to achieve and secure the above system wide transformation</td>
</tr>
</tbody>
</table>
A meeting of the Governing Body  
12 March 2015

ENCLOSURE 15  
CCG responsibility in relation to Domestic Homicide Review (DHR)

<table>
<thead>
<tr>
<th>CLINICAL LEAD: Alison Browne</th>
<th>Post Director of Nursing and Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>MANAGERIAL LEAD: Karen Bates</td>
<td>Post Associate Director of Nursing &amp; Quality</td>
</tr>
</tbody>
</table>

| AUTHOR: Karen Bates | Post Associate Director of Nursing & Quality |

RECOMMENDATIONS:
The Committee is asked to note the information relating to the CCG Responsibilities in the Domestic Homicide Review process.

SUMMARY:
The report identifies the CCG responsibilities relating to Domestic Homicide review

KEY ISSUES:
There is clear directive that the CCG has a responsibility to participate in the DHR process. In July 2014 NHS England gave guidance pertaining to CCG involvement which is indicated below:

Clinical Commissioning Groups

The CCG must provide a panel member and work with the Community Safety Partnership to ensure that action plans are implemented locally, and learning shared across NHS providers. CCG’s may be directed by the Secretary of State to participate in a Domestic Homicide Review, under Section 9(3) of the Domestic Violence, Crime and Victims Act (2004).

The CCG with all other agencies will be required to develop and support the DHR author in the recommendations and subsequent actions that will need to be implemented to assist in the reduction of further domestic homicides within Lewisham.

On submission and final approval of the Domestic Homicide Report to the Home Office the CCG will then be required to work with the London Borough of Lewisham Domestic Homicide Task and Finnish Group to ensure that lessons learnt and on-going actions are implemented. These actions may include supporting NHS England in delivering primary care support, review current commissioning processes to identify changes required to services or to monitor the implementation changes required within NHS organisations commissioned by the CCG.
CCG Representation.

Currently the CCG is representation at the following:

*DHR Task and Finish Group*

Associate Director of Nursing and Quality, Designate Nurse/Manager Safeguarding Adults

GP Lead for Drug Misuse Lewisham,

Head of Joint Commissioning

*Community Safety Partnership Board*

Associate Director of Nursing and Quality, Designate Nurse/Manager Safeguarding Adults

*Panel Meetings*

Associate Director of Nursing and Quality, Designate Nurse/Manager Safeguarding Adults

**CCG Monitoring**

The Associate Director of Nursing and Quality ensures that updates pertaining to DHR’s are updated to FLAG (For Action Learning Group) on a quarterly basis.

**References:**

The NHS Response to Domestic Homicide – NHS England July 2014 (appendix 1)

Multi - Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews

The functions of Clinical Commissioning Groups – NHS Commissioning Board March 2013

**CORPORATE AND STRATEGIC OBJECTIVES**

1. Commission high quality care services today – The processes in place for the implementation and management of Domestic Homicide reviews offers assurance to Commissioners that where incidents occur lessons are learnt and that there is in place a system to support the implementation and monitoring of actions following a domestic homicide.

**CONSULTATION HISTORY INCLUDING MEMBERS ENGAGEMENT:**

- For Action Learning
### PUBLIC ENGAGEMENT

- The report identifies that following review and sign of by the Home Office the outcome of Domestic Homicide reviews are publicised and the actions required by the London Borough of Lewisham

### HEALTH INEQUALITY DUTY

- This report sets out the CCG Accountability in relation to Domestic Homicide Review across the health and social care economy of Lewisham

### PUBLIC SECTOR EQUALITY DUTY

- The CCG recognises that it has a responsibility to ensure that it fulfils its responsibility to the residents of Lewisham ensuring that it all relevant information is gathered to complete the Domestic Homicide Review and that is supports and where identified as a lead for implementation any actions required to assist in reducing the incidence of Domestic Homicide. It is acknowledge that any and all residents within Lewisham regardless of protected characteristic may be involved in domestic abuse/homicide.

### RESPONSIBLE MANAGERIAL LEAD CONTACT:

<table>
<thead>
<tr>
<th>Name</th>
<th>Karen Bates</th>
</tr>
</thead>
<tbody>
<tr>
<td>E-Mail</td>
<td><a href="mailto:kbates2@nhs.net">kbates2@nhs.net</a></td>
</tr>
<tr>
<td>Telephone</td>
<td>02030493265</td>
</tr>
</tbody>
</table>

### AUTHOR CONTACT:

<table>
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<tr>
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<tr>
<td>Telephone</td>
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</table>
Appendix 1

The NHS Response to Domestic Homicide

Background and Introduction

In March 2013, the Government introduced a new cross-government definition of domestic violence and abuse, which is designed to ensure a common approach to tackling domestic violence and abuse by different agencies. The new definition states that domestic violence and abuse is: “any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse:

- psychological
- physical
- sexual
- financial
- emotional

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.”

This definition, which is not a legal definition, includes so-called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

A Domestic Homicide is defined as:
The death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect (see appendix 1) by—

(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or
(b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death.

A Domestic Homicide is identified by the Police usually in partnership with the Community Safety Partnership (CSP) with whom the overall responsibility lies for establishing a review of the case.
Where the CSP considers that the criteria for a Domestic Homicide Review (DHR) are met and should be undertaken, they will utilise local contacts and request the establishment of a DHR Panel. An independent chair will be appointed. The Review Panel must include individuals from the statutory agencies listed under section 9 of the Domestic Violence, Crime and Victims Act 2004, this includes NHS England, and Clinical Commissioning Groups.

**Purpose**

The purpose of this paper is to outline the actions required to discharge NHS England’s statutory obligations with regard to Domestic Homicide Reviews as outlined in the Domestic Violence, Crime and Victims Act 2004, and the requirements of providers and commissioners of health services.

**Domestic Homicide Reviews**

The purpose of a Domestic Homicide Review is to:

a) establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;

b) identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

c) apply these lessons to services including changes to policies and procedures as appropriate; and

d) prevent domestic violence and abuse and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.

DHRs are not inquiries into how the victim died or into who is culpable; that is a matter for coroners and criminal courts, respectively, to determine as appropriate.

**Providers (including GP’s and Primary Care)**

The Domestic Violence, Crime and Victims Act (2004) requires provider organisations to respond to requests for Individual Management Reports (IMR) in a timely manner, reflecting on any learning which might be gained from the issues raised in the IMR.

The IMR must be completed by a third party, rather than any persons involved in the care of the victim, perpetrator or family members. For small providers, this may mean making reciprocal arrangements with partner organisations or commissioning an independent organisation to complete the IMR.

If requested by the Chair the provider organisation must provide a panel member.
Clinical Commissioning Groups

The CCG must provide a panel member and work with the Community Safety Partnership to ensure that action plans are implemented locally, and learning shared across NHS providers. CCG’s may be directed by the Secretary of State to participate in a Domestic Homicide Review, under Section 9(3) of the Domestic Violence, Crime and Victims Act (2004).

NHS England (NHS Commissioning Board)

NHS England will provide a panel member, provide oversight of IMR’s at panel meetings, ensure that recommendations and actions are achievable, and disseminate learning across the NHS in England.

NHS England may support panel Chairs where obstacles to full NHS participation are experienced, using a range of relationship, contractual and professional influences.

NHS England may be directed by the Secretary of State to participate in a Domestic Homicide Review, under Section 9(3) of the Domestic Violence, Crime and Victims Act (2004).

NHS England will work in partnership with the CCG’s to ensure that local services deliver high quality, safe and effective services through the implementation of action plans.

NHS England will collate learning from Domestic Homicides and make recommendations to Education Commissioning organisations for professional development opportunities for all professions.

Management of the Domestic Homicide Process

The authority to request Individual Management Reports from NHS provider organisation lies with the Chair of the Panel, or the Community Safety Partnership who exercise this authority under the Domestic Violence, Crime and Victims Act 2004.

NHS England’s Regional Offices will designate a regional lead and provide a co-ordination role for attendance at Domestic Homicide Reviews, providing a central point for contact (for example, in London via ENGLAND.LondonInvestigations@nhs.net) to minimise the burden on non-NHS partners. A referral form is attached at appendix 2.

It is the responsibility of the Community Partnership to inform NHS England of a Domestic Homicide; however CCG’s must inform the Regional Lead if they are informed of a Domestic Homicide.

The NHS England panel member will be an NHS England employee, of Grade 8 or above (a role profile is included at appendix 3) and will be selected by the Local Area Team Director of Nursing in collaboration with the regional lead. The panel member will update the regional
lead monthly on the status of the Review, and an Area Team Domestic Homicide report will be sent to the Director of Nursing no less than bi-monthly by the regional lead.

NHS England will keep a library of recommendations for panel members to access, and panel member must work with regional leads to ensure recommendations are consistent and achievable, and then fed into an annual Domestic Homicide report.

The four regional leads will liaise closely with colleagues in the Home Office to support the review and evaluation of the Guidance.

The four regional leads will produce, with appropriate support, an Annual Report for NHS England on Domestic Homicide and the NHS.

Link to Home Office Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2013)


Nicola Clark
July 2014

To be reviewed August 2015.
ENCLOSURE 16
Safeguarding Children Annual Report

CLINICAL LEAD: Dr Faruk Majid
Post: Executive Lead Safeguarding

MANAGERIAL LEAD: Alison Browne
Post: Director of Nursing and Quality

AUTHOR: Dr Bola Adeyemi
Designated Doctor Safeguarding/Consultant Paediatrician

Maureen Gabriel
Designated Nurse Safeguarding and Looked After Children

RECOMMENDATIONS:
The Board is asked to: - note the Annual Report for Safeguarding Children.

SUMMARY:
To provide an Annual update on safeguarding children and to provide assurance in respect of the Lewisham Clinical Commissioning Group’s statutory responsibility in safeguarding children

KEY ISSUES:
Executive Summary
This is the Second Annual Safeguarding Children report to Lewisham Clinical Commissioning Group (CCG).
- The report provides information about national changes and influences, and local developments and activity, including how statutory requirements are being assured, and how challenges to business continuity relating to safeguarding children are being managed.
- In this reporting period, there has been the national launch of a safeguarding assurance and accountability framework, new statutory guidance to safeguard children, and health service reviews led by the Care Quality Commission (CQC) inspection programme for safeguarding children and Children in Care.
- The scale of organisational change in the NHS and across other organisations can create risks; Lewisham CCG has been working with its partners to mitigate any possible risks.
- The CCG has continued the governance and accountability arrangements, which
include regular reporting to the board. The CCG makes a significant contribution to the work of the Lewisham Safeguarding Children Board (LSCB).

- There is on-going quality assurance work with our providers, which includes quarterly monitoring templates reviewed at the Lewisham CCG Health Safeguarding Assurance meeting.

### 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

- 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

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NHS LEWISHAM

SAFEGUARDING CHILDREN

ANNUAL REPORT

April 2013 - March 2014

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1. The Purpose of the Report

1.1 The purpose of the Lewisham Clinical Commissioning Group Annual Safeguarding Children Report is to provide an overview of the statutory requirements and local arrangements to safeguard and promote the welfare of children across the whole health economy in Lewisham.

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 This report will inform the Governing Body of the main issues, risks, and key priorities relating to safeguarding children within Lewisham.

1.4 The report provides information about national changes and influences, and local developments and activity, including how statutory requirements are being assured, and how challenges to business continuity relating to safeguarding children are being managed.

2. Introduction

2.1 This is the Second Annual Safeguarding Children report to Lewisham Commissioning Group (CCG), but the first during a full year of CCG responsibility for safeguarding.

2.2 On the 1st April 2013 NHS Lewisham Clinical Commissioning Group (CCG) replaced the Primary Care Trust (PCT) as part of the NHS reforms.

2.3 This annual report will assure the NHS Lewisham Clinical Commissioning Group Governing Body and members of the Public that the CCG is fulfilling its statutory duties to safeguard children.

3.0 Safeguarding Obligations

The statutory safeguarding duties of CCGs are clarified in: Working Together to Safeguard Children, A guide to inter-agency working to safeguard and promote the welfare of children. (HM Government March 2013). In which the
document details that, Sections 11 and 13 of the 2004 Children Act have been amended through the Health and Social Care Act 2012 so that the NHS Commissioning Board (CB) (now known as NHS England) and CCGs have identical duties to those previously applying to Primary Care Trusts (PCT) and Strategic Health Authorities (SHA) – i.e. ‘to have regard to the need to safeguard and promote the welfare of children and to be members of Local Safeguarding Children Board’. The revised edition of Working Together to Safeguard Children (2013) also sets out expectations as to how these duties should be fulfilled.

3.1 Safeguarding Vulnerable People in the Reformed NHS – Accountability and Assurance Framework (NHS Commissioning Board, March 2013), provides further guidance on accountabilities for safeguarding children in the NHS.

4.0 Current Context

4.1 NHS Lewisham Clinical Commissioning Group (CCG) has maintained the governance and accountability arrangements in place which include regular reporting to the Governing Body.

- The Executive lead for safeguarding and the Director of Nursing represent the CCG on the Lewisham Local Safeguarding Children Board (LSCB).
- The Designated Professionals have regular meetings with the Executive Lead for Safeguarding and the Director of Nursing.
- There has been on-going quality assurance work with health providers including quarterly safeguarding performance templates submitted to the CCG Safeguarding Assurance Group and performance monitoring of serious case review action plans.

4.2 The number of children subject to a child protection plan increased from 235 in March 2013 to 304 in March 2014. An LSCB report concluded that the rise in children subject to plans was not due to changes in social care threshold, demographic changes or children remaining on plans longer. The rise is a reflection of increased referrals.

4.3 The overall number of children in care of the local authority remained stable with 507 children looked after by Lewisham. 46% of looked after children are placed in borough whilst 54% are placed out of the borough. There continues to be challenges in ensuring timely & high quality health assessments for these children.
4.4 There were 27 child deaths from April 2013 – 31st March 2013. This is a slight decrease from last year which was 34 child deaths.

4.5 Lewisham NHS Trust merged on 1st October 2013, with Queen Elizabeth Hospital in Greenwich following the dissolution of South London Healthcare NHS Trust. Both hospitals have emergency departments, acute medicine and maternity. The Trust is now known as Lewisham and Greenwich NHS Trust (LGT) and also includes Lewisham community health services.

4.6 In this reporting period, there has also been the national launch of a Care Quality Commission (CQC) review programme for Safeguarding and Looked After Children. The CQC will be carrying out unannounced inspections. The review began in September 2013 and will take two years to complete. The CQC are using their powers under Section 48 of the Health and Social Care Act 2008 to conduct this review and will publish a report for each local area inspected. It is a targeted review starting with the CCG areas that performed less well during the last safeguarding inspections. Key lines of enquiry are, how well local health services identify, help, protect and provide child-centered care and to ensure that children’s health needs are effectively met. Lewisham received an overall “Outstanding” grading during the last safeguarding inspection in 2012. The Designated Nurse has been working with the main health providers to prepare for the inspection.

4.7 Ofsted led inspections of the Local Authority Children's Services, which include a review of the Local Safeguarding Children Board (LSCB), are currently in progress across the country. It is anticipated that Lewisham health services will participate in the Ofsted inspections.

5.0 Key CCG Safeguarding Children Priorities and Achievements in 2013-2014

5.1 To ensure that Lewisham CCG continues to meet all the statutory safeguarding children responsibilities.

- Update: With the assistance of the workforce team, the CCG was successful in meeting the duty to train staff in safeguarding children. CCG staff accessed level 1 safeguarding children training online.
- The Designated Nurse Safeguarding/Child Protection retired in December 2013 after many years of distinguished service in the role for Lewisham. The CCG were successful in appointing a Designated Nurse who would fulfill the functions for Looked After Children and the Safeguarding role in January 2014.
5.2 To continue to work with the Safeguarding Leads within key provider services to ensure that safeguarding children arrangements across the health economy are robust. Including the monitoring of the safeguarding arrangements of commissioned Services

- **Update:** The NHS Lewisham CCG Health Safeguarding Assurance Committee is assigned the responsibility of ensuring assurance to the Governing Body that all commissioned services are fulfilling their responsibilities. Main health providers safeguarding leads attended the Committee’s quarterly meeting regularly throughout 2013-2014. There is also representation from independent hospitals such as BMI Blackheath and Cygnet.

5.3 To continue to work with LSCB in achieving joint safeguarding children priorities including child sexual exploitation, Female Genital Mutilation (FGM) neglect and domestic abuse.

- **Update:** Local multi-agency teams combating child sexual exploitation are fully represented from all relevant NHS agencies, including professionals from primary and secondary, physical and mental health care.

- **All women are routinely asked about Female Genital Mutilation (FGM) at antenatal booking and reassessed at delivery. Health data collection regarding number of women identified as having FGM commenced in June 2013**

5.4 To work closely with the local authority & key providers services to achieve improvements in health assessment targets for Looked after Children.

- **Update:** For the period 2012-13 the mean amount of LAC that had their initial health assessments (IHA) conducted within the statutory timescale (28 days) of going into care was 45%. However this has risen to 88% for the period 2013-14 demonstrating an improvement of 43% over the year.

5.5 To continue to work with GP Practices in strengthening their engagement with safeguarding children processes through regular meetings with General Practice Safeguarding Leads, improving General Practitioner contribution to Case Conferences, review of safeguarding policies and continued provision of training.

- **Update:** The Named GP supported by the Designated Doctor and Nurse has continued to lead bimonthly safeguarding meetings for General Practice safeguarding Leads.

5.6 To work with key providers to enhance communication between GPs and the Midwifery service in relation to vulnerable antenatal women.
Update: Lewisham and Greenwich Trust re-launched a “Maternity Safeguarding Pathway” in October 2013. This has improved communication between GPs and Midwives.

5.7 To work with local authority in improving health engagement with the Early Intervention & Team around the Child / Family process, thereby improving early help to vulnerable families and the quality of referrals to Children’s Social Care services.

Update: The numbers of “Common Assessment Framework” (CAF) reports are monitored by the CCG and the LSCB. The main providers using CAFs are Lewisham and Greenwich Trust (LGT). GPs are being encouraged to access early help services more. This is discussed with the GP safeguarding leads.

6.0 Governance & Accountability Arrangements

6.1 The current safeguarding governance arrangements for Lewisham CCG meet the statutory duty to safeguard and promote the welfare of children and young people.

6.2 Current 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

The Governing Body Lead 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

The Nurse Director 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 Safeguarding Children
- Designated Nurse Safeguarding and Looked After Children
- Designated Paediatrician for Child Deaths
- Designated Doctor for Looked After Children

The role of designated professionals 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, and of advice and support to other health professionals.

7.0 Safeguarding Assurance from Provider Health Organisations

The safeguarding children provision of commissioned health services are monitored via the CCG assurance processes and quality monitoring. GP services although not commissioned by the CCG through quality improvement contribute to the safeguarding performance and quality monitoring.

The Named GP for safeguarding children in Lewisham has submitted an annual report on safeguarding children to the CCG Health Safeguarding Assurance Group. South London and the Maudsley NHS Foundation Trust (SLAM) did not submit a Trust wide report but a Child and Adolescent Mental Health annual report was received. Lewisham and Greenwich NHS Trust (LGT) have submitted an annual safeguarding children report and a separate Looked After Children Report (LAC). A summary is given below of the key important indicators from the provider reports for safeguarding children for the commissioned health services during 2013-2014.

7.1 Lewisham and Greenwich NHS Trust

7.1.1 Lewisham and Greenwich NHS Trust was formed in October 2013 following the merger of Lewisham Healthcare NHS Trust with Queen Elizabeth Hospital after the dissolution of South London Healthcare NHS Trust. Safeguarding children and young people is a Trust priority with clear governance arrangements in place.

7.1.2 The Trust recognises that there are challenges following the merger. The Trust has identified that it is now reporting to three CCGs and LSCBs, Bexley,
Greenwich and Lewisham. The Trust is seeking to work with the three CCGS to agree a standard scorecard which will incorporate qualitative and quantitative data.

7.1.3 The Trust (LGT) has the statutory named nurse & doctor responsible for the operational safeguarding requirements within the organisation. They work in partnership with other health and local authority staff as part of the Lewisham Safeguarding Children Board (LSCB) task groups. They have regular supervision from the Designated Professionals. The Named professionals are supported in fulfilling safeguarding functions by a team of Safeguarding Advisors and administrative staff. Safeguarding Advisors are based in both acute and community sites. Safeguarding Advisors in the acute setting ensure that the needs of vulnerable children are not over looked when they present to hospital. During 2013-14 there has been varying vacancies in the safeguarding team which has had to be managed to reduce risks to the safeguarding children service.

7.1.4 The Trust has a comprehensive Safeguarding Training strategy. A variety of means are employed to provide training. The trust has set a target for 85% for all levels of safeguarding training. This target was achieved for level 1. The figures for levels 1, 2 and 3 are shown in the table below.

Table Safeguarding Training Presented to Quarterly CCG Safeguarding Assurance meeting data at 31st March 2014

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<td>32</td>
<td>79</td>
<td>111</td>
<td>71</td>
</tr>
</tbody>
</table>
7.1.5 The target for safeguarding children training advised for NHS organisations following the safeguarding national review in 2009 is 80%. Lewisham and Greenwich Trust’s Workforce and Development Directorate provide monthly reports on safeguarding training activity. This is closely monitored by the Safeguarding Committee. The CCG have put the LGT safeguarding training performance on the risk register.

7.1.6 The Trust has embedded Safe recruitment policy and procedures within the Human Resource (HR) Department. There is close monitoring by management that all staff are up to date with Disclosure Barring Service (DBS) compliance, and there is a clear process in place for management including withdrawing pay and suspension of staff who are non-compliant. Compliance with DBS checks was above 92% for all applicable directorates. The Trust is actively pursuing completion of the outstanding DBS checks.

7.1.7 The CCG Health Safeguarding Assurance group during the latter half of the year was receiving a separate report on maternity safeguarding pathways from Lewisham and Greenwich Trust. Several cases of young children were discussed by the LSCB where maternity identification of vulnerable women required improvement. The LGT “Maternity Safeguarding Pathway” was revised and re-launched in October 2013. The pathway will be audited to evaluate the impact during 2014-15 using data from women who booked for antenatal care in September 2013.

7.1.8 There remains a challenge to harmonise safeguarding provision across the Trust. This work is at an early stage. The Trust is required to provide assurance and representation to three Local Safeguarding Children Boards (LSCB) and three Clinical Commissioning Groups (CCGs) Lewisham, Greenwich and Bexley. This also requires that the Designated and Named safeguarding professionals across the three CCGs work closely when seeking safeguarding assurance from the LGT Trust.

7.2 South London and Maudsley NHS Foundation Trust

7.2.1 South London and Maudsley NHS Foundation Trust (SLAM) has undergone changes in the safeguarding governance structure. The Named Nurse for Safeguarding
Children who was also the lead for Lewisham left the post in December 2013. The Named Doctor also retired in February 2014.

**Trust Safeguarding Children Arrangements and staff changes:**

- Executive Lead for Safeguarding (Children and Adults) is the Director of Nursing (Neil Brimblecombe).
- The Trust Named Doctor Safeguarding Children is Dr Sarah Bernard
- Chris McCree is acting in the role of Assistant Director of Nursing Trust Named Nurse Safeguarding Children.

7.2.2 A SLAM Trust wide annual safeguarding report has not been received by the CCG for 2013-2014. However, the Lewisham Child and Adolecscent Mental Health Services (CAMHS) have written a safeguarding children annual report.

7.7.3 The report describes 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. Also key issues (such as Female Genital Mutilation and Child Sexual Exploitation) and lessons learned from Serious Case Reviews.

7.2.4 The CCG has noted the reduction in the SLAM safeguarding reporting and has requested confirmation of the safeguarding arrangements for SLAM going forward 2014-2015. The risks associated with the implementation of a revised structure and unfilled posts has also been noted.

7.3 **GP Services**

7.3.1 The responsibility of monitoring the contracts for independent practitioners is held by NHS England from April 2013. The CCG designated safeguarding professionals continue to provide advice about the quality of safeguarding provision and work closely with the Named GP for safeguarding in Lewisham.

7.3.2 The named General Practitioner receives regular supervision from the designated doctor. All General Practices in Lewisham have a 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. Although, these meeting are well attended a small number of practices have not engaged with safeguarding process and a few General Practice
safeguarding leads have not attended supervision meetings. This has been logged and action taken to address the practices who are not participating.

7.3.3 The Safeguarding Children Standards for General Practice, covering Safeguarding standards for training, communication, registration, employment and record-keeping has been updated during 2013-14 and is accessible from the GP interactive portal.

7.3.4 The Safeguarding Standards document incorporates the Lewisham Safeguarding Children Training Strategy for Primary Care which follows the Intercollegiate Guidance for Safeguarding Children Training recommendations.

- Non-clinical General Practice staff complete 3 yearly Level 1 updates. This is accessed on-line.
- Level 3 updates are provided by the Named GP, Designated Doctor and Nurse. Last year 6 sessions were run for a capacity of 25 participants. The content of the update sessions were revised and incorporate new learning from serious case reviews. The evaluations have been very positive.

7.3.5 The Named GP for Safeguarding Children has worked very hard to improve GP attendance at case conferences and the submission of reports. A recent audit showed a significant improvement and this will continue to be monitored.

8.0 Looked After Children

8.1 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.

8.2 The Designated Looked After Children Nurse post was appointed to the CCG in January 2014. It is therefore anticipated that for 2014-15 there would be a separate Looked After Children Health Commissioning report, which would ensure that the specific safeguarding vulnerabilities and health needs assessment of the LAC children are addressed.

8.3 As of 30/04/14 there were 507 children and young people looked after by Lewisham local authority, of these 54% were placed out of the borough. This compares to a total of 496 on 30/4/13. Of these 243 were female and 264 were male. In April 2014 there were 232 children placed in borough and 273 (54%) placed out of borough.
8.4 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. The majority of instances that the IHA were not achieved within the timescales were due to the young person refusing to attend the health assessments, or a delay in LAC health administrators receiving notification that the child had become looked after from social care.

8.5 The Lewisham LAC Team works within the framework based on the recommendations set out in the government guidance “Promoting the Health and Well-Being of Looked After Children” (DH 2009) as well as the NICE guidance “Promoting the Quality of Life of Looked After Children and Young People” (2010). These documents set out key responsibilities for health organisations and local authorities regarding LAC. This document is to be revised and will take into account the NHS reforms.

8.6 South London and Maudsley NHS Foundation Trust are commissioned to provide mental health services to Looked After Children. The mental health team (Symbol) offering this service have 107 Looked After Children receiving input.

8.7 School nurses, health visitors and community paediatricians support the LAC health team conducting LAC Health assessments. An issue that has been apparent during 2013-2014 for the CCG as commissioner of LAC health service, is the impact of the approximate 50% increase in Lewisham’s children made subject to a child protection plan which has had the effect of reducing the school aged nursing services (SANS) ability to see and complete LAC health assessments in a timely manner. To this end during 2014-15 a business case is to be drafted to look at options to support the LAC health team.

8.8 There are also risks that the high percentage of out of area placements may be at risk of not meeting the required targets for completion of health assessments. The placements in Kent are the largest proportion. Kent is in the process of reviewing the contracts and agreements with the CCG.

9.0 Partnership/LSCB

9.1.1 There has been Strong multi-agency partnership working, including internal and external partners. The main health providers and CCG safeguarding leads have met regularly with Children’s Social Care. This meeting is chaired by the Director of Children’s Services. This meeting has provided an opportunity to review the health
economy contacts/requests for service from a qualitative perspective to gain an understanding of the nature of the contacts that do not convert to referral, the appropriateness, timeliness of these contacts, and assurance of the quality of safeguarding practice in terms of the referral process and identify areas for improvement.

9.1.2 The Lewisham Safeguarding Children’s Board (LSCB) continues to drive forward the ‘Working Together’ requirements for safeguarding children across the agencies. The LSCB has acknowledged the challenges of the acute Hospital Merger for Lewisham and the impact of the NHS reforms. There is recognition in the Lewisham LSCB annual report that contribution to partnership working has continued effectively despite the changes.

9.1.3 There are seven task groups with full representation from health

- Child Death Review Panel
- Communications and Publicity
- Monitoring, Evaluation, and Service Improvement
- Policies, Procedures and Training
- Serious Case Reviews
- Neglect task Group
- Child Sexual Exploitation Pilot

9.1.4 Lewisham CCG, LGT and SLAM contribute fully to the work of the LSCB and its subgroups. Lewisham CCG Designated Nurse for Safeguarding Children is Chair of the LSCB Policies, Procedures & Training subgroup.

9.1.5 LSCB has an Executive Board which directs and oversees the business of the LSCB. The Executive Safeguarding Leads or CEOs of NHS Trusts and the CCG are usually represented on the Executive Board of the LSCB.

9.1.6 The LSCB has requested annual reports from partner agencies to hold to account services contribution to safeguarding children. There is a schedule to present reports. Lewisham CCG presented the 2012-2013 Safeguarding Children Annual Report to the LSCB in March 2014.

9.2 Serious Case Reviews/ Multi-Agency Reviews

9.2.1 Working Together to Safeguard Children which is the statutory guide to interagency working to safeguard & promote the welfare of Children was updated in March 2013.
Serious Case Reviews and the Child Death Review process are discussed in one chapter under the title “Learning and Improvement Framework”.

9.2.2 LSCBs may use any learning model which is consistent with the principles in the guidance, including the systems methodology recommended by Professor Munro. Therefore the requirement for organisations to undertake Individual Management Reviews (IMRs) has been removed.

9.2.3 Two Lewisham Serious Case Reviews (SCR) were started during 2013 and are in progress. The SCRs will be published in a redacted form for anonymity of the cases. The two SCRs have identified learning for health organisations, especially identification of safeguarding risks during the antenatal period for both cases.

9.2.4 SCR Case O: An 8 week old baby was found to have multiple fractures and the young parents were not able to account for the cause of these. The family were not known to Children’s social care. The agencies contributing to the SCR are all universal health services.

9.2.5 SCR Case S: A baby was admitted to hospital aged 1 week with loss of weight and on investigation was positive to narcotic drugs. This case was also not active to children’s social care. Health agencies are the only partners contributing to SCR process.

9.2.6 Two multi-agency learning reviews (MARs) of cases that did not meet the threshold for a SCR were also conducted and completed during 2013.

9.2.7 Although there were specific themes for each case there were similar themes that emerged from the cases reviewed. These included:
- Failure of children and families to attend appointments and how is this managed by health organisations
- Missed opportunities to assess and identify vulnerability and risk factors
- Professionals not having adequate access to history in service users records to inform decision making

9.2.8 Learning has been incorporated into health provider action plans and monitored via the CCG Health Safeguarding Assurance Group. The CCG governing body has received reports on the progress of the SCRs.

9.3 Lewisham Child Death Overview Panel (CDOP)

9.3.1 The “Child Death Overview Panel” (CDOP) is a sub-committee of the LSCB and is responsible for reviewing information on all child deaths.
This subcommittee is multi-agency and includes a senior Paediatrician and a Public Health Professional. The disclosure of information about a deceased child is to enable the LSCB to carry out its statutory functions relating to child deaths. The LSCB should use the aggregated findings from all child deaths, collected according to a nationally agreed minimum data set, to inform local strategic planning on how best to safeguard and promote the welfare of the children in their area. The Designated Nurse for safeguarding is a member of the CDOP.

9.3.3 The CDOP panel reviewed 36 deaths in children and young people, normally resident in Lewisham, during 2013/2014. Twelve of the 36 deaths reviewed were unexpected deaths.

9.3.4 A total of 26 of the deaths reviewed in 2013/2014 occurred in the first year of life; 18 of these were in children who died when they were aged less than one month old. Six of the deaths reviewed were of children aged between one and four years of age and four were of children aged over ten. None of the deaths occurred in children between the ages of five and nine.

9.3.5 Of the 36 deaths reviewed in 2013/2014, 15 occurred in children of black ethnic origin and nine were in children of black African origin. Overall, approximately 85% of the deaths reviewed occurred in children of black or minority ethnic origin, which is greater than the proportion of children from Black and Minority ethnic (BME) groups in the population of Lewisham as a whole. Children in BME groups overall, therefore, do seem to be over-represented in the deaths of children reviewed in 2013/2014. This, however, may not be true generally. The question as to whether children from any particular group or groups are over-represented amongst Lewisham children who die is being examined in an analysis of all deaths in Lewisham children. This analysis will be the subject of a separate report to the LSCB.

9.3.5 Cause of Death

Using the national method, the 36 deaths reviewed were classified by cause of death as follows:

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<th>Category</th>
<th>Name and Description of Category</th>
<th>Total</th>
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<tbody>
<tr>
<td>1</td>
<td>Deliberately inflicted injury, abuse or neglect</td>
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<td>2</td>
<td>Suicide or deliberate self-inflicted harm</td>
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<td>3</td>
<td>Trauma and other external factors</td>
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<td>4</td>
<td>Malignancy</td>
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<tr>
<td>5</td>
<td>Acute medical or surgical condition</td>
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As in previous years, the most common cause of death was extreme prematurity. Three out of the 15 perinatal deaths were found to have modifiable factors.

In six of the deaths reviewed in 2013/2014, failure to identify or to manage maternal infection or sepsis was identified as a concern. The Chair of the CDOP has written to the Trust concerned seeking assurance on this and a number of other points in these cases. In response to this letter, the Trust initiated a review and the outcome is awaited.

9.4 Multi-Agency Safeguarding Hub (MASH)

9.4.1 The Lewisham Multi Agency Safeguarding Hub (MASH) has been in place since 13 December 2012. MASH brings together a variety of agencies into an integrated co-located multi-agency team where information is shared appropriately in order to make timely and appropriate decisions. The team include staff from Children’s Social Care, the Early Intervention Service, Health and the Police Public Protection Desk. Information is also obtained from Probation, and the Youth Offending Service.

9.4.2 Lewisham took the approach of implementing the MASH process by a frontline practitioner taking the lead, namely a Team Manager based in the Referral and Assessment Service. MASH is not a separate / specialist arm of the service; but integrated as part of existing working practices. The MASH process does not replace the assessment process in the Children’s Social Care assessment teams.

9.4.3 Each agency identifies what information they hold on a child/young person and the adults around them. Each agency then assesses whether it is appropriate for the information they hold to be shared (in line with the information sharing arrangement) and a summary is provided to Children Social Care within 6 hours.

9.4.4 The LGT Safeguarding team take turns to sit in the MASH and participate in the process.

9.5 Section 11 audits

9.5.1 A biennial assessment of all LSCB member agencies and organisations in relation to their duties under Sec 11 Children Act 2004 is undertaken by the LSCB. This is a self-assessment tool that aims to assess the effectiveness of the arrangements for
safeguarding children at a strategic level. Each agency or organisation must ensure that any statements made within the tool are backed by evidence. Consideration must be given to evidencing improved outcomes for children young people and their families as a result of the arrangements.

9.5.2 Section 11 audits were completed by The CCG, Lewisham GP services, Lewisham and Greenwich NHS Trust and SLAM. The Section 11 submissions were divided into two cohorts and presented to the LSCB on a rota basis for scrutiny and comments by the LSCB. Gaps in compliance identified were assimilated into safeguarding action and work plans. Health agencies will be requested to participate in the audit during 2015/16 cycle.

10 Summary

- This report demonstrates Lewisham CCG compliance with statutory safeguarding requirements.
- The report also illustrates that governance arrangements are robust for provider health organisations across Lewisham, with Board accountability and a continued investment in maintaining safeguarding professional posts

11 Priorities for 2014-2015

11.1 Maintaining a focus on safeguarding improvement to ensure the CCG area can demonstrate sustained safeguarding improvement in the event of any safeguarding inspection.

11.2 Ensure national priorities continue to be embedded into CCG safeguarding assurance, Female Genital Mutilation, Child Sexual Exploitation and Missing Children

12 Recommendations

The Governing Body is asked to note the contents of the Annual Report in relation to safeguarding activity and the responsibilities of NHS Lewisham Clinical Commissioning Group

Maureen Gabriel Designated Nurse Safeguarding and Looked After Children

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

  http://www.rcpch.ac.uk/child-health/standards-care/childprotection/updates/child-protection-updates

  http://www.parliament.uk/business/committees/committees-a-z/commonsselect/home-affairs-committee/inquiries/parliament-2010/childgrooming/

- Working Together to Safeguard Children & Young People: A guide to inter-agency working to safeguard and promote the welfare of children 2013
  Department for Education 2013.
  https://www.gov.uk/government/publications/working-together-to-safeguardchildren

- Safe From Harm: Children’s Views Report by Dr Roger Morgan, Children’s Rights Director for England, 2004
  www.rights4me.org.uk


Annual Reports informing Lewisham CCG annual Safeguarding Children Report
• South London and Maudsley NHS Foundation Trust CAMHS Annual Safeguarding Children Report 2013-2014

• CDOP annual report 2013-2014 Public Health London Borough of Lewisham

• General Practice Safeguarding Children Annual Report April 2013 – March 2014

1. Welcome and Introductions

MW welcomed all to the meeting.

2. Apologies

Apologies were taken and noted.

3. Declaration of Interests (DoI)

It was recognised that some of the Clinical Directors were partners at practices where the Public Health saving proposals would impact on the practice’s income. The CCG has requested additional information concerning the impact on member practices however at the time of the meeting this had not yet been received. It was agreed that Clinical Directors whose practice had a financial interest in the Public Health savings proposals would leave the meeting for this item.

4(a). Minutes of previous meeting

Minutes of the Delivery Committee meeting on Thursday 27 November were agreed.
4(b). Action Log

All outstanding actions had been addressed and the action log updated.

5. Matters Arising

AR left the meeting

CCG Draft Response to the Public Health Savings Consultation

MW tabled the CCG’s draft response to the Lewisham Public Health savings proposals 2015/16 consultation. The CCG’s response has been informed by the three questions included within the consultation:

1. What impact do the proposals have on the ability of partners to deliver their own health improvement activities?
2. Are there any commissioning plans, service reconfigurations in partner organisations which may impact on the ability of the council to deliver the savings proposed?
3. Are there any further mitigating actions which partners could suggest which may support the Council to minimise any adverse impact of the proposals without incurring additional costs.

The CCG has set out the following overarching principles that the savings proposals should support:

- Population-based commissioning
- Equitable access
- Tackling health inequalities
- The aims or goals of our joint commissioning intentions
- Stronger communities for adult integrated care and for children and young people.

In response to RW’s request for assurance in relation to the neighbourhood model as a key mitigation for some of the savings proposals DR stated that timing is an issue as plans are not yet in place, as a result no assurance could be given that the neighbourhood model will successful mitigate the impact of the savings.

HE stated that the proposal not to roll out the pre-diabetes intervention goes against the CCG’s prevention strategy and that neighbourhood reconfiguration would not mitigate the missed opportunity to prevent diabetes. DR responded that the NHS Health checks programme is mandatory and there is no intention to undertake fewer health checks. The pre-diabetes intervention is not a core health check requirement.

MR stated that the introduction should include a statement of regret that money is being taken away from the public health budget. MW stated that the savings will be re-invested in services that have a public health impact however where the money will be re-invested is currently unknown. TR responded that for the CCG to provide a full response the comparative public health value of these services needs to be known.

TR highlighted that a plan B is needed should some of the savings be unachievable, i.e. the first proposal requires the negotiation of a 1.5% deflator to the contact value when it is expected that NHS England guidance is going to recommend a tariff inflator.

In response to RW’s question asking how the budget is ‘ring-fenced’ if savings are required TR stated that the budget is ‘ring-fenced’ to be spent on services with a public health impact. However public health outcomes are wide ranging, the savings that have been identified in the public health budget will
be spent by the Council on services that they currently fund through other budgets which they can identify as having a public health benefit. DR stated that many Council’s in London are asking Public Heath to identify savings in excess of 18% which will be used to protect parks and leisure services whereas Lewisham Council is taking a different approach.

TR highlighted that more savings will be needed in future years and the CCG’s response should highlight that a reduction in public health spending was not the intention of transferring the budget from the NHS to the Council.

Concerns were expressed that the proposals will widen health inequalities.

In response to TR’s question on whether Public Health spending was currently in line with budget DR stated that some of the savings identified were current underspends.

SM highlighted that it is important that the response comments on the process; the CCG is unable to contribute to a meaningful discussion or provide an assessment of the impact without knowing which services are not going to be cut as a result of the £2.6m savings.

It was agreed that further comments would be sent to MW by 10am on 23.12.2014.

AR re-joined the meeting.

6. Deep Dive

MW stated that the Delivery Committee was being held a week earlier than the usual in the meeting cycle and as a result the integrated performance report is not complete. A verbal report will be given by TR and the full report will be distributed with the Governing Body Papers. Following the Q2 assurance meeting with NHS England where the CCG were challenged on the eight performance indicators it had been agreed that the focus of this meeting would be on three of those indicators – winterbourne, IAPT and dementia.

Winterbourne View

MW reported a target had been set for London which requires 50% of clients who were identified on 1 April 2014 to be discharged by 31 March 2015. Lewisham CCG’s quarter 2 data submission reported 7 clients meeting the criteria. Of these 7 clients 1 is also being reported by NHS England. All have been reviewed within the last six months. There are clear discharge plans for 2 clients with discharge dates of 6 and 15 January. There is a plan for independent reviews of the remaining 4 clients.

Concern was expressed over the methodology of the NHSE review and how it is ensured that the outcome is in the patient’s best interest. DC responded that CCGs across London are in negotiations with NHS England regarding the review process as it is currently based on length of stay not need. It is accepted that people should be reviewed but it may not be in the patient’s best interest for them to be moved. Lewisham CCG has two patients who will be independently reviewed however the MDT believes that they are in the right place. There is 1 patient under a s37/41 order and the team will reapply to the court as the MDT do not believe this placement is based on need.

In response to RW’s question regarding the advice and support available to the people within the process DC stated that independent advice and support is available some take it up and some families take it up on their behalf.
In response to RW’s question on whether there were any new patients meeting the criteria since April 2014 DC stated that there were no new patients, any new patients would be managed by a multi-disciplinary team and regularly reviewed.

MW concluded that it was unlikely that 50% of Lewisham CCG clients were going to be discharged within NHS England’s timescales. There will be intense scrutiny that these patients are in the right/appropriate care setting however confidence was expressed in the CCG’s review process.

RW recommended that the Bubb report is reviewed, some of the recommendations are significant and the CCG will need to ensure it is prepared.

**Action:** Heather Hughes to provide a summary of the Bubb report for Delivery Committee.

**IAPT**

DV stated that there were two national targets set against delivery of IAPT, access rate and recovery rate. The access target is 15% out of the total population of need will access the service and enter treatment. The recovery target is 50% of patients who access the service will move to recovery.

IAPT access has dropped to 2.7% in Q2 against a plan of 3.5%. The service is planning to identify suitable patients for group IAPT work to recover towards the 15% required run rate in Q4. The group work will focus on long term condition support. It was requested that the Membership is made aware of the groups and what support they will be providing so appropriate patients can be referred.

**Action:** Communication to Membership on the IAPT group work.

HE stated that the CCG needs to ensure that what IAPT provides fits in with the CCG’s strategy. KG stated that IAPT has built up over the years without taking a long term view. A review of talking therapies including IAPT is needed which needs to include the mapping the Local Authority spend on talking therapies. It was acknowledged that the IAPT service is expensive when benchmarked with other services and the voluntary sector could be commissioned to fulfil some of the lower intensity work with IAPT continuing to work with those with more complex needs.

**Action:** The scope, breadth and timescale for the Talking Therapy review to be brought back to the January meeting.

RW highlighted that public awareness of IAPT was low and asked if this had improved. TR responded that it is not surprising that people have not heard of IAPT as it is a description of a policy not a service however the service may need to be rebranded.

In response to RW’s question regarding those who had been triaged away from the IAPT service and whether their needs are being met. DV responded that those who are triaged away from the IAPT service are referred to other services. A recovery audit is currently being done which will include those who are triaged away and people who do not recover.

RW asked that the report include ethnicity data as previous reports had indicated that the South Asian community do not recover as well. HE stated that this data was available and indicates that the access rate matches the population of Lewisham.

DA expressed concern that group work may not serve the needs to the patients as well as individual support. The groups need to include the right people and therapists. There is a lack of support for patients with ‘distress’ and a lot of people are pushed into IAPT when there is nothing else available. DA encouraged commissioners to fully scope the voluntary sector and look wider than MIND.
MR requested that DNA rates are reviewed and also better access times for working people.

MW requested that waiting times are reviewed, if the average is 39 days who is waiting longer than 39 days and what is the standard?

**Dementia**

KG reported on the challenges to the dementia action plan which the Delivery Committee reviewed in November. Lewisham's CCG’s dementia diagnosis rate has reduced slightly in November to 52.6%.

KG highlighted that one of the key tasks is to undertake the coding exercise. A business case was prepared to encourage all GP practices to undertake a coding exercise however this has not been approved by NHS England following the release of the DES for a £55 payment per patient for diagnosis as it was considered to be double funding. The deadline to sign up to the dementia DES has been extended to 31.12.2014 and a letter has been written to practices to encourage sign up.

**Action:** Letters encouraging practices to sign up to the dementia DES to be sent.

HE stated that many practices had not signed up to the DES due to workload pressures and confusion over the different DESs. In response to KG’s suggestion of an evening event for GPs to raise the profile HE responded that Lewisham’s experience of evening events are not positive as many practices are open extended hours. HE requested that it is included on the agenda for the neighbourhood meetings in January.

**Action:** Dementia DES to be included on the agenda for January neighbourhood meetings.

MW highlighted the importance of the Mayor signing up to the dementia alliance to raise public awareness.

RW highlighted the importance of raising awareness of carers and care home staff. RW suggested the use of dementia champions to engage communities.

In response to DA’s question about whether neighbouring CCG’s whose dementia diagnosis rates are high had been contacted to see what they had done, KG responded that he had spoken to the lead commissioner in Newham who said they had not done anything specific but had a young population. Southwark CCG had invested in a psychiatric liaison nurse.

In response to RW’s request for assurance that those who had been identified with dementia received good care HE stated that the dementia pathway is good and patients are given a personal contact to guide them through the care available.

7. **Verbal Headlines on the Integrated Performance Report**

TR gave a verbal report highlighting the following:

- FLAG raised concerns regarding LAS challenges in both Category A (life threatening conditions) performance and staff engagement and vacancy figures which are beginning to have an impact on clinical indicators. Delivery Committee requested that the concerns identified should be escalated to the lead commissioner for London Ambulance Service.

- A&E is still under significant pressure and performance is worse than last year. The additional winter schemes are in place or being put in place. MW reported that he was attending a
A regional tripartite meeting on 19.12.2014 and further actions are in place following the intensive support team visits.

- LGT has stated that the RTT standards should be met in December 2014 but challenges remain in trauma and orthopaedics. There are still 5 patients waiting longer than 52 weeks at KCH however the CCG has been informed that all will be treated by the end of December.

- Performance against the diagnostic standard improved in October 2014 at 98.8% but is still below the 99% standard.

- The recovery of the 62 days referral to treatment performance is now delayed to Q4. LGT hosted a cancer summit for hospital clinicians, GPs and managers across the system on 16 December. The CCG has requested the write up.

- At month eight the CCG is reporting an overall underspend of £2.82m against its issued budgets, representing a £0.28m favourable variance against plan. The CCG is forecasting to deliver its £3.81m planned surplus in full. The CCG has spent less cash than might be anticipated this is as a result of receiving the winter pressure funding and payment has not yet been made to the Trusts.

- The forecasted year end overspend on the acute budgets is reducing however there is no obvious cause.

- The CCG is meeting the Better Practice Payments Code in terms of the value of invoices paid but not in terms of the number of invoices paid.

In response to MW’s question regarding whether a response had been received from KCH on their plan to attain the minimum NHS IG standards TR stated that he had written to Southwark CCG again and also requested that the Information Governance Manager chases this up but to date no response had been received.

The full integrated performance report will be produced for the January Governing Body meeting.

8. Any Other Business

The draft operating plan and contracting timeline was tabled. It was agreed that the process is managed through the Delivery Committee with progress reported to the Governing Body in the Chief Officer’s report.

9. Date of Next Meeting

The next meeting would be held on Thursday 22 January 2015
<table>
<thead>
<tr>
<th>REF</th>
<th>ACTIONS</th>
<th>BY WHOM</th>
<th>TIMESCALE</th>
<th>STATUS/COMMENT</th>
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<tbody>
<tr>
<td>Dec 6</td>
<td>Heather Hughes to provide a summary of the Bubb report for Delivery Committee.</td>
<td>Heather Hughes</td>
<td>Jan</td>
<td>15.01.15: Enclosure 1.1 of the meeting on 22.01.2015</td>
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<td>Dec 6.1</td>
<td>Communication to Membership on the IAPT group work.</td>
<td>Kenny Gregory</td>
<td>Jan</td>
<td>15.01.15: Commissioners have communicated with the IAPT service to share the schedule of upcoming groups taking place in Lewisham.</td>
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<tr>
<td>Dec 6.2</td>
<td>The scope, breadth and timescale for the Talking Therapy review to be brought back to the January meeting.</td>
<td>Kenny Gregory</td>
<td>Feb</td>
<td>15.01.15: All talking therapies within Lewisham will be incorporated within a review to scope and consider need versus the current level of local provision. A specification will be drafted by February to ensure the project is started by March 2015.</td>
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<tr>
<td>Dec 6.3</td>
<td>Letters encouraging practices to sign up to the dementia DES to be sent.</td>
<td>Kenny Gregory</td>
<td>Jan</td>
<td>15.01.15: Letters were sent at the end of December – a joint letter from KG and AO’S and a second letter by HE</td>
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<tr>
<td>Dec 6.4</td>
<td>Dementia DES to be included on the agenda for January neighbourhood meetings.</td>
<td>HE</td>
<td>Jan</td>
<td>15.01.15: This will be factored into the coding exercise project that is currently being developed as result of the additional £10k that has been allocated to LCCG by NHSE.</td>
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<td>Nov 6.2</td>
<td>TR to follow up with Southwark CCG / Kings CMB on the response from KCH on their action plan to attain the minimum NHS IG standards.</td>
<td>TR</td>
<td>Jan</td>
<td>14.01.15: Response has been received from KCH (see report from IGSG) but it does not provide adequate assurance. Action referred to IGSG</td>
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<tr>
<td>Nov 7</td>
<td>The Prescribing Medicines Management Group / Areas Prescribing Committee to review evidence for prescribing of antibiotic prophylaxis and long term courses of antibiotics.</td>
<td>PMMG / APC</td>
<td>Jan</td>
<td>23.12.14: There is a Lewisham, Greenwich and Bexley joint group arranging to meet to update local antibiotic guidelines in line with the recently updated Antimicrobial Guidelines for primary care issued by Public Health England (PHE). The group (which is based on LGT to reflect local resistance issues) will have input from the secondary care microbiologists and be aware of secondary care guideline and national advice on ensuring antibiotics are used appropriately. A separate group will be working to produce</td>
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<td>Nov 7.1</td>
<td>Proposal from the FLAG sub group for the format of the quality report to be discussed with MW.</td>
<td>MW/GH</td>
<td>Jan</td>
<td>14.01.15: AB met with MW format of the quality report agreed.</td>
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<td>Nov 7.2</td>
<td>Audit Committee to review the assurance received by the implementation of the new quality report in due course</td>
<td>Audit Committee</td>
<td>March</td>
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<td>Oct 8</td>
<td>A further report on IAPT recovery rates / service development options to be provided to the Delivery Committee in January 2015.</td>
<td>KG</td>
<td>Jan</td>
<td>15.01.15: Enclosure 8 of the meeting on 22.01.2015</td>
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<td>Sept 8.6</td>
<td>To consider how work coming out of the RSS, i.e. ophthalmology is going to be resourced.</td>
<td>DB/OA</td>
<td>Jan</td>
<td>15.01.15: Enclosure 7 App. 4 of the meeting on 22.01.2015</td>
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<td>12.12.14: It has been agreed by the SMT that due to the change in format of the December Delivery Committee this update on RSS will be submitted in January 2015.</td>
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<td>11.11.14: Briefing paper on Ophthalmology will be submitted for December.</td>
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<td>10.10.14: It is necessary to wait until all practices are live on RSS and this is on-schedule for completion next month. At that point a review of the outputs from the RSS will be conducted.</td>
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Delivery Committee

Thursday 22 January 2015

Present
Martin Wilkinson (MW)  Chief Officer, (Chair)
Alison Browne (AB)  Nurse Director
Dr Hilary Entwistle (HE)  Clinical Director
Dr Faruk Majid (FM)  Senior Clinical Director
Dr Angelika Razzaque (AR)  Clinical Director
Tony Read (TR)  Chief Financial Officer
Marc Rowland (MR)  Chair
Ray Warburton (RW)  Lay Member

Attending
Dr David Abraham (DA)  Senior Clinical Director
Bobbie Fasham (BF)  Corporate Services Officer (Minutes)
Mike Hellier (MH)  Head of System Intelligence
Susanna Masters (SM)  Corporate Director
Sukhvinder Sandhu (SS)  IAPT Service Manager, SLaM
Magdalene Rosairo (MRo)  Head of IAPT Service, SLaM
Ashley O’Shaughnessy  Associate Director Commissioning
Neil Stevenson (NS)  Assistant Director (acute), SECSU
Darren Vella (DV)  Senior Joint Mental Health Commissioning Manager

Apologies
Diana Braithwaite (DB)  Commissioning Director, LCCG
Dee Carlin (DC)  Head of Joint Commissioning, LCCG & LBL

1. Welcome and Introductions

MW welcomed all to the meeting.

2. Apologies

Apologies were taken and noted.

3. Declaration of Interests (DoI)

There were no new interests declared.

4(a). Minutes of previous meeting

Minutes of the Delivery Committee meeting on Thursday 18 December were agreed.

4(b). Action Log
Dec 6.2: All talking therapies within Lewisham will be incorporated within a review to scope and consider need versus the current level of local provision. Business cases to be included on the forward planner of Finance and Investment Committee. Action closed

Dec 6.4: A dementia coding exercise project is currently being developed as a result of the additional £10k that has been allocated to Lewisham CCG by NHS England. Action closed.

Nov 7.2: The review of the assurance received by the implementation of the new quality report has been included on the audit committee forward planner.

All outstanding actions had been addressed and the action log updated.

5. Matters Arising

Implications of the Bubb Report for Lewisham CCG

The Delivery Committee thanked Heather Hughes for the thorough and helpful report and agreed that positive assurance had been received that much of what is recommended in the Bubb report is already in place in Lewisham.

MW made the following comments:
- The Council savings referred to as part of the Continuing Care Review had not been agreed by the CCG
- The transition planning could be supported by the SEL strategy.

In response to RW’s question on the patient’s right to challenge inpatient placements in the current structures MW responded that this was covered in response to Winterbourne and that arrangements are in place through the Community Treatment Reviews. The report highlights that the Bubb report looks to build on these by increasing the number of external people involved in the review.

6. Report from Sub-Groups

Connect Care Programme Board

TR gave the report of the Connect Care Programme Board held on 08.12.2014 and highlighted the following:
- A number of small delays on a few different issues have caused an overall 30 days slippage on the project to date. This will affect the Greenwich site however it is unclear whether this will affect the Lewisham site which was scheduled to go live after Greenwich.

In response to HE’s question regarding the go live date for Lewisham TR stated that he would circulate this outside the meeting.

Action: TR to circulate the go-live date for Connect Care in Lewisham

HE highlighted the importance of IT to progressing the neighbourhood working and the requirement to have an interim solution for the neighbourhood hubs. TR responded that the development of the neighbourhoods was a separate issue to Connect Care. MW requested that a report on the progress of the neighbourhood teams including the barriers and how these might be overcome is taken to the AICPB.

Action: Report on the progress of the neighbourhood teams to be taken to the AICPB and shared with the Delivery Committee for Information.
In response to MW’s question regarding the set-up of a primary care IT group TR stated that the terms of reference was going to be sent to Neighbourhoods Leads with a request for them to suggest the membership of the group. The Primary Care IT Group will report into the Delivery Committee.

The Committee noted the report from the Connect Care Programme Board

Information Governance Steering Group

TR gave the report of the Information Governance Steering Group (IGSG) held on 14.01.2015 and highlighted the following:

- The IGSG agreed an approach for Personal Impact Assessments (PIA) to be undertaken for all changes to CCG business. It was agreed to test the PIA on the LIMOS programme.
- A third party Confidentiality Protocol was agreed as a framework for sharing data with third party organisations. This is being used to share synonymised data with Optimity Matrix who is working on the Vanguard bid.
- A workshop to review IG risks and Information flows will be held in March. This will be used to update the Risk Register and inform the future work programme.
- The IGSG is still awaiting the CSU’s report from the Root Cause Analysis into the Information incidents involving the CCG’s server and a subsequent incident relating to a virus on a shared folder.
- Progress in the collection of evidence for level 2 IG Toolkit compliance was reviewed. The CCG is on track to complete this by end of February 2014.
- A response has been received from Kings relating to their failure to comply with minimum IG requirements in 2013/14. It does not provide adequate assurance and the SIRO will raise this via the Kings Contact Management Board.

RW thanked TR for his assistance with the recent incident relating to a spam email which contained a virus and asked that emails notifying staff of similar incidents are also sent to external contacts. In response to AR’s question regarding whether all Governing Body members should use nhs.net email addresses for CCG business TR responded that this was encouraged.

Action: TR to discuss use of nhs.net email addresses with the independent members of the Governing Body.

In response to MW’s question regarding whether there were any concerns following the collection of evidence for level 2 IG Toolkit compliance TR stated that he was confident the CCG would achieve level 2 across the board with some areas achieving level 3.

The Committee noted the report from the IGSG

FLAG

FM gave the report of the FLAG meeting held on 08.01.2015 and highlighted the following:

- FLAG received a report on access to primary care services and a report on user feedback during December 2014 from Healthwatch. FLAG will be working with Healthwatch to align reporting on actions and to standardise the format of reports. This will make it easier to identify persisting quality or service breaches.
- 32 quality alerts were received during December. The thematic breakdown continues to show two main areas of concern, District Nursing and Radiology.
- LAS performance continues to be a concern. A letter has been drafted which will be sent to Brent commissioners seeking assurance.

- The GP Intelligent Monitoring Reports were reviewed by FLAG. The banding of Lewisham GP practices is comparable to GP practices in Lambeth and Southwark. In Lewisham 3 practices are in band 1, considered to be at highest risk.

- The Quality exception report was received. The reduction in pressure ulcers reported may reflect the reduction in duplication and the single RCA process developed by the CCG’s Associate Director of Nursing and Quality.

DA reported that he had raised concerns about District Nursing at the Contract Monitoring meeting on 19.01.2015 and spoke to Beth Williams, Community Nursing Manager at LGT. It was confirmed that it was appropriate to continue to mention these concerns at the performance meetings until outcomes improve however it was acknowledged that the recruitment of senior nurses was on-going and it will take time for the service to improve. DA highlighted that attendance at the performance meeting was poor and needs to be monitored.

MW highlighted that the GP out of hours provider, SELDOC, was commissioned by opted-in member practices, however the CCG does have a strategic oversight role. The LMC also have a role to support practices to review performance.

In response to RW’s question regarding the methodology used by the CQC to produce the GP intelligent monitoring report MR responded that the methodology had been changed and the banding is considered accurate. HE stated that practices in band 1 are a concern. MW stated that the CCG will request information from NHS England on how they are addressing this through the contract to enable the CCG to look at what support it might be able to provide.

**Action:** MW to write to NHS England regarding the Lewisham practices in band 1.

In response to RW’s question regarding the progress made on understanding the number of suspected and attempted suicides AB stated that the next CQRG with SLaM is on 23.01.2015.

**The Committee noted the report from FLAG**

**Prescribing and Medicines Management Group**

AB gave the report of the Prescribing and Medicines Management Group (PMMG) meeting held on 9.12.2014 and highlighted the following:

- The LMC responded positively regarding data sharing and migrating to EMIS for LIMOS. This is likely to be rolled out in February 2015. Where the LIMOS team are located is currently under review.

- The Medicine Optimisation and Education Training (MOET) proposal has been approved by the neighbourhoods, the LMC and LPC. Training dates are being arranged by the project manager.

DA highlighted the importance of the interface with community nursing and LIMOS.

AB reported that Mike Salter was retiring in March 2015. The job has been advertised internally interviews are scheduled for 09.02.2015.

**The Committee noted the report from the PMMG System Resilience Group**
MW gave the report of the System Resilience Group (SRG) meeting held on 7.01.2015 and highlighted the following:

- The meeting focused on solutions to the current challenges facing the local urgent and emergency care system. Performance against the 4 hour standard has further deteriorated in the last few weeks. LGT’s action plan in response to the verbal feedback from the visits in December of the Emergency Care Intensive Support Team proposes four high impact changes to patient flow.

- McKinsey’s has been commissioned by NHS England, CCGs and LGT to support diagnostic and action planning over the next 6 week period.

- A Chief Officer / Resilience Lead / Lead Clinicians System Wide Summit is planned for 28 January to review progress to date and identify any further support from across the system to improve patient experience and performance.

TR welcomed the external support and asked why McKinsey’s was the chosen firm. MW responded that McKinsey’s have some experience of this type of work and the SRG and NHS England were satisfied that McKinsey was the right choice. AO highlighted that McKinsey’s have meet with DB to understand the local context.

In response to DA’s question regarding whether McKinsey’s were going to be speaking with GPs, MW stated that Lead Clinicians are invited to the Summit on 28 January. DA highlighted the importance of maintaining people in the community which requires clinical support. MW stated that DA and MR would be welcome at the Summit.

HE asked how the SRG receives feedback on system issues from GPs, for example more people are being discharged without a planned hospital discharge. MW stated that feedback should be sent via the GP Quality Alert System however for the issue highlighted the concern should be raised with Glynn Jones, Service Manager for Joint Social Care and Health.

The Committee noted the report from the SRG

7. Integrated Performance Report

TR introduced the Integrated Performance Report.

It was noted that Lewisham CCG’s performance on the NHS England top 8 standards had not significantly moved from the report received by the November Delivery Committee. Challenges still remain on the A&E 4 hour wait, cancer waiting time, 18 week referral to treatment times and diagnostics. TR highlighted that in excess of £10.5m had been invested in the system and targets are still not being met and emphasised that this investment will not be available in 2015/16.

MW highlighted that the update on Winterbourne View report states that there are 6 CCG funded people in this cohort. One of these patients has successfully been discharged and it is expected that another will be discharged by the end of Q4. Community review sessions for 3 of the remaining 4 patients have been scheduled and it has been agreed that 1 review is inappropriate.

Finance

TR gave the month 9 finance report. At month nine the CCG is forecasting to deliver £0.87m above its planned surplus of £3.81 at year end. The following was highlighted:

- The CCG is forecasting to deliver the 2014/15 QIPP target in full.
- The level of risk in the CCG’s financial position is reducing. Year end agreements with the main providers are being discussed and a year-end agreement with LGT has been reached.

- Performance against the Better Practice Payments Code (BPPC) is below plan for the count and measure of invoices. Recovery actions have been put in place and TR expressed confidence that the CCG will achieve the standard.

In response to DA’s question on why the CCG was struggling to meet the BPPC TR stated that there was an issue with the SBS system at the beginning of the year, patient details are no longer included in invoices which makes it difficult to identify whether the invoice is correct and some members of staff are taking too long to approve invoices. In response to RW’s question on why the position on non-NHS invoices was worse than NHS invoices, TR stated that most NHS invoices are linked to contracts.

**Quality**

The Quality Indicators report was noted.

RW highlighted that the responsiveness to complaints was very poor at KCH and LGT. AB stated that LGT have an action plan to improve performance. There are still legacy and backlog issues. Karen Bates has spent some time with the LGT Complaints Lead and it has been identified that many of the concerns raised would not have become complaints if a more frontline Patient Advice Liaison Service was available. MH reported that George Abisi went to the KCH CQRG on 20.01.2015 and further information would be reported back to the Committee.

In response to RW’s question regarding the Adult Safeguarding Training performance at LGT and KCH AB reported that LGT had improved however more information was needed on KCH.

**Action:** AB/FM to contact Southwark CCG regarding the response to complaints and adult safeguarding training performance at KCH.

MW requested that a direction of travel is indicated against the quality indicators in the report and where Trusts have more than one site, site specific information would be useful.

**Action:** Direction of travel to be indicated against the quality indicators and site specific information to be included in the quality indicators report.

AB highlighted that community services measures are still missing however quality of care had improved as indicated by the safety thermometer and reduction in pressure ulcers. DA stated that this could be included in the contract monitoring scorecard however pending measures will be needed to highlight areas that still require improvement.

**QIPP – Referral Support Service (RSS) Update**

AO gave an update on the implementation of the RSS. To date 39 GP practices have shown interest in participating and currently 36 GP practices are ‘live’ with 3 currently receiving training to go ‘live’ by the end of January. In excess of 7000 referrals have been processed. To support the evaluation of the RSS, 20% of patients are sent survey forms each month. For the period of July – November 2014 77 completed forms were received. Feedback has been positive with 78% of patients rating their overall experience as ‘excellent.’

With reference to the action from the Delivery Committee to consider how the information received through the RSS informs the development of Community services AO reported that the focus to date has been on implementation and providing support to practices. However with regards to the large numbers of Ophthalmology referrals a meeting was held with the chair of the LSL Local Ophthalmic
Committee. An agreement in principle was reached for Community Opticians to refer into RSS instead of directly into secondary care. Discussions took place with the group on having a community opticians triaging in the RSS, peer review; and developing alternative community services building on the MECs service.

In response to DA’s question about the capacity for training GP practices AO responded that issues can be raised at the regular monthly meetings and any training required can then be addressed.

DA stated that MSK is already a community service and putting these referrals through the RSS could make it more complicated. AO responded that the aim is to streamline the process and MSK triage will be part of the RSS process.

DA highlighted the need for the RSS to have a Lewisham view. AO responded that there is a team who work solely on Lewisham referrals and there are opportunities to work with this team to address any issues.

HE highlighted that the RSS has benefited practices by relieving time spent chasing appointments. In addition a huge amount of information has been received on referrals.

MR thanked the team for the work on implementing the RSS. AO agreed to bring back a lessons learnt report in April 2015.

Action: Lessons Learnt report on implementing RSS to be brought to the April meeting.

Activity

NS gave the month 8 contract report.

TR stated that the outpatient overperformance is not necessarily driven by the QIPP underperformance and further evidence would be required to demonstrate this.

TR highlighted an error in the report at 1.3 which should read under perform.

DA stated that consultant to consultant referrals remain a concern.

In response to DA’s question on the disparity between sites on unwell babies NS stated that the Trust has been asked for an explanation.

8. IAPT Recovery Rate Audit / Service Development Options

Sukhvinder Sandhu and Magdalene Rosairo joined the meeting and introductions were made. A presentation was given which provided an:
- overview of IAPT service activity against national targets
- overview of the patient journey through the service
- a breakdown for the patient cohorts that are not recovering following access to the service

The results of a recovery audit of patients who did not recover in November 2014 were reviewed. It was noted that a 1/5 of patients made significant improvement but did not meet the recovery threshold. Of those who did not improve the following factors were observed:
- high levels of complexity
- long term health conditions
- therapy interruptions (patient delays and multiple cancellations / DNAs)
- significant drug and alcohol use
- life events / on-going psychosocial stressors (e.g. debt, employment)

It was requested that ethnicity data for the recovery audit was reviewed.

In response to DA's question regarding the tracking of patients who DNA and whether they go onto more acute services MRo responded that patients were not tracked.

MW highlighted the risk of the council savings associated with debt advice and the importance of supporting integration and the right advice being available from other services.

The Committee discussed the recommendations for a number of operational changes that the IAPT service can implement and also a number of service changes that may require the CCG to invest in new resources.

Improving the recovery rate by limiting the number of episodes a client can have was discussed. HE highlighted that multiple episodes and the cluster score are separate issues. It was highlighted that limiting the number of episodes could have a knock on effect to other services. It was suggested that a different form of assessment is needed for those attending multiple times.

RW thanked the team for their report but stated that waiting times were a concern and highlighted the importance of treating those with dual-diagnosis as a whole person and seeing the connections.

In response to TR’s question regarding whether non-improvement factors were unique to Lewisham or if this was a challenge nationally and also if the current service has the right capacity and shape to manage, HE stated that it is not helpful to compare the Lewisham IAPT services with IAPT services elsewhere.

The Delivery Committee AGREED that the scope / specification of the talking therapy review would be signed off by Chair’s Action. Business cases following the review would be considered by the Finance and Investment Committee.

9. Operating Plan Update

SM gave the report highlighting the national planning guidance and timetable for the CCG’s Operating Plan 2015/16 and the proposed approach, local timetable and governance arrangements to develop and agree Lewisham CCG’s Operating Plan.

MW highlighted with reference to the timeline that the ICT PLT had been rescheduled for 12 February as a result of the NHS industrial action planned for 29 January and therefore the Corporate Objectives PLT may need to move to March. HE highlighted that the March PLT is practice based and cannot be used for the Corporate Objectives and a new date would need to be found.

In response to RW’s comment about the extensiveness of the national planning guidance SM stated that meetings to discuss the 2015/16 priorities for each of the five Corporate Objectives were taken placed and each area had been given a resource pack to inform their discussions.

RW requested that the NHS England top 8 standards are prominent.

In response to RW’s question about the engagement on the Joint Commissioning Intentions SM stated that engagement activity had taken place between December 2014 and January 2015 and a paper was going to the Joint Public Engagement Group meeting summarising the outcomes on 29.01.2015.
The performance trajectories were discussed. It was agreed that the CCG will commit to meeting the acute standards but highlight that it is a significant risk as the standards are not currently being met. It was agreed that the trajectories for IAPT and Dementia could be lower than the standard as the CCG was starting from a lower performance level.

In response to DA’s question on cancer waiting times (62 days from GP referral to treatment) and the performance of the tertiary providers, MW stated that one of the CCG’s measures should be on the 42 day referral to highlight provider to provider issues. MH highlighted that GSTT consistently report 10-13 patients where the referral is received post 42 days. A joint tracking post between LGT and GSTT in neurology should improve performance.

The Delivery Committee NOTED the national planning guidance and timetable for the CCGs Operating Plan 2015/16, SUPPORTED the recommendation that the Governing Body delegates to the Delivery Committee the responsibility to sign off the final submission to NHS England and AGREED Chair’s action be taken to agree the proposed performance trajectories and the planning activity and finance measures.

10. 2015/16 Contract Update

Acute and Community

TR gave the update. The first meeting with LGT has taken place, which was an exploratory meeting beginning to consider appetite for a longer term view and managing risk differently. LGT’s view of income is unsustainable and unaffordable. The starting point is different from previous years in that LGT has a £8m deficit for 2014/15.

Mental health and Joint Commissioning

DV gave the update. The second meeting with SLaM is taking place on 28.01.2015 and will focus on discussing the future contract pressure points in more detail.


SM gave the progress report on the delivery of the CCG’s five Corporate Objectives as at end of December 2014. At the end of December there were no corporate objectives assessed as ‘red’ in two or more domains and therefore no exception reports have been requested.

TR highlighted that the risk RAG for the RTT, A&E and cancer plans is red but the progress and impact RAGs are green and suggested that the impact RAG should be amber.

In response to TR’s question regarding the amber impact rating of the corporate governance arrangements, SM stated that changes to the constitution had been submitted to NHS England but a response is yet to be received and in addition conflict of interest declarations have not been completed by member practices.

The Delivery Committee NOTED the progress that has been made to deliver the CCG’s Corporate Objectives for 2014/15.

12. EPRR Assurance Return and Action Plan

BF gave the report highlighting that Lewisham CCG had completed the Emergency Preparedness, Resilience and Response (EPRR) 2014/15 assurance process and had self-assessed its level of compliance as “substantial” against the core standards. This rating and an action plan to close the
assurance gaps has been agreed with NHS England. The action plan addresses the 5 amber and 1 red rating.

In response to MW’s question regarding the red rating BF stated that this relates to the requirement for the CCG to have a separate plan for pandemic influenza and a plan will be drafted as an annex to the EPRR Policy and taken to the June Risk Management Group for review and the July Delivery Committee for approval.

The Delivery Committee NOTED the assurance score and AGREED positive assurance had been received, on behalf of the Governing Body, that the CCG is aware of and prepared for its EPRR responsibilities.

13. Key Items to be reported to the Governing Body

The key items to be reported to the Governing Body include:
- On track to achieve level 2 IG Toolkit compliance
- The concern over the practices in band 1 and the agreed action to contact NHS England
- Winterbourne update
- Positive progress being made on the implementation of the RSS
- IAPT recovery audit and agreed actions
- Proposed approach to develop and agree Lewisham CCG’s Operating Plan agreed
- Positive assurance received in relation to EPRR

14. Quarter 2 2014/15 IFR Activity

The Q2 2014/15 IFR Activity report was taken for information.

15. Minutes from sub-groups

FLAG
The approved minutes of the FLAG meeting held on 11.12.2014 were taken for information.

Prescribing and Medicines Management Group
The approved minutes of the Prescribing and Medicines Management Group meeting held on 12.11.2014 were taken for information.

System Resilience Group
The approved minutes of the System Resilience Group meeting held on 03.12.2014 were taken for information.

16. Any Other Business

There was no other business.

17. Date of Next Meeting

The next meeting would be held on Thursday 26 February 2015
<table>
<thead>
<tr>
<th>REF</th>
<th>ACTIONS</th>
<th>BY WHOM</th>
<th>TIMESCALE</th>
<th>STATUS/COMMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan 6</td>
<td>TR to circulate the go-live date for Connect Care in Lewisham</td>
<td>TR</td>
<td>February</td>
<td></td>
</tr>
<tr>
<td>Jan 6.1</td>
<td>Report on the progress of the neighbourhood teams to be taken to the AICPB and shared with the Delivery Committee for Information.</td>
<td>MW</td>
<td>January</td>
<td>06.02.2015: A update on the Neighbourhood Community Teams was given to the AICPB at their meeting on 06.02.2015 (enclosure 1.1)</td>
</tr>
<tr>
<td>Jan 6.2</td>
<td>TR to discuss use of nhs.net email addresses with the independent members of the Governing Body.</td>
<td>TR</td>
<td>February</td>
<td></td>
</tr>
<tr>
<td>Jan 6.3</td>
<td>MW to write to NHS England regarding the Lewisham practices in band 1.</td>
<td>MW</td>
<td>February</td>
<td>29.01.2015: Email sent</td>
</tr>
<tr>
<td>Jan 7</td>
<td>AB/FM to contact Southwark CCG regarding the response to complaints and adult safeguarding training performance at KCH.</td>
<td>AB/FM</td>
<td>February</td>
<td></td>
</tr>
<tr>
<td>Jan 7.1</td>
<td>Direction of travel to be indicated against the quality indicators and site specific information to be included in the quality indicators report.</td>
<td>GH</td>
<td>February</td>
<td>18.02.2015: Complete the February quality report includes site specific information and direction of travel.</td>
</tr>
<tr>
<td>Jan 7.2</td>
<td>Lessons Learnt report on implementing RSS</td>
<td>AO</td>
<td>April</td>
<td>12.02.15: Lessons Learnt reports are produced each year for all schemes. RSS will be included as a part of the overall QIPP 2014/15 Lessons Learnt Report.</td>
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Strategy and Development Committee Meeting
Thursday 4 December 2014

Members:

Dr David Abraham (DA) Senior Clinical Director, LCCG
Dr Hilary Entwistle (HE) Clinical Director, LCCG
Dr Marc Rowland (MR) Chair, LCCG
Susanna Masters (SM) Corporate Director, LCCG
Charles Malcolm-Smith (CM-S) Head of Strategy & Organisational Development, LCCG
Dr Jacky McLeod (JM) Clinical Director, LCCG
Tony Read (TR) Chief Financial Officer, LCCG
Diana Robbins (DR) Lay Member, LCCG
Martin Wilkinson (MW) Chief Officer, LCCG

In Attendance:

Bobbie Fasham (BF) Corporate Services Officer, LCCG (Minutes)
Mike Hellier (MH) Head of System Intelligence
Dr Faruk Majid (FM) Senior Clinical Director, LCCG
Jane Miller (JM) Deputy Director, Public Health
Dr Angelika Razaque (AR) Clinical Director

1. Welcome and Introductions

DA welcomed all to the meeting.

2. Apologies for Absence

Apologies for absence were taken and recorded.

3. Declarations of Interests

There were no new interests declared.

4(a) Minutes of the previous meeting

The minutes of the meeting on 2 October 2014 were agreed as an accurate record.

4(b) Review of Action Log/Tracker

The following items were discussed and updated.

04.09.2014/10a: The importance of benchmarking was recognised and the Committee is aware of the difficulties in accessing data. The CCG now has access to Dr Foster and Public Health has access to hospital episode statistics. It was agreed to close this action and it was requested that TR bring back a report on the opportunities highlighted by Dr Foster.

Action: TR/MH to review the analysis benchmarking available through Dr Foster

All outstanding actions had been addressed and the action log updated.
5. **Matters Arising**

There were no matters arising.

6. **Report from PEG**

DR gave the report of the PEG meeting on 06.11.2014 and highlighted the following:

- The PEG Terms of Reference were reviewed and updated in respect of the membership and clarity on its purpose and areas of focus. The importance of senior-level support from partners was requested and agreed.

- The proposal for a CCG public reference group to be established was agreed. A business case and implementation plan will be developed.

- Following on from previous discussions on the findings of the GP patient survey, which identified that BME groups feel less supported, it was agreed that further research is needed to understand what support services users need to manage their long term conditions.

DR reported that the meeting with FM, Chair of FLAG, to clarify the purpose of PEG was useful. There had been a misapprehension that the role of PEG was to produce patient experience data. It was clarified that the principle role of PEG is to promote and monitor public engagement in commissioning. It was agreed that a separate meeting would take place with FLAG to focus on the Friends and Family Test.

MW requested that the terms of reference include that PEG will oversee the production of the public engagement annual report and report this to the Governing Body.

The Committee NOTED the report from PEG and subject to the amendment regarding the public engagement annual report APPROVED the revised Terms of Reference.

7. **Annual Equalities and EDS Report**

CM-S requested that the Committee approve the Lewisham CCG Annual Equality report and note the progress made regarding the Equality Delivery System 2 (EDS2) assessment.

The Annual Equality Report fulfils the CCG’s statutory duty to publish information that demonstrates how the CCG is meeting the Public Sector Equality Duty and has to be published by 31 January 2015.

The EDS2 assessment is a framework that supports Lewisham CCG to review current equality performance and identify future priorities and actions. Overall Lewisham CCG is assessed as developing for EDS2 for goals 1, 2 and 4 and achieving for goal 3.

The rational for the rating of Goal 4 was discussed. CM-S highlighted that the current evidence does not show that all Governing Body members are taking an active role. MW stated that the CCG should be able to demonstrate 3 or 4 things that the CCG has done differently as a result of the EDS. SM stated that the evidence for goal 4 also included a review of the Board Papers. A prioritisation of the nine protected characteristics for Lewisham is needed to ensure the task is proportionate. JMi stated that there are two pages on health inequalities for Lewisham in the JSNA which could support the prioritisation of certain characteristics.

The following comments were made:

- Remove the reference to the people of Croydon
- All members of the Governing Body have a requirement to promote equalities not just the lay member who leads on patient and public involvement.
- The report is general rather than specific and therefore reads more like a strategy than a report. It was suggested that evidence that line managers are carrying out their responsibilities should be
found in the appraisal documentation. What is the impact on the QIPP projects of the Equalities Impact Assessment? Are there any metrics for the Interpreting service? The section on serious incidents can be strengthened by the work FLAG has undertaken.

- Staff satisfaction at some of the providers is a concern, a lever to ensure equality and diversity is taken seriously by providers should be included.
- The CCG needs to be tangible about what it is setting out to achieve.
- Capacity is an issue. PEG picked up on a specific issue regarding BME groups feeling less supported with their long term condition in January 2014 and has not yet been able to implement any solution to tackle this.
- Due to the diversity of the population we serve this should be at the heart of every conversation and needs to be more integral to the way we work.

The Committee REQUESTED that further work is carried out on the report to ensure it is more sensitive to Lewisham and demonstrates the evidence of the work undertaken.

Actions:
- CM-S to work with DA and JM to amend the report to ensure it is more sensitive to Lewisham and demonstrates the evidence of the work undertaken
- A Governing Body workshop to be arranged to review the equalities objectives for 2015/16

8. CCG Strategic Plan Update

CM-S gave the report. At its September meeting the Committee recognised the need for further development of the CCG vision and ambition, this work has been undertaken and appendix 1 updated based on the outcomes of the Governing Body workshop on 04.10.2014. Measures which were previously incorporated within ‘better health’ have been more appropriately associated with aspects of care.

In response to MR’s question on whether the primary care framework could be included SM stated that this is included in the primary care strategy and requested the primary care development group review the framework.

Action: Primary Care Development Group to review and comment on the Strategic Commissioning Framework for Primary Care Transformation in London

JMi suggested that the indicators should be expressed as rates rather than numbers and also indicate a higher level of ambition. Indicators on patient experience were discussed. MH stated that the long term condition measure was robust. In response to JM’s question on the interpretation of GP Out of Hours ‘poor scores’ MH stated that this measure was negatively scored. MW asked that positive experience of care should be triangulated with staff experience measures.

Action: CM-S/MH to work on the explanation and presentation of the outcome measures for a public document.

The strategy will be developed further to include the updated financial context and to ensure that it is fully aligned with the south east London strategy. It was agreed that a presentation of the draft CCG strategy and SEL strategy would be given at the January Governing Body meeting

The Committee NOTED the draft updates to the CCG 5 year strategy and REQUESTED further work on the outcome measures.

9. Outcomes Monitoring Framework
MH gave the report which presented the 2013/14 outcome data, highlighted trends for Lewisham CCG and compared these with a set of like CCGs.

JMi highlighted that Lewisham Council is benchmarked against different areas to the CCG and suggested that Public Health share the criteria that is used to select the areas against which the Council is benchmarked.

The following indicators were highlighted:

- **Premature Mortality**
  - Potential Years of Life Lost from Causes Amenable to Healthcare: There has been a significant downward trend for Lewisham CCG which has overtaken the like CCGs. Premature mortality from stroke, vascular dementia, heart disease and respiratory disease is on a downward trend whereas cancer has increased and is now responsible for about a third of the total of potential years of life lost.

In response to DA’s question on how often is the data for “years of life lost” updated against the demographic JMi stated that she would check. It was agreed that the downward trend in premature mortality should be communicated to Membership. HE responded that at the last two PLTs relevant data had been communicated to members however it was difficult on each occasion to get the information that was required.

**Action:** JMi report back on how often the data for “years of life lost” is updated against the demographic.

- **Improving Care for People with Long Term Conditions**
  - Lewisham’s unplanned hospitalisation rates for ambulatory care sensitive conditions such as diabetes, heart failure and respiratory conditions continue to reduce, but are still behind the “like CCGs”.
  - Patient experience includes how well supported those with long term conditions feel and their perceived health. The CCG improved in 12/13 and has maintained that level and both are better than the “like CCGs”.

- **Helping People to Recover from Episodes of Ill Health following Injury**
  - The indicators relate to emergency admissions that should usually not require hospital admission. Both the indicators for adults and children have improved but are still behind the “like CCGs”.
  - The indicators for patient perceived health gain – both hip and knee replacement surgery show significant gain, however groin hernia and varicose veins demonstrate lower health gain.

JMi highlighted the continued upward trend in under 75 mortality for liver disease which is an important indicator for alcohol use.

SM stated that there are three levels of monitoring data, the health and wellbeing dashboard, the CCG’s outcomes framework and the CCG’s performance dashboard. It is important that the same benchmarking is used to ensure clearer read across.

**Action:** MH to ensure the same benchmarking is used across all reports.

**The Committee NOTED the trends on the CCG outcomes.**

10. **Better Care Fund**

SM gave the report. Lewisham’s revised Better Care Fund (BCF) plan was submitted on 19 September and subsequently went through a National Consistent Assurance Review (NCAR) process. The outcome
of this process was that Lewisham’s BCF plan was classified as ‘approved with support’ mainly due to the requirement to provide additional evidence on ‘contingency plan and risk sharing’ arrangements. Additional evidence as required by the NCAR process was submitted on 30 November and it is expected that the outcome will be shared mid-December.

It is a requirement that a pooled budget is established for the BCF with Lewisham Council. This will require a new section 75 agreement. Approval from the Governing Body of the section 75 agreement will be required before April 2015. TR highlighted that governance arrangements need to be agreed that enable the fund to be spent and details how any savings will be shared between the partners or reinvested in the fund. The pooled fund could be managed by the CCG or Lewisham Council. TR advised that it should be managed by the Local Council giving the ability to manage surplus between different financial years.

It is recognised that the delivery of a reduction of emergency admissions will require a significant investment in primary and community based services. It is acknowledged that the pace and scale of this change could be considerably quicker if non recurrent pump priming and double running funds could be identified to supplement the operational costs supported by the BCF. It was proposed that the Lewisham partnership should be able to utilise the non-recurrent funds available to pump prime approved Business Cases by the CCG and Lewisham Council to implement the BCF.

In the event that emergency admissions are not reduced as planned, there is an income risk to the Better Care Fund of cica £1.5m in 2015/16. The CCG’s Finance and Investment Committee has approved the use of 2014/15 flexibilities to create a non-recurrent risk reserve to mitigate this risk.

In response to JM’s question regarding the expenditure risk should the reduction in emergency admissions not materialise sitting solely with the CCG, TR stated that it was common for the risk to sit with the organisation that is the normal funder. However it is not yet clear how the savings will be shared or whether they are used to fund cost pressures or further work to quicken the pace of change.

JMi highlighted that there is no evidence that integration saves money and with a growing population to achieve savings will be a challenge.

In response to DR’s question regarding where the money for the pooled budget is coming from TR stated that £19m is coming from health of which £11m is currently spent by the CCG on commissioning activities.

In response to DR’s question whether this heightens the risk of not being able to use reserves for the acute overspend TR stated that specific reserves have been budgeted for acute overspend and he expected that the CCG will be able to meet its statutory duties for 2014/15.

In response to FM’s question regarding the clinical negligence risk of integrated care TR stated that the responsibility lies with the service provider who is responsible for providing the care under the contract.

The Committee NOTED that Lewisham’s BCF plan had been classified as ‘approved with support’. The Committee NOTED the requirement to create a formal pooled fund from 2015/16 for the BCF through the establishment of a new section 75 agreement with Lewisham Council. The Committee AGREED the use of non-recurrent funds to pump prime approved businesses cases to implement the BCF and the creation of a non-recurrent risk reserve of £1.5m to mitigate the risk that emergency admissions will not be reduced as planned.

11. SEL Clinical Leadership Group Feedback

CM-S requested that the feedback forms were completed and returned by those attending the Clinical Leadership Groups.
MR reported on the CBC workshop on 28.11.2014.

MW highlighted the design guides that were commissioned by the Clinical Leadership Groups and the requirement for Clinical Directors to give feedback.

**Action:** MW to circulate the design guides to Clinical Directors

12. **London Clinical Senate Annual Report, 2013/14**

The London Clinical Senate Annual Report 2013/14 was taken for information. MR highlighted the resource of independent clinical advice that was available to CCGs if required.

13. **Health and Wellbeing Performance Dashboard**

The Health and Wellbeing Performance Dashboard was taken for information. In response to the question on why 1a and 1b was red JMi responded that this was in relation to the benchmarking rather than trend.

14. **Update on the Cancer priority outcome in the Health and Wellbeing Strategy**

The update on the Cancer priority outcome in the Health and Wellbeing Strategy was taken for information.

15. **Reducing Emergency Admissions for people with Long Term Conditions**

The update on reducing emergency admissions for people with Long Term Conditions was taken for information.

16. **Lambeth Southwark and Lewisham Sexual Health Strategy and Consultation**

The Lambeth, Southwark and Lewisham (LSL) Sexual Health Strategy was taken for information. JM stated that Lewisham specific issues, such as HIV late diagnosis and prevalence, are not included in the strategy. AR also highlighted that there was inequality of provision regarding cervical screening now that this was not performed by sexual health clinics. JMi responded that Ruth Hutt as the public health lead focused on the Lewisham population but there had not been engagement on the issue from the CCG. Alison Browne is meeting with Ruth to discuss quality.

**Action:** Include the Sexual Health Strategy as a future agenda item.

17. **Minutes from sub-groups**

PEG: The approved minutes of the meeting held on 04.09.2014 were taken for information.

Adult Integrated Care Programme Board: The Chair’s reports for the meetings held on 05.09.2014, 03.10.2014 and 14.11.2014 were taken for information.

18. **Any Other Business**
JMi highlighted that Lewisham is an outlier on paediatric asthma admissions and that the asthma pathway group had prepared a number of initiatives that could improve this but did not know where to get approval. SM responded that proposals should come to the CCGs Joint SMT and Clinical Directors meeting.

**Action:** Asthma business case to be presented to the Joint SMT and Clinical Directors.

19. **Date of Next Meeting**

Thursday 5\textsuperscript{th} February 2015.
<table>
<thead>
<tr>
<th>REFERENCE</th>
<th>ACTIONS</th>
<th>LEAD/S</th>
<th>DEADLINE</th>
<th>STATUS/COMMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>04.12.2014/4</td>
<td>Dr Foster&lt;br&gt;TR/MH to review the analysis benchmarking available through Dr Foster</td>
<td>TR/MH</td>
<td>April</td>
<td>30.01.2015: Included on the forward planner for the Strategy and Development Committee meeting on 02.04.2015</td>
</tr>
<tr>
<td>04.12.2014/7a</td>
<td><strong>Annual Equality Report</strong>&lt;br&gt;Cm-S to work with DA and JM to amend the report to ensure it is sensitive to Lewisham and demonstrates the evidence of the work undertaken</td>
<td>CM-S / DA/JM</td>
<td>January</td>
<td>30.01.2015: Completed</td>
</tr>
<tr>
<td>04.12.2014/7b</td>
<td><strong>Annual Equality Report</strong>&lt;br&gt;A Governing Body workshop to be arranged to review the equalities objectives for 2015/16</td>
<td>CM-S</td>
<td>March</td>
<td>30.01.2015: To be scheduled</td>
</tr>
<tr>
<td>04.12.2014/8a</td>
<td><strong>Strategic Commissioning Framework for Primary Care Transformation in London</strong>&lt;br&gt;Primary Care Development Group to review and comment on the Strategic Commissioning Framework for Primary Care Transformation in London</td>
<td>JM</td>
<td>January</td>
<td>30.01.2015: Discussed at the Primary Care Development Group meeting on 19.01.2015 as part of the review of corporate objectives for 15/16.</td>
</tr>
<tr>
<td>04.12.2014/8b</td>
<td><strong>CCG 5 Year Strategic Plan</strong>&lt;br&gt;CM-S/MH to work on the explanation and presentation of the measures</td>
<td>CM-S / MH</td>
<td>January</td>
<td>30.01.2015: Pending completion of updated strategy</td>
</tr>
<tr>
<td>04.12.2014/9</td>
<td><strong>Outcomes Monitoring Framework</strong>&lt;br&gt;JMi report back on how often the data for &quot;years of life lost&quot; is updated against the demographic.</td>
<td>JMi</td>
<td>February</td>
<td>30.01.2015: The data comes out once a year and is two years behind. It is presented as a 3 year rolling average of the directly standardised rate of the potential life years lost per 100,000 population. Lewisham’s position is improving. The DSR is improving for England, London &amp; Lewisham. The Lewisham rate was significantly worse than England and London in 2009/11 &amp; 2010/12, however it was not significantly different from England in 2011/13, although it was still significantly worse than London in 2011/13.</td>
</tr>
<tr>
<td>04.12.2014/9</td>
<td><strong>Outcomes Monitoring Framework</strong>&lt;br&gt;MH to ensure the same benchmarking is used across all reports.</td>
<td>MH</td>
<td>February</td>
<td>30.01.2015: CCG benchmarking on outcomes always use the like CCGs from Commissioning for Value. The methodology has been shared with Public Health.</td>
</tr>
<tr>
<td>Date</td>
<td>Topic</td>
<td>Responsible</td>
<td>Due Date</td>
<td>Notes</td>
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<tr>
<td>04.12.2014</td>
<td>SEL Clinical Leadership Groups</td>
<td>MW</td>
<td>December 2014</td>
<td>30.01.2015: Circulated with the papers for the meeting on 05.02.2015</td>
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<tr>
<td>04.12.2014</td>
<td>Sex Health Strategy</td>
<td>BF/ Ruth Hutt</td>
<td>April</td>
<td>30.01.2015: Included on the forward planner for the Strategy and Development Committee meeting on 02.04.2015</td>
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<tr>
<td>04.12.2014</td>
<td>Asthma Business Case</td>
<td>Dr Angelika Razzaque</td>
<td>February</td>
<td>30.01.2015: Included on the forward planner for the Joint Clinical Directors and SMT meeting on 19.02.2015</td>
</tr>
<tr>
<td>04.09.2014</td>
<td>CCG 5 Year Strategy</td>
<td>TR</td>
<td>January 2015</td>
<td>30.01.2015: Included in the papers for the meeting on 05.02.2015 (enclosure 5) 23.09.2014: The local strategy financial case is in line with the SEL strategy. New NHSE planning guidance is expected in December and will be used to update current financial planning assumptions for both and also for 2015/16 budgets.</td>
</tr>
<tr>
<td>04.09.2014</td>
<td>CCG 5 Year Strategy</td>
<td>CM-S</td>
<td>October 2014</td>
<td>30.01.2015: Pending completion of updated strategy 27.11.2014: Further development of the strategy on-going, including update to committee at December 2014 meeting. 25.09.2014: CCG 5 year strategy – to be finalised with development of revised 5 year strategy.</td>
</tr>
<tr>
<td>05.06.2014</td>
<td>Primary Care Development Group ToR</td>
<td>AO</td>
<td>September 2014</td>
<td>30.01.2015: Included in the papers for the meeting on 05.02.2015 (enclosure 3) 02.10.2014: Action is outstanding 04.09.2014: Action is outstanding</td>
</tr>
</tbody>
</table>
ATTENDANCE

PRESENT: Mayor Sir Steve Bullock (Chair), Cllr Chris Best (Cabinet Member for Community Services), Elizabeth Butler (Chair, Lewisham and Greenwich Healthcare Trust), Dr Danny Ruta (Director of Public Health, LBL), Tony Nickson (Director, Voluntary Action Lewisham), Peter Ramrayka (Voluntary and Community Sector), Rosemarie Ramsay (Healthwatch Lewisham), Dr Marc Rowland (Chair of Lewisham Clinical Commissioning Group and Vice-Chair of the Health and Wellbeing Board), Brendan Sarsfield (Family Mosaic).

IN ATTENDANCE: Andrew Billington (Senior Commissioner (HIV Prevention and Sexual Health Commissioning, Lambeth), Jacky Bourke-White (Chief Executive at Age UK Lewisham and Southwark), Elizabeth Clowes (Assistant Director, Commissioning Social Inclusion, Lambeth Integrated Commissioning Team, Lambeth), Mark Edginton (representing Jane Clegg), Henry Hobson (Community Connections project, Age UK Lewisham and Southwark), Ruth Hutt (Consultant in Public Health, Public Health, LBL), Carmel Langstaff (Service Manager, Strategy and Policy, Community Services, LBL), Susanna Masters (Corporate Director, Lewisham Clinical Commissioning Group), Katrina McCormick (Deputy Director, Public Health, LBL), Warwick Tomsett (Head of Commissioning Strategy and Performance Resources, Children and Young People, LBL, representing Frankie Sulke), Sarah Wainer (Head of Strategy, Improvement and Partnerships, Community Services, LBL), Martin Wilkinson (Chief Officer, Lewisham Clinical Commissioning Group), Kalyan DasGupta (Clerk to the Board, LBL).

APOLOGIES: Apologies were received from Aileen Buckton (Executive Director for Community Services, LBL), Dr Simon Parton (Chair of Lewisham Local Medical Committee), Frankie Sulke (Executive Director for Children and Young People, LBL), Jane Clegg (Delivery, NHS SE England – South London Area, London Region).

1. Minutes of the last meeting and matters arising

1.1 The minutes of the last meeting (23 September 2014) were agreed as an accurate record.

1.2 There were no matters arising.

2. Declarations of Interest

2.1 There were no declarations of interest.
3. **Adult Integrated Care Programme, Better Care Fund and Draft Joint Commissioning Intentions**

3.1 Sarah Wainer (Head of Strategy, Improvement and Partnerships, Community Services, LBL) introduced the section on the Adult Integrated Care Programme and invited the Board to note the update. Susanna Masters (Corporate Director, Lewisham Clinical Commissioning Group) introduced the section on the Better Care Fund and the Draft Joint Commissioning Intentions.

3.2 Susanna invited feedback on the Draft Joint Commissioning Intentions and highlighted the following points:

- The Draft Joint Commissioning Intentions are for the whole population, including children services commissioned by the CCG, and cover Lewisham Council’s Adult Social Care and Public Health plans, as well as CCG plans.

- There are a number of significant challenges for Lewisham:
  - People are living longer: 50% of our ASC spend on services is for people aged 75+.
  - More people have one or more long term condition, which now takes up 70% of the health service budget.
  - Deprivation is increasing.
  - Too many people die early from deaths that could be avoided by healthier life styles.
  - People’s experience of care is very variable.
  - Services are under increasing strain due to rising demand, increasing costs and limited budgets.
  - There is an affordability gap, which cannot be addressed by efficiency and productivity. This means the solution is to work together to change what we do and how we do it.

- The approach taken to care is person-centred, with six priority areas:
  - Prevention and early intervention
  - GP practices and primary care
  - Neighbourhood community care for adults
  - Enhanced care and support for adults
  - Children and Young People’s care
  - Supporting Enablers

- A shorter version of the Joint Commissioning Intentions is available.

- A specific consultation on the Draft Joint Commissioning Intentions is also planned for the Joint Commissioning Intentions during November to January 2015.

3.3 The following points were raised or highlighted in the discussion:
• The proposed approach fits in well with commissioning work underway locally and also ties in with national commissioning plans and priorities.

• The CCG’s Operating Plan will align across the six South East London boroughs and be drafted in good time for members to feed their comments in. The timing of its production will depend on national guidance on priorities and on resource assumptions, expected by January 2015.

• The Chair requested that any significant potential changes to the Joint Commissioning Intentions, as it is ‘translated’ to the CCG’s Operating Plan as a result of national guidance, be e-mailed to the Board before 20 January 2015.

3.4 The Board agreed to consider the implications of national guidance on the development of the CCG Operating Plan in early 2015.


4.1 Jacky Bourke-White (Chief Executive at Age UK Lewisham and Southwark) and Henry Hobson (Community Connections project, Age UK Lewisham and Southwark), introduced the report, using studies to illustrate the impact of the project.

4.2 The following points were highlighted in the discussion:

• The link between the voluntary sector and social care is crucial to people in the community.

• The work of Age UK and the Community Connections project is a good example of how to increase the capacity of the voluntary sector.

• With the help of additional facilitators, it would be possible to replicate the work of the Age UK/Community Connections project at scale, to meet the needs of Lewisham’s population at large.

• Engaging GPs in the project has proved challenging. In Southwark, for example, 19 out of 47 GP practices are referring into the wider care system.

• Lewisham is also exploring a web-based, online social prescribing tool. A similar tool is already being trialled in Liverpool.

4.3 The Board agreed to consider a full evaluation of the Community Connections project at the end of the current funding cycle. The Board also agreed to continue to explore the link between the voluntary sector and social care at a future date.

5. Health and Wellbeing Board Strategy Progress Update

5.1 HWB Strategy Performance Dashboard
Dr Danny Ruta (Director of Public Health, LBL), presented the report, highlighting the following points:

- A review of Lewisham’s Health and Wellbeing Strategy Delivery Plan shows that good progress is being made in implementing the strategy, with the majority of actions rated as green. Plans are in place to address actions rated amber or red.

- Potential years of life lost (PYLL) from causes considered amenable to healthcare has significantly reduced in Lewisham.

- Human Papilloma Virus has decreased significantly.

- The alcohol related admission rate is increasing.

- The smoking quit rate is decreasing, although Lewisham is still performing better than the London average.

- The rate of new admissions to long-term care is decreasing, but the percentage of older people (65+) still at home 91 days after discharge from hospital has not changed significantly.

- The avoidable emergency admission rate is reducing and the emergency admission rate for acute conditions that should not usually require hospital admission is decreasing.

5.2 The following issues were raised or highlighted in the discussion:

- Future reports need only focus on exceptions.

- The time-lag between flagging actions and the recording of the outcomes of those actions can sometimes be as long as ten (10) years. A more refined monitoring schedule is needed to explain the overall direction of travel.

5.3 Reducing Emergency Readmissions for People with Long-Term Conditions

Martin Wilkinson (Chief Officer, Lewisham CCG) updated the Board on the progress towards the objectives and outcomes to date on reducing emergency admission for people with long-term conditions, highlighting the following points:

- The work aligns well to the joint work being undertaken through the Adult Integration Programme and the Better Care Fund, with the report updating on the actions against each of the 4 deliverables underpinning Priority 9 attributed to Lewisham CCG.

- The Lewisham Neighbourhood Primary Care Improvement Scheme (LNPCIS) has been structured to support a reduction in emergency admissions with a specific focus on long-term conditions. It also directly supports practices to
work collaborative together to improve the quality of and reduce variation in the delivery of services and care to patients with diabetes, COPD, hypertension and cancer.

- Wider pathway work has focused on conditions like Diabetes, COPD and Dementia.

5.4 In the discussion, it was agreed that future reports will supply quantitative data (supplementary to the high-level data already in the dashboard) to measure the local impact of the intervention.

5.5 Update on Cancer priority outcome in the Health and Wellbeing Strategy

Katrina McCormick (Deputy Director of Public Health, LBL) updated the Board on the progress towards achieving the outcome of Lewisham’s Health and Wellbeing Strategy, Priority Area 2: Increasing the number of people who survive colorectal, breast and lung cancer for 1 and 5 years in the Health and Wellbeing Strategy.

She also provided an overview of activity in relation to cancer in Lewisham.

The report highlighted the following points:

- A range of activity has been undertaken to promote early diagnosis by Lewisham Council, Lewisham CCG, the Community Health Improvement Team and community and voluntary organisations. The “Be clear on Cancer” campaigns, run periodically by Public Health England, have been promoted.

- Lewisham CCG has successfully secured funding from Macmillan to employ a GP Cancer lead. The CCG clinical facilitators will be working with the GP, once in post, to promote screening and early diagnosis in primary care.

5.6 The following issues were raised or highlighted in the discussion:

- Because the impact of the same intervention can vary from one demographic to another, the Lewisham data, to be instructive, also needs to be compared to data from boroughs with similar demographics, e.g. Haringey. Such comparisons might help to explore if there are differences in coverage of screening programmes and, if so, what lessons can be learnt.

- One of the reasons why the coverage rate for Breast Screening in Lewisham is below national rates could include the fact that, because of the churn in Lewisham’s population, some people do not receive appointment reminders. Cervical screening coverage rates have increased in the past year, but this is partly due to the cleansing of GP registers, thereby reducing the denominator.
The Board noted the reports.

Lambeth Southwark and Lewisham Sexual Health Strategy

Ruth Hutt (Consultant in Public Health, Public Health, LBL) summarised the contents of the Lambeth, Southwark and Lewisham Sexual Health Strategy, which was launched in April 2014 for a period of consultation. Ruth confirmed that the strategy had been presented at individual boroughs’ relevant health scrutiny committees. Andrew Billington (Senior Commissioner (HIV Prevention and Sexual Health Commissioning, Lambeth) informed the Board about the consultation process.

The following issues were highlighted:

- The Strategy has identified three key target user groups: men who have sex with men, young people and Black minority ethnic communities.

- Focus groups were held in each borough with these groups to discuss the Strategy and gain feedback.

- Changes will be made to the action plan as a result of the consultation, including with regard to female genital mutilation, Hepatitis, the workforce, community and voluntary sector involvement, partnership working and links between different strategies.

- An implementation plan, incorporating the responses to the consultation, is being developed and will be finalised by the end of November. The implementation plan will show key actions over the next two years to deliver the Strategy. Key early actions are underway now.

- A link to the Strategy will be circulated to the Board. The following links were already supplied as background documents within the report:

  Lambeth, Southwark and Lewisham Sexual Health Strategy 2014-2017
  Lambeth, Southwark and Lewisham, Sexual Health Epidemiology, 2013/14


The following points were raised or highlighted in the discussion:

- The Strategy was reviewed and detailed feedback provided by, among others, primary care networks, the three borough’s Local Medical Committees and Local Pharmacy Committees, and each relevant scrutiny committee; Healthwatch in each borough; local voluntary sector organisations; local NHS (including providers of clinical sexual health services), as well as by children and young people’s services.
• Should the services close in their present form, alternative options for meeting the needs identified will need to be considered. The voluntary and community sector will need to be engaged much more pro-actively, building on Lewisham’s considerable history of HIV-related work with community organisations.

6.4 The Board:

1. Agreed the Lambeth, Southwark and Lewisham Sexual Health Strategy.

2. Suggested that, in order to provide a broader context, figures for Birmingham and Manchester comparable to the ones provided in sections 1.5 and 1.6 of this report be provided in the next report to the Board.

7. Emergency Services Review

7.1 Carmel Langstaff (Service Manager, Strategy and Policy, Community Services, LBL) updated the Board on arrangements for reviewing performance in relation to the recommendations of the Emergency Services Review.

7.2 The Board’s attention was specifically drawn to the recommendations listed in Section 5 of the report.

7.3 The Board was informed that the CCG has ensured that appropriate arrangements for the review of recommendations not included in the dashboard are in place.

7.4 The Board agreed that performance against the Emergency Services Review would in future be considered within the Health and Wellbeing Board performance dashboard or where recommendations fell outside the dashboard would be performance managed by the CCG.


8.1 Carmel Langstaff (Service Manager, Strategy and Policy, Community Services, LBL) updated the Board on the Health and Wellbeing Board draft work programme.

8.2 In addition to the items in the draft Work Programme and those requested in the course of the meeting, Carmel highlighted that the following items had been proposed:

• Lewisham’s Draft Housing Strategy (January 2015)

• Interim Report on CCG Operating Plan with regard to Commissioning Intentions (January 2015 – Susanna Masters)
• Item 10 in January 2015 ("Findings from the Second Voluntary Sector Mental Health Conference") will be for information only.

• A future meeting of the Board should receive an analysis of the implications of the NHS Forward View. This analysis could possibly be incorporated into the report on the South east London strategy (January 2015).

The meeting ended at 16:40 hrs.
MEETING NOTES

Clinical Strategy Committee
Thursday 20 November 2014, 10:45 – 12:45
519, 5th Floor, 160 Tooley Street
Chair – Amr Zeineldine

Members in Attendance
Amr Zeineldine (AZ) Chair CCB and CSC
Jane Fryer (JF) NHS England
Howard Stoate (HS) Bexley CCG
Sarah Blow (SB) Bexley CCG
Andrew Parson (AP) Bromley CCG
Angela Bhan (ABh) Bromley CCG
Adrian McLachlan (AL) Lambeth CCG
Andrew Eyres (AE) Lambeth CCG
Martin Wilkinson (MW) Lewisham CCG
Jonty Heaversedge (JH) Southwark CCG
Andrew Bland (ABl) Southwark CCG
Peter Gluckman (PG) Independent Chair, SE London Stakeholder Reference Group
Steve Whiteman (SW) Royal Borough of Greenwich (for Directors of Public Health)

Other Attendees:
Simon Hall (SH) Greenwich CCG (for Annabel Burn)
Rebecca Rosen (RR) Greenwich CCG (for Ellen Wright)
Gemma Gilbert (GG) NHS England, London Region
Caroline Taylor (CT) Commissioning Strategy Programme
Anna English (AEn) Commissioning Strategy Programme

Apologies:
Ellen Wright (EW) Greenwich CCG
Chris Streather (CS) Managing Director, South London AHSN
Will Tuckley (WT) London Borough of Bexley
Nada Lemic (NL) Director of Public Health, NHS Bromley CCG, SE London Public Health Lead
Annabel Burn (ABu) Greenwich CCG
Marc Rowland (MR) Lewisham CCG

DECISIONS FROM THIS GROUP MEETING

<table>
<thead>
<tr>
<th>ID</th>
<th>Type</th>
<th>Risk / Issue / Action / Decision Description</th>
<th>Owner</th>
<th>Meeting</th>
<th>Agreed Date</th>
<th>Due Date</th>
<th>Status</th>
<th>Comments</th>
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<tbody>
<tr>
<td>017</td>
<td>Action</td>
<td>Any declarations to be fed back to AEn</td>
<td>AEn</td>
<td>CSC</td>
<td>20 Nov</td>
<td>6 Jan</td>
<td>Open</td>
<td></td>
</tr>
<tr>
<td>018</td>
<td>Action</td>
<td>Members to share System Redesign for London NHS Commissioners document locally</td>
<td>ALL</td>
<td>CSC</td>
<td>20 Nov</td>
<td>6 Jan</td>
<td>Open</td>
<td></td>
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<tr>
<td>019</td>
<td>Action</td>
<td>Forward plan to be discussed with COs to ascertain if SRG continuing</td>
<td>CT</td>
<td>CSC</td>
<td>20 Nov</td>
<td>6 Jan</td>
<td>Open</td>
<td></td>
</tr>
</tbody>
</table>
1. Welcome and Apologies:
1.1. Amr Zeinedine welcomed members. Apologies were noted as listed above.
1.2. The minutes of last meeting were AGREED as an accurate account of the discussion that took place.
1.3. Amr Zeinedine asked that members give any updated declarations of interest to Anna English (Action 17)
1.4. Caroline Taylor ran through the actions that had been closed since the previous meeting as reflected in the action log above

### OUTSTANDING ACTIONS FROM PREVIOUS GROUP MEETINGS

<table>
<thead>
<tr>
<th>ID</th>
<th>Type</th>
<th>Risk / Issue / Action / Decision Description</th>
<th>Owner</th>
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<th>Due Date</th>
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<th>Comments</th>
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<tbody>
<tr>
<td>16</td>
<td>Action</td>
<td>111 procurement initiative to be given standing update slot on each agenda</td>
<td>AEn</td>
<td>Clinical Strategy Committee</td>
<td>18th Sept</td>
<td>20th Nov</td>
<td>Open</td>
<td>To be added to next agenda 12/11 ABh advised to discuss at January meeting</td>
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### ACTIONS CLOSED AT THIS MEETING

<table>
<thead>
<tr>
<th>ID</th>
<th>Type</th>
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<th>Owner</th>
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<th>Agreed Date</th>
<th>Due Date</th>
<th>Status</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>015</td>
<td>Action</td>
<td>Agree where GP standards to be sent for consideration (governance)</td>
<td>ABI</td>
<td>CSC</td>
<td>24th July</td>
<td>31st July</td>
<td>Closed</td>
<td>20/11 agenda item, Close</td>
</tr>
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</table>

2.1. Andrew Eyres took members through the draft paper that would be shared with COs and chairs with NHS England later today. He asked for feedback from members and advised that the deadline for feedback to the London Health Commission was the end of November. He asked if there was anything from a south east London perspective that needed adding. There were no further comments from members, who had already been sighted on this document.

2.2. Amr Zeinedine said that CCGs and NHS England must take a proactive approach to this work, and members agreed.

3. System Redesign for London NHS Commissioners:

3.1. Andrew Eyres took members through the proposals about how CCGs work together across London; he highlighted the priority areas on page 12. He continued by describing the proposals for resourcing: London wide enabling work and implementation locally. NHS England had agreed £1 million to support London wide working on the priority issues.

3.2. Andrew Eyres asked the committee to share this document with CCG members (Action 18).

3.3. Andrew Bland said that a small group for south east London would need to be set up (mirroring the system design team for London), 4 or 5 members. He suggested a need to test the governance structures that are shown in the SPG paper. Andrew Eyres added that it was important that the language was correct and reflected that it was a co-produced document.

4. Stakeholder Reference Group Update:

4.1. Peter Gluckman updated members on the work of the Stakeholder Reference Group. He asked the group to use the Stakeholder Reference Group to help shape engagement on any significant decisions.

4.2. Peter Gluckman advised that the Stakeholder Reference Group was coming to the end of its current life cycle and asked if members wished Stakeholder Reference Group to continue to plan ahead and put dates in the diary for future meetings.

4.3. Peter Gluckman was proposing to bring a report to the January meeting outlining the work undertaken over the last 21 months to enable the CCGs to make a decision about the future.

4.4. Peter Gluckman asked if John King as Chair of the Patient and Public Advisory Group for Our Healthier South East London could join Stakeholder Reference Group.

4.5. Caroline Taylor suggested that she work with Peter Gluckman to draft a forward programme for discussion with COs to enable the Clinical Strategy Committee to make a decision. Members AGREED this process and agreed that in the meantime future meetings should be scheduled provisionally (Action 19).

5. Transforming Primary Care in London:

5.1. Gemma Gilbert from NHS England took members through the paper on transforming primary care. She advised that the paper had been developed with CCGs and was still a work in progress. Gemma Gilbert stressed that the current version was not for wider sharing but a final version would be made available.

5.2. The next stage would be to include local plans and local engagement and there would be a need to work with CCGs to do this. Gemma Gilbert and her colleagues would be able to attend local events. She brought members’ attention to the enablers section. The following points were raised:
• The aims were agreed, but how to deliver is the challenge. Co-commissioning alone will not achieve this, but it will help
• What was in the paper presented fits with the south east London Case for Change and the local plans
• Andrew Bland reflected on the links with the south east London strategy and the need to plan by borough to achieve the outcomes if not already doing so
• The implications if practices chose to opt out would require further consideration
• Some of the workforce work across London could be used in the south east London strategy
• It was noted that this was a document for commissioners and did not reference Health Education England, but Gemma Gilbert confirmed that Local Education and Training Board had been included in the work
• It was noted that Health Education South London was included in the south east London strategy. This conversation would be wider than just primary care

5.3. Amr Zeineldine asked that IEG take this piece of work forward and come back to CSC with any recommendations (Action 20)

5.4. Andrew Bland emphasised the need to think about enablers and start to do the work

5.5. Gemma Gilbert confirmed that NHS England was happy to attend CCG events if that would be helpful

5.6. Angela Bhan reflected on the importance of engaging with HESL for the whole strategy, and also with providers

5.7. Andrew Bland suggested that CCGs have local discussions on Primary Care Transformation on the programme, and this group should track progress. Health and Wellbeing Boards and Governing Bodies would receive the final document once it is published on 26 November

6. Co-commissioning of Primary Care:

6.1. Andrew Bland advised that at a recent meeting with NHS England about primary care co-commissioning the timetable and delegation arrangements for primary care co-commissioner were clear and proposals have to be submitted by 30 January 2015. He continued that there were two emerging options for south east London, join at level two – joint committee or level two plus – joint committee with a view to full delegation later

6.2. In the workshop being held in December there is a need to move from a proposition to a decision on:
• Governance
• Conflicts of Interest
• Finance
• Commissioning resources

6.3. It was noted that CCG membership would need to support any proposal and Andrew Eyres reminded the group of the requirements related to any proposed change to a CCG constitution

6.4. Amr Zeineldine asked whether there was any flexibility in the deadlines and Jane Fryer advised that the timescale for proposals could not be varied. She also clarified that if full delegation was required, this was expected to be from April

6.5. Sarah Blow agreed to write up this discussion (Action 21)

6.6. Andrew Bland suggested that level two would allow CCGs to understand the issues before taking on the full risk, Jonty Heaversedge commented on the need for safe governance to be combined with the value of having clinical leadership in CCGs.

6.7. It was agreed that CCG members would wish to have a clear description of the benefits
6.8. Rebecca Rosen suggested that co-commissioning could offer different opportunities to support local networks

6.9. Adrian McLachlan said that there needed to be a clear message that is shared with members outlining the journey and practicalities. There is also a need to think about patients, patient groups and Health and Wellbeing Boards

6.10. Amr Zeineldine summarized the conversation:
- The detailed further delegated work would be to COs
- This committee would continue to take an overview
- Governing Bodies need to be clear about what they are being asked and to make recommendations for consideration by members
- It was noted that south east London was looking at a level 2, with the potential for full delegation later
- Jonty Heaversedge suggested that a description of what would happen practically for members would be useful

7. Collaborative Agreement:

7.1. Caroline Taylor advised that this document had been discussed at the last meeting and with NHS England. She took members through what would be required if they wished to put different arrangements in place together, with an initial proposal for a joint committee, which would be a committee of each CCG’s membership

7.2. Caroline Taylor continued that the NHS England position was not fully resolved as to whether they would be a member of a joint committee or make a decision beforehand or subsequently. Caroline Taylor advised that any decision made should be a unanimous decision of all CCGs

7.3. Sarah Blow asked how the decision of a joint committee rather than a committee in common had been reached. Caroline Taylor explained the process and the legal advice she had received

7.4. One risk identified was that if a joint committee was a committee of the membership, then the relationship with the CCG was not clear. Andrew Eyres noted that the collaboration between CCGs and NHS England was a key element

7.5. Rebecca Rosen added that the important issue was the ability to make good decisions and Martin Wilkinson suggested that we need to be specific about why we are setting up this group, emphasised the importance of unanimous decisions

7.6. Amr Zeineldine suggested that the paper be further iterated to take forward proposals for these governance arrangements and a timescale for this work

7.7. Andrew Bland confirmed that there would be a meeting with NHS England later today which would inform the discussion in relation to system change in primary care co-commissioning and specialised co-commissioning. He suggested therefore that there would be a need to return to this issue

7.8. Caroline Taylor asked members to think about the timetable set out on page five of the paper and that proposed this item would go first to IEG and then come back to the next meeting of this group (Action 22)

7.9. Andrew Eyres reminded members that there were limited opportunities to change constitutions

8. Any Other Business:

8.1. There was no other business discussed

8.2. Amr Zeineldine thanked the group for their time
Next Meeting

15 January 2015  10.45 – 12.45 Xenia, 2 Seker Street, SE1 8UF