AGENDA
A meeting of the Governing Body in public

Date: 13 November 2014
Time: 9:30 – 12:00
Venue: Kings Church meeting rooms, 21 Meadowcourt Road, Lee, SE3 9EU
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 GP representatives, including the Chair/ and or Deputy Chair is present.

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.

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**INTEGRATED GOVERNANCE**

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<td>13.</td>
<td>Integrated Performance Report Including Quality, Finance, QIPP and Performance</td>
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<td>To receive and endorse the reports</td>
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14. **Update on System Resilience in Lewisham, Greenwich and Bexley**  
Enc 10  
Martin Wilkinson

15. **Questions in relation to agenda items from members of the public**  
Chair

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| 16. **Strategy and Development** – Chair’s report from meeting held on 2 October 2014  
*To add London Health Commission Report*  
Enc 11  
Dr David Abraham |

| 17. **Joint Commissioning Intentions for Integrated Care**  
*To receive and approve*  
Enc 12  
Dr David Abraham |

| 18. **South East London 111 Procurement Strategy**  
*To discuss and agree the approach*  
Enc 13  
Diana Braithwaite/Niamh Wilson |

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

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| 22. **District Nursing Service and Lessons Learned Report**  
Enc 14 |

| 23. **Lewisham CCG Annual Engagement Report 2014**  
Enc 15 |

| 24. **Primary Care Development Strategy 2014 -2016**  
Enc 16 |

| 25. **Approved Committee minutes for information only**  
**Delivery Committee** ( August/September 2014 )  
Enc 17  
**Audit Committee** (July 2014)  
Enc 18  
**Strategy and Development** (September 2014)  
Enc 19  
**Health and Well Being Board** ( July 2014)  
Enc 20 |
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<td>26.</td>
<td>Audit Committee Terms of Reference</td>
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| 27. | 12:00 | Date of next meeting – 8 January 2015; 9:30 – 12:00  
Room 1 Civic Suite, Lewisham Town Hall |

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.
Guidance for the management of conflicts of interest during a CCG meeting
From the CCG Constitution. Section 8

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:

- an individual GP or a non-GP partner from a member practice who is not conflicted
- a member of a relevant Health and Wellbeing Board;
- a member of a governing body of another clinical commissioning group.

8.5.5 These arrangements must be recorded in the minutes.
| Name & Title | Organisation | Ends of Interest | Roles held within health care | Roles held outside health care | Other Interests | Volunteer & Other roles | Academic status or qualifications | Number of Directorships, including non-renumerated chairty | Name and Role in Partnership | Positions held in member practices | Relationship to an existing appointee | Members of any governing body that you have an interest in or role in has been reserved | Appointed seat(s) on Clinical governance committees, local or regional | Represented organisations where you believe could impair or otherwise influence your judgement or actions in your role within the NHS | Individuals seeking to do business with the CCG |
|-------------|--------------|-----------------|-------------------------------|-------------------------------|----------------|------------------------|----------------------------------|-------------------------------------|-----------------------------|-----------------------------------|----------------------------------|---------------------------------------------------------------|-----------------------------------------------|---------------------------------------------------------------|
| A. Ben Austin, Dr | GP Partner, Lewisham CCG, South East London | GP Partner | GP Surgery; GP Partner - South East London CCG | GP Partner - South East London CCG | None | None | None | None | None | None | None | None | None | None |
| M. Brown, Dr | GP Partner | GP Partner | GP Surgery; GP Partner - South East London CCG | GP Partner - South East London CCG | None | None | None | None | None | None | None | None | None |
| J. Clarke, Dr | GP Partner | GP Partner | GP Surgery; GP Partner - South East London CCG | GP Partner - South East London CCG | None | None | None | None | None | None | None | None | None |
| M. Davis, Dr | GP Partner | GP Partner | GP Surgery; GP Partner - South East London CCG | GP Partner - South East London CCG | None | None | None | None | None | None | None | None | None |
| R. Farrington, Dr | GP Partner | GP Partner | GP Surgery; GP Partner - South East London CCG | GP Partner - South East London CCG | None | None | None | None | None | None | None | None | None |
| A. K. Franks, Dr | GP Partner | GP Partner | GP Surgery; GP Partner - South East London CCG | GP Partner - South East London CCG | None | None | None | None | None | None | None | None | None |
| J. L. Johnson, Dr | GP Partner | GP Partner | GP Surgery; GP Partner - South East London CCG | GP Partner - South East London CCG | None | None | None | None | None | None | None | None | None |
| L. Khan, Dr | GP Partner | GP Partner | GP Surgery; GP Partner - South East London CCG | GP Partner - South East London CCG | None | None | None | None | None | None | None | None | None |
| M. Lock, Dr | GP Partner | GP Partner | GP Surgery; GP Partner - South East London CCG | GP Partner - South East London CCG | None | None | None | None | None | None | None | None | None |
| A. M. Malik, Dr | GP Partner | GP Partner | GP Surgery; GP Partner - South East London CCG | GP Partner - South East London CCG | None | None | None | None | None | None | None | None | None |
| L. N. Malik, Dr | GP Partner | GP Partner | GP Surgery; GP Partner - South East London CCG | GP Partner - South East London CCG | None | None | None | None | None | None | None | None | None |
| J. Patel, Dr | GP Partner | GP Partner | GP Surgery; GP Partner - South East London CCG | GP Partner - South East London CCG | None | None | None | None | None | None | None | None | None |
| M. Patel, Dr | GP Partner | GP Partner | GP Surgery; GP Partner - South East London CCG | GP Partner - South East London CCG | None | None | None | None | None | None | None | None | None |
| A. R. Rahim, Dr | GP Partner | GP Partner | GP Surgery; GP Partner - South East London CCG | GP Partner - South East London CCG | None | None | None | None | None | None | None | None | None |
| R. R. Rehman, Dr | GP Partner | GP Partner | GP Surgery; GP Partner - South East London CCG | GP Partner - South East London CCG | None | None | None | None | None | None | None | None | None |
| A. Shah, Dr | GP Partner | GP Partner | GP Surgery; GP Partner - South East London CCG | GP Partner - South East London CCG | None | None | None | None | None | None | None | None | None |
| M. Singh, Dr | GP Partner | GP Partner | GP Surgery; GP Partner - South East London CCG | GP Partner - South East London CCG | None | None | None | None | None | None | None | None | None |
| A. S. Siddiqui, Dr | GP Partner | GP Partner | GP Surgery; GP Partner - South East London CCG | GP Partner - South East London CCG | None | None | None | None | None | None | None | None | None |
| M. Uddin, Dr | GP Partner | GP Partner | GP Surgery; GP Partner - South East London CCG | GP Partner - South East London CCG | None | None | None | None | None | None | None | None | None |
| A. Younis, Dr | GP Partner | GP Partner | GP Surgery; GP Partner - South East London CCG | GP Partner - South East London CCG | None | None | None | None | None | None | None | None | None |
Welcome and Announcements

Dr Rowland welcomed all to the meeting and introduced Dr Razzaque, recently appointed as a Clinical Director to the Lewisham CCG Governing Body.

Dr Rowland reported that Dr Chen had resigned from the role of Clinical Director and recorded his thanks for her dedication and hard work.

Declarations of Interest

Dr Razzaque declared her interest in Queens Road Surgery and SELDOC, which will be added to the Governing Body register of interests.

Action: Lesley Aitken
There were no interests declared which would knowingly affect the business of the meeting.

**LEW 14/99 Previous Minutes**

The minutes of the previous meeting were taken as a true record.

**LEW 14/100 Action Log and Matters Arising**

The following updates were taken:

14/81: A report on the IAPT service and the equalities policy and plan to come back to the Delivery Committee.

14/83: In response to Mr Warburton’s question regarding when the Governing Body could expect to see an improvement in the cover sheets Mr Wilkinson responded that improvement would be on-going and this has been included as part of the CCG’s equalities objectives.

14/87: Action outstanding Ms Masters and Ms Buckton to follow up.

14/56: The work to undertake four focus groups with BME patient groups will have taken place by 19.09.2014. A report will be provided to the PEG in November.

14/27: A progress report on the Virtual Patient Record (VPR) deployment and risk management will be provided to the September Delivery Committee.

14/31.3: Lewisham CCG is working with partner organisations on the Quality Summit response. This will be presented at the Governing Body meeting in November.

All outstanding actions had been addressed and the action log updated.

**LEW 14/101 Chair’s Report**

Dr Rowland gave a verbal report and highlighted the following:

- Lewisham CCG’s first AGM was held on 10.09.2014. Feedback has been excellent. Dr Rowland expressed his thanks to all those involved and everyone who participated in the robust discussions.
- The integration work and the Better Care Fund are dominating agenda topics at most meetings.
- A lot is happening locally with regards to the federation agenda.
- Attendance at a meeting of Lewisham Church Leaders on 06.09.2014.
- Attendance at a meeting with the Chief Medical Officer for London and Simon Stevens, Chief Executive of NHS England. The hope is to develop Lewisham in a positive way and influence development elsewhere.

The Governing Body NOTED the report.

**LEW 14/102 Chief Officer’s Report**

Mr Wilkinson gave the report and highlighted the following:

- The six CCGs in south east London are considering the detailed feedback from NHS England on the south east London strategy following the June submission. A review meeting with the CCGs and NHS England has been scheduled for early October. In the meantime the Clinical Leadership Groups will continue to refine and test the service models.
- A number of questions were asked at the AGM about services commissioned by NHS England. The NHS England AGM is on 18.09.2014 at the Queen Elizabeth II conference centre, starting at 17.30 with registration from 17.00.
In response to Mr VanDal’s question on the VPR launch event Mr Read stated that VPR is a joint programme between Lewisham CCG, Lewisham GP practices and LGT. Dr Arun Gupta and Dr Simon Parton attended the event on behalf of the CCG.

Dr Parton reported that the presentation at the launch event had been good. Two main concerns were raised:
1. Information overload – who owns the information
2. Clinical governance – concerns over results and follow ups

In response to Dr Ruta’s question Dr Parton stated that almost all GP clinical information will be accessible, however not all clinical information will be available to all providers and controls within the system will manage access restrictions.

The Governing Body NOTED the report

LEW 14/103 Audit Committee Chair’s Report

Mr Warburton gave the report and highlighted the following:
- The Audit Committee has reviewed and refreshed its annual cycle of business to June 2016. It was noted that two important tasks fall outside that timeframe.
- The Committee acknowledged the importance of presenting an annual report to the Governing Body as good practice however it was agreed that instead the Committee will focus on reviewing its effectiveness.
- Progress made in developing the Risk Registers and BAF for 2014/15 was noted.
- Internal audit gave the Information Governance review a significant assurance rating. A Risk Management review is planned later in the year and provides an opportunity to look at issues relating to the Francis action plan.
- A number of changes are occurring at the SLCSU. The CCG has written to the CSU setting out its expectations.
- The Committee received annual reports from Counter Fraud and Security Management and were satisfied that sufficient assurance had been received in both areas. It was noted the Counter Fraud Anti-Bribery Risk Assessment Tool gave 12 recommended areas of action of which 11 have been completed and one is currently in progress.
- The Committee received for comment some draft budget setting guidance prepared by the Chief Financial Officer.
- The Committee was pleased to hear the End of Year Debt for 2013/14 had been significantly reduced and that it was expected that all debt would be recovered.
- The Committee considered the waiver of tender in regards to a single source supplier for a review of District Nursing Services. It concluded that a waiver of SFIs was justified in process terms; however this was not done in a timely manner. Training on statutory control and purchasing rules has since been completed with staff.
- Following the Department of Health’s proposals for new constitutional requirements for audit committees the Committee is considering the skills range required by the Audit Committee membership and the potential benefits of extending the membership to include additional independent members.

The Governing Body NOTED the report

LEW 14/104 Risk Management and Board Assurance Framework

Mr Wilkinson gave the report. 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.

There is one risk “Primary Care” that has a “very high” residual risk score.
In Ms Robbins absence Mr Wilkinson gave her comment on risk ref. Quality 1: There is potentially still a gap in the patient experience and inequalities information and processes, which can be further strengthened.

Mr Wilkinson referring to Risk Ref. Neighbourhoods stated that further information from risk profiling, the VPR action plan and BCF needs to be added.

Action: Alison Browne

Mr Wilkinson stated that last year the CCG was concerned about the capacity and leadership of the local provider in relation to community services. Pressure needs to continue on the local provider to ensure their focus is not diverted from community services as this is vital to the success of the Corporate Objectives and CCG Strategy.

Mr VanDal requested a review of how assurance is described in the BAF and consideration given to the balance of information received at Governing Body and Quality Committees. The BAF has two components; to monitor the quality of providers and to monitor actions required to improve quality. This is not clear in relation to Risk Ref. Neighbourhoods. Ms Brown responded that metrics to measure improvements in community services have been developed and on-going contract monitoring is in place. Prof David stated that the improvement in community services does not seem to be improving as quickly as we would like and it needs to remain a focus of the Governing Body.

Mr Read referring to Risk Ref. Quality 2 stated that there are significant performance issues and challenges achieving the referral to treatment requirement standard these have not been adequately drawn out in the BAF. There is work across the whole system to improve performance and additional funds have been identified.

Action: Diana Braithwaite

Dr Abraham referring to Risk Ref. Primary Care stated that the way that the risk has been defined ties capacity and capability together. The red rating of the risk relates to the existing workforce. At the AGM the public were concerned about the capacity of primary care to cope with the growing population of Lewisham and increase of care provided in the community. The risk also needs to look forward.

Action: Diana Braithwaite

In response to Dr McLeod’s question regarding whether the impact on practices of the new builds across the borough is being monitored Mr Wilkinson responded that the planning office had discussed the projected growth with the health service. It was suggested that this should be referred to the Health and Wellbeing Board to map population increase against neighbourhood capacity. In response to Dr McLeod’s question regarding proactively communicating with new residents on the services available Dr Entwistle responded that most GPs are keen to increase their practice list size and many GPs would leaflet a new development.

Dr Abraham highlighted the need to focus on the development of the 111 Directory of Services keeping it simple, consistent and reliable.

Mr Warburton made the following comments:
- Concerns expressed by the public at the AGM regarding primary care access. This is an important concern that should be visible in the primary care objective.
- Referral to treatment and A&E performance do not surface as much as they should.
- In some areas assurance gaps are acknowledged but there are no actions to address them. For example it is acknowledged that ‘outcomes and inequalities data is limited and slow moving’ however there is no action to address this or if there is nothing that can be done to address this it should be stated.
- It is positive that the reference to meeting minutes as an assurance source is fewer
- The Audit Committee should be asked to review assurances sources.

Action: All Risk Owners
The Governing Body NOTED the Risk Management Report, NOTED the BAF and CONFIRMED appropriate target scores had been set for the seven risks.

LEW 14/105 Delivery Committee Chair’s Report

Mr Wilkinson gave the report and highlighted the following:

- The August Delivery Committee meeting was not quorate. Decisions were subsequently ratified by absent members and processes put in place to ensure comments received and actions taken forward. Availability of members and the holding of Committee meetings in August will be reviewed.
- Positive assurance has been received from the Information Governance Steering Group (IGSG) on LGT’s recovery action to achieve the minimum Information Governance toolkit standards for 2014/15. Similar assurance is being sought from Kings.
- It was noted that there has been no loss or inappropriate sharing of data as the result of the Information Governance incident relating to the integrity of some specific data on the CCG’s IT server. This did not affect patient information. The IGSG will review the lessons learnt report.
- Lewisham CCG is working with the other five CCGs in south east London on the contract with the CSU for commissioning support services. New service specifications, KPIs, pricing and contract clauses have been agreed. It is anticipated that the contract will be signed in September.
- Operational resilience and capacity planning was discussed. The Committee agreed that Lewisham CCG would not sign off winter bids if they incur double costs and assurance is being sought on this from the CSU. Due to some IT changes regarding the patient admin system on the QE site LGT and the TDA have agreed to report on the RTT constitutional standard annually. This is not a risk for Lewisham patients as not that many will attend the QE site for electives.
- The Committee considered the lessons learnt report on District Nursing. It was agreed that the Governing Body will receive a report in public in November. It was noted that greater and timelier efforts could have been made engaging with the public during the audit.
- The Committee received an exception report on the increased Cdifficile incidents.
- Monitor’s investigation into the Governance arrangements at SLaM is now expected early October and not mid-September as stated in the report.
- Concern was raised at the level of acute overperformance. Mr Read is planning additional financial modelling for the Strategy and Development Committee to reflect possible income and expenditure scenarios that are different to the budget forecasts approved by the Governing Body.
- The Committee asked for a number of improvements to the quality report and additional work on the RAG ratings to ensure they really reflect concerns and in order to gain positive assurance.

In response to Dr McLeod’s question on the CSU contract Mr Wilkinson responded that South London CSU plans to merge with the North West CSU and Kent and Medway CSU to form South East CSU from 01.10.2014. The services Lewisham CCG chose to commission from the CSU were not impacted by the decisions of the other CCGs however where commonality exists it is of benefit to review those services collectively to achieve additional purchasing power. Lewisham CCG is reviewing the communications and procurement services; financial services and governance are being brought in-house, and management of the acute contract, business intelligence support and IT is staying with the CSU. The contract is likely to run for 18 months, during this time the services being commissioned from the CSU will be monitored and other potential providers scoped where appropriate.

The Governing Body NOTED the report

Lew 14/106 Integrated Performance Report

106.1 Quality

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Dr Majid gave the quality exceptions report and highlighted the following:

- The LGT quality improvement plan is monitored by the CQRG which is chaired by either Lewisham or Greenwich CCG. Assurance that an action plan and monitoring processes are in place has been received.
- Whether the district nursing quality concerns should be RAG rated amber or red has been discussed. It was agreed that the amber rating is appropriate. LGT have accepted the findings of the audit. In August the Director of Clinical Services gave a presentation to all Member practices and gave personal assurance that the action plan is being seen through at Board Level.
- How the CCG gets assurance that the CIPs will not have an adverse effect on quality was discussed. Staff and patient feedback is integral.
- A safeguarding training trajectory has been requested from LGT to ensure the Trust has reached the target of 80% by quarter 4 2014/15.
- A total of eight serious incidents in maternity services have been reported for LGT to date for 2014/15. A report has been requested to review whether there are any recurring issues in care.
- LGT has not, for a fifth successive month, met the 70% target for all complaints to have been addressed within 25 days. This has been RAG rated red and the CCG is no longer able to accept legacy issues as a reason for not meeting the target and demanded immediate action.
- Concern has been raised about the increase in suicides for SLaM. Whilst there has been a national increase in suicides further information is required and has been requested for the next SLaM CQRG in September.
- Reports generated by SLaM do not give assurance of training or CRB compliance. Urgent action is being taken to rectify this by the end of September and SLaM has agreed to take on the same reporting framework used by LGT.
- The CQC action plan for the BMI Hospital at Blackheath is on target and the RAG rating has changed to green.
- The number of quality alerts submitted by GPs has reduced however it does not follow that this is the result of the removal of the incentive. GPs will only report quality alerts if actions are taken as a result and feedback is given.
- A meeting has taken place to review the progress on the Francis action plan.

Mr Warburton stated that strong action by the CCG with regards to safeguarding concerns at SLaM is welcomed. In response to whether the RAG rating for the increase in suicides should be changed from amber to red Dr Majid stated that the CCG did not have the information to identify whether there is a thematic underlying cause. Following the CQRG, where further information will be presented, the RAG rating will be reviewed.

In response to Mr Warburton’s request for more details on the themes from quality alerts Ms Browne stated that themes will be identified in future reports.

**Action: Alison Browne**

Mr Read stated that he felt assured that the CCG has appropriate arrangements to review plans but not appropriate arrangements to receive plans. Both LGT and GSTT have challenging CIPs and it gets harder to identify cost improvements as the year goes on and the potentially negative impact on quality increases. A conversation with the Trusts through the CMB may be required.

**Action: Tony Read / Alison Browne**

In response to Mr VanDal’s question on how urgent quality alerts are responded to Ms Browne stated that the CCG had employed a nurse to triage every quality alert and if a patient is at risk immediate action will be taken and fed back to the GP.

In response to Mr Warburton’s concern that in the first four months of 2014/15 there have been the same number of mental health serious incidents reported as the whole of 2013/14 Mr VanDal stated that the number of serious incidents reported does not necessarily reflect quality of care. If only a few serious incidents were reported this would cause concern as it may reflect a negative culture of not reporting in the Trust.
In response to Mr VanDal’s question on the impact on patients of not meeting the constitutional standards Mr Wilkinson stated that a quality summit has taken place with LGT and mitigations are in place. A deep dive on cancer has also been requested for the next CQRG.

Mr Read highlighted that a response to a complaint may be delayed by its complexity and the focus should be on the substance of the response rather than the speed. Dr McLeod responded that the timeliness of a response demonstrates the provider’s attitude to patient feedback. The red rating is justified based solely on the timeliness of the response.

Mr Read requested that the effect of transferring the acute stroke unit from the Queen Elizabeth to the Lewisham Hospital site should be monitored to ensure the standard is not diluted.

Action: Alison Browne

Mr Read asked whether Lewisham CCG was assured on quality issues relating to KCH and GSTT.

Action: Alison Browne

106.2 Performance

Mr Read gave the report and highlighted the following
- The Delivery Committee reviewed an exception report on the increase number of Cdifficile cases in Lewisham residents. Antibiotic prescribing reports have been issued to GP practices and work with NHS England to agree a process for obtaining patient consent to view their medical information is on-going.
- LGT met the 18 weeks referral to treatment standard in May and June 2014. However there has been worsening performance at KCH. Additional funding has been announced to ensure the standard is recovered in Q4 2014/15. Referral to treatment reporting for Queen Elizabeth has been suspended due to the implementation of a new patient based clinical system.
- A revised A&E recovery plan, trajectory and winter plan has been agreed by the System Resilience Group. The Lewisham site is currently achieving the 95% standard but the Queen Elizabeth is not which is resulting in LGT failing the standard overall.

Dr Parton expressed concern that the number of Cdifficile infections had gone up when antibiotic prescribing in practices has gone down. Dr Abraham highlighted that there is an issue with the blanket prescribing of powerful antibiotics in hospital, which is being taken up by Dr Donal O’Sullivan.

Mr Warburton stated that the cancer first treatment 62 days screening referral target has not been achieved for 6 months in the past 12 months and should be RAG rated red.

Action: Mike Hellier

Mr Warburton stated that the action on cdifficile was welcomed, requested an update on the actions and asked the Governing Body to reflect on how the “target” of 33 cases was described. Mr Hewett responded that he had met with Sally Kingsland from NHS England and the national Caldicott Guardian is writing guidance on the issue of consent. A report will come back to the Delivery Committee. Mr Read suggested the use of “threshold” instead of “target.”

Action: Mike Hellier/Graham Hewett

106.3 Finance

Mr Read gave the month 4 finance report and highlighted the following:
- At month 4 the CCG is reporting an overall underspend of £1.41m against its issues budgets. This represents a £0.14m favourable variance against plan, taking into account the requirement to deliver a £3.81m surplus at year end.
- The CCG has received no changes to its allocations in month 4. There are a number of expected allocation increases that will occur from month 5 onwards including winter monies, system resilience funding and specialised services misattributions. The CCG is expecting £2.3m to be returned from NHS England linked to an acute contract variation to correct a specialised
services activity misattribution identified in 2013/14 and £3.7m which relates to the return of the CCG’s 2013/14 surplus.
- Programme budgets and running cost budgets are under-spent.
- The CCG is delivering on the Better Practice Payments Code.
- The acute budget year to date is £0.8m over-spent and the forecast year end position is a £4.13m overspend. The main areas of variance are within elective, outpatients, drugs and devices and critical care. The implementation of the referral support system is not going to recover the variance in outpatients in year however more practices are signing up and an impact is expected in quarter 3 and 4 2014/15.
- Whilst the CCG is on track to achieve its financial duties in 2014/15 an acute overspend is not sustainable going into future years and this will cause significant pressure from April 2014 onwards.

Dr Abraham highlighted that Kings is increasing the capacity of its critical care unit and asked whether colleagues in Lambeth and Southwark have experienced an increase in critical care activity at Kings.

Mr Warburton requested more information on the GSTT overspend.

Mr Warburton highlighted that concerns had been raised regarding the size of the quality agenda and suggested that if the running cost budget is underspent then further resource could be put into managing the quality agenda. Mr Read responded that the CCG has a maximum running cost allowance of £25 per head for 2014/15 which will be reduced to £22.50 from April 2015. Lewisham CCG is currently operating at the level required from April 2015, if more was spent on running costs less could be spent on patient care. Mr Wilkinson added that a lot of resource is put into quality and ensuring patients are safe and highlighted that internal audit were satisfied with the present arrangements for FLAG.

Dr Parton stated schemes developed to reduce the acute overspend take time to produce results. Public engagement needs to be a priority and campaigns such as the yellow-man need to be enhanced.

The Governing Body NOTED the Quality Exceptions report, NOTED the summary metrics report on Corporate Objectives, NOTED the exception report on healthcare acquired infections and NOTED the month 4 Finance Report.

LEW 14/107 Changes to the NHS Lewisham Clinical Commissioning Group Constitution

Mr Hewett reported that the changes to the NHS Lewisham CCG constitution recommended to NHS England by the Membership in June have now been approved.

A further six amendments to the constitution are recommended to ensure sufficient details of the CCG’s strategy and approach to public engagement are included to meet the legal requirements clarified in the recent Bristol CCG case. The four neighbourhoods have reviewed the amendments and recommended the changes to the Membership Forum.

An additional two amendments to the constitution are proposed to resolve an internal inconsistency regarding approval of the appointment of independent members to clarify that appointments are subject to approval by the Membership Forum.

The Membership Forum will be asked to ratify the changes at its meeting on 08.10.2014 prior to submission to NHS England for approval by 01.11.2014.

The Governing Body NOTED the legal advice and SUPPORTED the proposed amendments to the CCG’s constitution.
LEW 14/108  Remuneration Committee Terms of Reference

Mr Warburton requested that the Governing Body approve a change to the Remuneration Committee Terms of Reference so that in relation to business concerning the remuneration of Lay Members the quorum shall consist of any 2 members excluding the lay members.

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

LEW 14/109  Questions in Relation to Agenda Items from Members of the Public

Q – Support was expressed for the VPR however it was asked whether the CCG was confident that it would be successful in a cost-effective and timely way given that previously public sector IT schemes had not been. Mr Read responded that the CCG Governing Body had approved the VPR business case and is confident that the VPR will deliver value for money and improve the way care is co-ordinated. The VPR uses existing technology that is already widely used. The VPR does not create a new record but the ability to connect existing records from different places. The owners of those records will determine how much of the record is available to view.

Q – Referring to the Referral Support Service it was asked whether patients should be concerned that this will be a way of controlling referrals and therefore they might not get the referral they need. Dr McLeod responded that there is variation in clinical practice amongst GPs. The Referral Support Service aims to improve the quality of care in the community by ensuring that the referral is appropriate and of high quality. Mr Wilkinson added that no financial target has been given to GPs and all referrals will be made based on clinical need.

LEW 14/110  Strategy and Development Committee Chair’s Report

Dr Abraham gave the report and highlighted the following:
- Reports were received from the Public Engagement Group, Joint Public Engagement Group and the Maternity Commissioning Steering Group.
- An updated version of the CCG’s strategy was presented. Further work will be undertaken on the strategy to engage with the membership and to further develop the clarity of the vision and ambition.
- The draft Primary Care Strategy was presented. Work will be undertaken to ensure that the planned improvements in outcome measures are more clearly defined.
- The Committee noted the proposed scope and content of the Joint Commissioning Intentions for Integrated Care. Informed by the refreshed CCG Commissioning Strategy and the CCG’s Operating Plan, three priority areas for action have been identified to achieve system wide change: community wide engagement and development, strong primary care, and integrated community based care.
- The Committee reviewed the feedback received from NHS England on our SEL strategy and it was noted that further work is being done to ensure alignment between commissioner and provider planning assumptions.

The Governing Body NOTED the report

LEW 14/111  Primary Care Development Strategy

Mr Wilkinson presented the primary care development strategy 2014-16 which details the actions that Lewisham CCG will take to support primary care providers to improve local health outcomes and the quality of health care services. The strategy was considered by the Strategy and Development Committee at their meeting on 4 September 2014 and subject to the comments made the Strategy and Development Committee recommended that the Governing Body approve the Primary Care Development Strategy 2014-16.
The strategy is a sub strategy of the main CCG strategy and is aligned with the SEL strategy on primary care. The strategy has been developed in consultation with the Governing Body, the Primary Care and Planned Care Group, Public Health, LMC and the Membership.

Comments from the Strategy and Development Committee included:
- The importance of the role that the supporting strategies and implementation plans will play in delivering the aims of the primary care strategy.
- The outcome measures need to be more clearly defined and aligned with the operating dashboard.
- The focus of the strategy is largely on GP practices however it was acknowledged that there are other primary care practitioners and that the scope needs to be widened.

Prof David stated that it was very disappointed that general practice nurses are not mentioned in the definition of primary care nor reflected in the workforce. Lewisham CCG is undertaking an audit of practice nursing and this needs to be reflected.

Mr Warburton stated that the public are concerned about access and this should be a central part of the strategy. Mr Wilkinson responded that this was included within the implementation plan. Dr Entwistle stated that the perception of access needs to be addressed; different people require different types of care. Dr Parton stated that people need better access to the appropriate provider.

In response to Mr Warburton’s question about the role of the GP and whether this was really to act as a gate keeper, Dr Rowland stated that this is one of the roles of a GP however the role has broadened in recent years.

Dr Parton stated that commissioners, providers and the public are currently engaged with what is needed from primary care. Primary care has moved over the last 5 years to an open door, same day access service at the expense of a holistic view. Other resources are needed to ensure patients get long term good care and the public need to be engaged with the conversation.

In response to Mr Warburton’s question on how the CCG was going to guard against the conflicts of interests of the GP members of the Governing Body Dr Abraham stated that all GP members had declared their interests and this particular item focuses on primary care quality not on investment.

Dr Ruta made the following comments:
- Practice nursing is so underappreciated and under resourced and has such potential that they should be specifically mentioned in the document by professional title.
- Further information should be included on breaking down boundaries. It is alluded to under integrated care but the strategy should specifically state that more secondary care will be delivered in a primary care setting.
- The estate section is a key plank of the strategy and needs to expand on how estate, particularly the council and voluntary and community sector estate, will be utilised.

Mr Read stated that the Strategy and Development Committee highlighted the importance of supporting strategies. Co-location and the use of assets are important under the wider context of integration and needs to be considered under wider community working.

Mr VanDal highlighted that there were various models to bring specialist services into the community but the strategy was not at the stage at which the detail could be worked up.

Dr Parton stated that he would not support including a statement about moving more work from secondary care into primary care unless it was adequately resourced.

The Governing Body AGREED for the Primary Care Strategy to be APPROVED by Chair’s action following work to include the comments made by the Strategy and Development Committee and Governing Body.

Action: Ashley O’Shaughnessy
LEW 14/112  Potential Audit and Risk Management Issues

The following issues were identified:
- Review Board Assurance Framework assurance sources

LEW 14/113  Any Other Business

There was no other business reported at this meeting.

LEW 14/114  Questions from Members of the Public

There were no further questions from members of the public.

LEW 14/95  Reports Taken for Information

The annual audit letter for the year ended 31 March 2014 was taken for information.

The approved minutes from the following meetings were taken for information:
- Delivery Committee (26 June 2014 and 24 July 2014)
- Audit Committee (3 June 2014)
- Strategy and Development Committee (5 June 2014)
- Health and Wellbeing Board (25 March 2014)

LEW 14/96  Date of Next Meeting

The next meeting of the Governing Body would be held on Thursday 13 November 2014; 9:30 – 12:00, venue to be confirmed.
<table>
<thead>
<tr>
<th>Minute Reference</th>
<th>Action</th>
<th>Responsible Person</th>
<th>Timescale</th>
<th>Status/Comments</th>
</tr>
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<tbody>
<tr>
<td><strong>September 2014</strong></td>
<td></td>
<td></td>
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<tr>
<td>14/98</td>
<td>Dr Razzaque to complete a conflict of interest declaration form and interests to be added to the Governing Body register of interests.</td>
<td>Lesley Aitken</td>
<td>November 2014</td>
<td>This has been completed and the registered revised.</td>
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<tr>
<td>14/104</td>
<td>Risk Ref. Neighbourhoods - further information from risk profiling, the VPR action plan and BCF to be added.</td>
<td>Alison Browne</td>
<td>November 2014</td>
<td>Appropriate Neighbourhood locations, adequately sized to ensure that the detail in the BCF Application can be fully realised, have been proposed, pending agreement between CCG and L&amp;G. ICT/IG requirements clarified and specifications being drawn up. Operational processes, including Single Point of Access, are being developed. Phase 1 of VPR (now called Connect Care) due for roll-out in February 2015. Access will be available to only one of the initial components of Neighbourhood Community Teams (DNs), but not to the other (Adult Social Care). IG processes being developed may overcome the problem until independent access available to ASC. Better Care Fund precepts being incorporated in risk stratification initiatives, which will then feed in to NCTs and resultant care planning.</td>
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<tr>
<td>14/104.1</td>
<td>Risk Ref. Quality 2 - significant performance issues and challenges achieving the referral to treatment requirement standard to be further drawn out in the BAF.</td>
<td>Diana Braithwaite</td>
<td>November 2014</td>
<td>Reviewed by the Risk Management Group (281014) – amendments to be reflected in the BAF report for November.</td>
</tr>
<tr>
<td>14/104.2</td>
<td>Risk Ref. Primary Care – review the way the risk is described to consider future implications. At the AGM the public were concerned about the capacity of primary care to cope with the growing population of Lewisham and increase of care provided in the community.</td>
<td>Diana Braithwaite</td>
<td>November 2014</td>
<td>Reviewed by the Risk Management Group (281014) – amendments to be reflected in the BAF report for November.</td>
</tr>
<tr>
<td>14/104.3</td>
<td>All risk owners to address assurance gaps in the BAF</td>
<td>All risk owners</td>
<td>November 2014</td>
<td>Reviewed by the Risk Management Group (281014) – amendments to be reflected in the BAF report for November.</td>
</tr>
<tr>
<td>14/106</td>
<td>Themes from quality alerts to be identified and included in future reports</td>
<td>Alison Browne</td>
<td>November 2014</td>
<td>These will be included in the FLaG report from October 2014.</td>
</tr>
<tr>
<td>14/106.1a</td>
<td>A conversation with the Trusts on unidentified CIPs to be taken through the CMB.</td>
<td>Tony Read / Alison Browne</td>
<td>November 2014</td>
<td>For 2014/15 LGT have set an organisational CIP programme totalling £26.5m. £23m savings have been identified to-date. 60% of identified schemes are now fully developed and £1.5m schemes are currently in the &quot;pipeline&quot; development stage. There are 209 schemes in the portfolio, each of those undergo a quality assessment. Few of the schemes, depending on the project, do not need to undergo a full review, as they don’t have direct clinical impact on patient safety, clinical effectiveness or patient experience; these are categorized as “non-applicable”. Out of the 209 schemes: •There are 79 categorized as non-applicable.</td>
</tr>
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130 which require a full QIA. (among which 9 are identified as significant risk)
• 9 are complete and waiting to be signed off.
• 61 are in progress.
The Director of Nursing and the Deputy medical director are responsible to review the schemes and assess any risks. A standard 565 metrics is implemented, which is reviewed by the quality leads, in consultation with the programme managers, focusing on 3 particular areas:
- Patient Safety
- Clinical effectiveness
- Patient experience
If a scheme identifies all 3 of the above areas; it is noted as a significant risk.

| 14/106.1b | The effect of transferring the acute stroke unit from the Queen Elizabeth to the Lewisham Hospital site should be monitored to ensure the standard is not diluted | Alison Browne | November 2014 | Action plan updated to reflect issues and concerns from both QE & UHL. The red challenges will be resolved as part of the transfer. Both sites had issues with repatriation and length of stay, but work is being undertaken to ensure that these two issues are sorted. The consultant vacancy at QE will be resolved with the transfer to UHL, The stroke association has commented on the improved facility being provided at the UHL site will |
A core assessment of the new unit at the end of Q4. There is a detailed plan for the transfer of the 20 patients (with full patient and family involvement). To minimize any impact, any patients who are to be discharged 3 to 4 days after the move, will not be moved to the new unit, but discharged from QEH. There are small numbers of patients identified who will be discharged from the stroke pathway and remain at the QEH for on-going care. The consequence of the single unit is that more patients are expected to be transferred through the repatriation route. The Trust has improved on the direct discharge from the HASU from PRUH, and now LGT is also starting the programme of doing the direct discharge from Kings.

| 14/106.1c | To ensure that Lewisham CCG takes assurance on quality issues relating to KCH and GSTT. | Alison Browne | November 2014 | Deputy Director of Nursing and Head of Information attend the GSTT and KGH CQRGs and escalate issues up and down through FLAG- these are recorded on the LCCG Quality exception report. |
| 106.2a | Review the RAG rating of the cancer first treatment 62 days screening referral target | Mike Hellier | November 2014 | The RAG rating reflects a rolling year rather than a year to date position. This is particularly important for this target where there are low numbers of people entering this pathway, so |
one person waiting longer than 62 days can make the target red in a month. The monthly chart that accompanies indicates whether this is a one month issue or has continued. Recently, there has been one person waiting over 62 days each month. A revised performance framework to reflect how the CCG approaches RAG ratings is being drafted for approval by Delivery Committee.

| 106.2b | An update on action plan to address the rise Cdifficile infections to go back to Delivery Committee | Mike Hellier / Graham Hewett | November 2014 | The update is on the forward planner for the November Delivery Committee. |
| 106.3a | Ask whether colleagues in Lambeth and Southwark have experienced an increase in critical care activity at Kings. | Tony Read | November 2014 | A review of critical care bed days across providers and commissioners in South East London suggests that that Lewisham CCG activity is comparable to other CCGs. |
| 106.3b | Further information on the GSTT overspend to be provided in the finance report | Tony Read | November 2014 |  |
| 14/111 | Primary Care Strategy to be approved by Chair’s action following work to include the comments made by the Strategy and Development Committee and Governing Body. | Ashley O'Shaughnessy | November 2014 | The Primary Care Strategy has been refreshed to include Governing Body comments. A joint Public Engagement event was held with Healthwatch's 'patient reference' group. Feedback from the public has been reviewed by the Primary Care Strategy Group and will be included in the Strategy. |

**July 2014**

<p>| 14/87 | Further conversation on how we can assure effective joint public engagement which is | Susanna Masters / Aileen Buckton | September 2014 | A meeting has taken place to review the way in which joint public |</p>
<table>
<thead>
<tr>
<th>Date</th>
<th>Item Description</th>
<th>Responsible Person(s)</th>
<th>Time Frame</th>
<th>Notes</th>
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<tbody>
<tr>
<td>14/87b</td>
<td>Public Friendly cover sheets for Governing Body papers to be considered</td>
<td>Susanna Masters</td>
<td>November 2014</td>
<td>This would be reviewed for the November meeting.</td>
</tr>
<tr>
<td>May 2014</td>
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<tr>
<td>14/56</td>
<td>Ethnicity information was discussed at PEG, which showed that some patients were having a less than good experience; the reasons for this would be explored further.</td>
<td>Diana Robbins/Susanna Masters</td>
<td>September</td>
<td>Patient focus groups were agreed by the Public Engagement Group as the means to gain greater understanding of the issues underlying the data. Two groups have been undertaken by the Public Engagement team. PEG will receive a full analysis of the outcomes of these focus groups and the further groups.</td>
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<tr>
<td>March 2014</td>
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<tr>
<td>14/31.3</td>
<td>To give a presentation on the Quality Summit</td>
<td>Dr Faruk Majid</td>
<td>To be confirmed</td>
<td>A presentation on the outcomes of the Quality summit has been deferred to ensure that we have received responses from all relevant organisations.</td>
</tr>
</tbody>
</table>
1. Primary Care Development Strategy 2014-16

The Governing Body agreed the strategy to be approved subject to incorporation of comments made by the Strategy Development Committee and the Governing Body. The Strategy, which can be found in the Governing Body papers for information, has been amended to reflect:

- The wider range of primary care contractors – maps can be found in Enclosure 16 appendix A.
- Practice Nursing has been explicitly mentioned as a key member of the primary care workforce.
- The development of estates in collaboration with the Local Authority is stated.
- Patient Public Engagement Section 7.6 has been added.
- Equalities and Diversity Analysis amended on advice of the Lead.

Healthwatch Patient Reference Group

A meeting held on 26th September 2014 produced some helpful and welcome insights into the interpretation of the Primary Care Development Strategy. The issues raised by the group were reviewed by the Primary Care Development Group, responsible for overseeing the production of the Strategy.

The comments were linked back to the high impact changes, where possible, the Healthwatch Patient Reference Group (HPRG) did mention a number of issues that were not necessarily the responsibility of the CCG. However, in the spirit of collaboration and partnership working, the CCG committed to feedback these to be actioned by the appropriate agency.

The areas highlighted at the event on 26 September 2014 are listed below.

Proactive Care
- Health promotion – targeting school age children to have the maximum impact.
- Identification of people who rarely attend practices to ensure they are well and offering patient education.

Accessible Care
- Access to appointments at surgeries
- Appropriate use of other primary care professionals, out of hours, community pharmacy.

Co-ordinated Care
- The importance of care planning and how patients are identified who would benefit from a care plan.
- The importance of improving communication between services to deliver care plans
- The involvement of carers in the planning and delivery of the care plan.
Patient education

**Continuity of care**
- Reiteration of the importance of good communication between service providers.

**Other issues**
- The use of audit to improve the quality of care
- Developing case studies to showcase good practice.

The CCG will continue to engage with local people to identify priorities for the future and to evaluate the progress towards achieving the necessary improvement in outcomes of commissioning plans.

2. **Transforming General Practice Services: Development Standards**

The pre-engagement DRAFT NHS England ‘Transforming General Practice Services: Development Standards’ is due to be published for consultation in November. The development standards reflect and have been defined by patient voices, clinical leaders, best practice, innovation and best evidence. There are 3 sets of standards covering; (i) accessible care, (ii) co-ordinated care and (iii) proactive care.

The CCGs role in supporting improving quality in GP practices (as outlined in our commissioning intentions and corporate objectives) has synergies with the standards. Consequently, the CCG will need to work in partnership with NHS England Primary Care Contracting. In addition, the South East London (SEL) Strategy programme – specifically the Primary Care & Long-term conditions work stream agreed (19.09.14) that standards for GP practices should be delivered at a regional level. Consequently, this objective will be subject to the delivery of the SEL work stream and indeed publication of the final NHS England development standards.

3. **Chair of Greenwich CCG Governing Body**

At an extraordinary meeting of their Governing Body on 22 October 2014 Dr Ellen Wright was appointed as the new Chair of Greenwich CCG Governing Body.

Lewisham CCG has already passed on its thanks to Dr Hany Wahba, the outgoing Chair, for all his collaborative work across South East London working with us and the other CCGs locally.

4. **Better Care Fund**

Lewisham’s Better Care Fund (BCF) was submitted on 19 September 2014, as required by national guidance. Since then a Nationally Consistent Assurance Review (NCAR) process was undertaken to review all BCF plans as either “approved”, “approved with support”, “approved with conditions”; “or not approved”.

The results of the NCAR were published on 30 October. Lewisham’s BCF plan has been classified as ‘approved with support’. This recognises that whilst out BCF plan was considered strong, the review process identified a few areas for improvement, which will be required to be
addressed before we can move to a fully approved status. We will be working with our NHS area team lead Matthew Trainer to agree the timetable to submit the additional information required.

The national breakdown of NCAR results shows that 6 areas have had their plans ‘approved’, 90 are ‘approved with support’, 48 are ‘approved subject to conditions’ and 5 are currently ‘not approved’.

Copies of the Lewisham’s Better Care Fund submission can be obtained from Susanna.masters@nhs.net.

5. Governing Body Workshop

The Governing Body held a workshop on 1 October 2014 with the aim to review the CCG’s strategic vision and those factors that may impact on its success. The Governing Body discussed the CCG’s visions and ambitions, exploring best care and the possible measures needed to be in place to achieve this, and discussed ambitions for better health for our population.

It was agreed that further work will be undertaken on the strategy to engage with the membership, to further develop the clarity of the vision and ambition for health care in the future aligned with the South East London strategic plan by the Strategy and Development Committee.

6. Publications

Two major reports have been published recently:

The Five Year Forward View

NHS England has produced a five year forward view for the NHS working with other national bodies which articulates how the NHS needs to evolve over the next five years. Please find the report at http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf


Martin Wilkinson
Chief Officer – Lewisham CCG
November 2014
1. Main Issues discussed

1.1 Self-Assessment of the Effectiveness of the Audit Committee – Members had participated in a self-assessment of the effectiveness of the Audit Committee using an HFMA (Healthcare Financial Management Association) tool. Committee members committed to some administrative and process improvements, extended dialogue with external assurance providers, extending the self-assessment to include non-Committee members and to explore ways to improve how to gain assurance from other Committees. The Committee also considered its role with regards to quality and clinical audit. The Committee is considering how to best address an identified current gap in terms of financial management experience and skills within the membership.

1.2 Terms of Reference - were reviewed as part of the rolling Audit Committee business programme. Some minor amendments were drafted and the revised terms of reference are provided to the Governing Body for information at the meeting of 13 November 2014.

1.3 Review progress of Clinical Audit and how to pick up issues for the Audit Committee - The CCG has used the Good Governance Institute tool for Commissioning for Quality. The Committee noted that the CCG does not yet have a fully mature approach to clinical audit and aspires to move to a position where clinical audits programmes of key providers are developed in partnership with the CCG and aligned with the CCG’s corporate objectives and key risks to be addressed by a new quality strategy.

1.4 Annual Accounts timetable and plan – The dates for the submission of 2014/15 Annual Report and Accounts have been confirmed as:
Draft – 23 April 2015 (same as for 2013/14)
Final audited – 29 May 2015 (one week earlier than 2013/14)

The Committee has rescheduled Audit Committee meetings in order to review the Annual Report and Accounts prior to submission on behalf of the Governing Body.

Despite all that was fedback to NHS England by this CCG, and others, about the difficult timetable for the 2013/14 accounts, the Committee noted that the timetable for the 2014/15 accounts remains very challenging.

1.5 Progress report from Internal Audit – the Committee reviewed the work of Internal Audit since July. It noted that two further reviews had been completed, and was satisfied that progress on and planning for further in-year reviews was in hand. Among other things, financial reporting to the Governing Body was discussed.

1.6 Audit Commission Consultation on 2015/16 work programme and scales of fees
The Audit Commission will cease in March 2015 as per the requirements of the Local Audit and Accountability Act 2014. A temporary body will appoint new external audit companies...
for public sector bodies, although for the CCG, the current contract for external audit expires in 2017 with an option to extend until 2020.

The proposed scale of audit fees for 2015/16 is £63k (a 25% decrease on 2014/15 fees). The Committee considered the consultation and agreed that no response was necessary by the CCG.

The Committee noted that the CCG will need to establish an independent auditor panel for 2017.

2. **Key achievements**

2.1 **Transition of provider of Local Counter Fraud Specialist (LCFS) and Local Security Management Specialist (LSMS) services** - The Committee noted the commencement of LCFS and LSMS services by TIAA with effect from 1 October 2014 and noted that a well-managed handover took place for both services between Management, TIAA and London Audit Consortium (LAC). In this regard, the Committee had particular praise for Kam Johal of LAC.

2.2 The Committee praised Internal Audit for the clarity and usefulness of their completed reviews, and Management for its positive responses.

3. **Key challenges addressed**

3.1 The Committee has identified a skills gap relating to financial management expertise and experience (see paragraph 1.1)

3.2 There is scope to improve the CCG’s approach to clinical audit with providers to align audit programmes with the CCG’s strategic priorities (see paragraph 1.3).

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

4.1 **Progress report against annual internal audit plan for 2014/15** – Two reviews had been completed in quarter 2. The quality management review achieved an overall assessment of “significant assurance with minor development opportunities” and the financial management review achieved an assessment of “significant assurance.”

Responses to and actions to implement previous internal audit recommendations are being promptly dealt with by Management. At 28 October 2014 all recommendations had been implemented other than the seven new ones raised in the above reports that are agreed and within the targeted due dates.

4.2 **Local Counter Fraud Specialist - Progress report** - A fraud awareness session for staff took place on Thursday 23 October 2014. Further training will be arranged to which Governing Body members will be invited. Training had gone live for Prevent and Deter and staff have been informed that by law the CCG is required to share payroll information for the purpose of data matching with other public sector agencies.
A review of the recruitment of interims by the CCG is in progress. There is one outstanding recommendation (of 18) relating to the Fraud Risk Assessment action plan with regard GP Governing Body Members Conflicts of Interest. This is due to be completed by end December 2014.

There have been no losses or special payments to date in 2014/15. There have been no occasions to waiver SFIs since the last Audit Committee report.

5. **How did the meeting promote quality and safety, help address inequalities and fairness and/or promote and draw on public engagement?**

No direct impact. Improvements to clinical audit systems should positively impact on future quality and safety of services audited.
Governing Body meeting on 13 November 2014

Report from the Chair of the Finance and Investment Committee
Date of Meeting(s) reported: 9 September 2014
Author: Tan Vandal, Chair of Finance and Investment Committee

1. Main Issues discussed

1.1 Confirmation of Chair – Tan Vandal is confirmed as Chair of the Finance and Investment Committee.

1.2 Business Case for Intermediate Care Expansion – The Committee considered and approved a business case proposing a two year enhanced pilot to increase the capacity and capability of intermediate care services in borough.

1.3 Benefits include increased capacity of intermediate care services by 3 beds and continuation of double handed care services agreed by the Delivery Committee in September 2013.

1.4 Estimated costs:
   - £50k – 2014/15
   - £135k – 2015/16

2. Key achievements

2.1 Following provision of the Committee’s requested further information the business case was approved through Chair’s action

3 Key challenges addressed

3.1 The additional capacity will focus on “step up” care and consequently impact positively on avoiding unnecessary hospital admissions.

4 Key risks (include assurances received positive and negative)

4.1 The Committee required further action as follows:
   - Focussed engagement with GP practices within each neighbourhood to ensure the step up model of care is embedded
   - Formal evaluation at 12 months; including a financial and price review.

5 How did the meeting promote quality and safety, help address inequalities and fairness and/or promote and draw on public engagement?

5.1 Additional capacity will assist the avoidance of unnecessary admissions which will in turn contribute positively to the recovery of the NHS constitutional standards (e.g. A&E standards).
ENCLOSURE 6
Governing Body Terms of Reference: Quoracy Rules

<table>
<thead>
<tr>
<th>CLINICAL LEAD:</th>
<th>Dr Marc Rowland</th>
<th>Post Chair of the Governing Body</th>
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</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. consider the quoracy rules for Governing Body meetings
2. make a recommendation if these need to be amended

SUMMARY:
The appropriateness of the Terms of Reference of the Governing Body was questioned at the Governing Body in September 2014 in relation to the rules for achieving quoracy.

Currently the constitution states sets out the rules for quoracy as:

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 conflictual out of a particular agenda item will not contribute to the quoracy of the Board for the duration of that agenda item.

This means that the Governing Body will be deemed to be quorate if the only members present are the elected GP representatives (including the Chair of the Governing Body) and none of the four independent members.

Governing Body is asked to consider whether the rule as it currently stands is appropriate and if not make a recommendation for change.

KEY ISSUES:
- The current Terms of Reference for the Governing Body state that it will be quorate even if none of the independent members are in attendance i.e., the two lay members, the Registered Nurse and the Secondary Care Doctor.
- The Governing Body Terms of Reference are incorporated within the CCG’s constitution.
- Any alteration to the Terms of Reference will require an amendment to the
CCG’s constitution and will need to be agreed by the membership and ratified by NHS England.

**CORPORATE AND STRATEGIC OBJECTIVES**
Robust Governance

**CONSULTATION HISTORY INCLUDING MEMBERS ENGAGEMENT:**
- none

**PUBLIC ENGAGEMENT**
- No public engagement has taken place and none is intended

**HEALTH INEQUALITY DUTY and PUBLIC SECTOR EQUALITY DUTY**
There is no impact

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E-Mail: grham.hewett@nhs.net  
Telephone: 020 3049 3315
A meeting of the Governing Body  
13th November 2014

ENCLOSURE 7  
Risk Management Report and Board Assurance Framework

<table>
<thead>
<tr>
<th>CLINICAL LEAD:</th>
<th>Dr Marc Rowland</th>
<th>Post Chair</th>
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</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>
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</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
3. Confirm that the Risk Management Group has set appropriate target scores for each of the seven risks.

Risk Management Report
The BAF (Attached) groups the risks to achieving the Governing Body’s five Corporate Objectives into seven broad overarching risks.

Risk owners have made significant changes to the BAF since the Governing Body meeting in September and work has been done to improve the format and readability of the document.

Formatting changes:
- A front page has been added and includes a version control table and an automatic "Date Printed" field to ensure integrity of the document.
- The risk scoring matrix has been added to the front page and at the top of all the risk pages.
- A key has been added to the front page to explain the terminology used.
- 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 now shown in red text
- A new column has been added “Response” to indicate what the CCG will do about the risk. i.e. mitigate, accept, transfer, close.
- 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.

**Substantive changes:**

**Quality Risk 1**  
Further assurances have been received regarding the CCG’s systems and processes to monitor the safety, patient experience and clinical effectiveness of commissioned services including significant external assurance from Internal Audit. These additional assurances have led the risk owner to reduce the overarching residual risk to Moderate 6.

**Quality Risk 2**  
The risk owner has rewritten this risk to improve the clarity and extent of controls and to include new controls established for winter planning. As a reflection of the on-going performance difficulties at the acute hospitals and the pressures in the system potentially impacting on the constitutional and contractual commitments the overarching residual risk score has been increased to High 12.

**Financial Governance**  
Additional controls and assurances have been recorded by the risk owner. The controls for expenditure and cash management have been separated. There is no change in the overarching risk score.

**Non-financial governance**  
Further assurances and controls have been added to this risk, which was subject to a deep dive at Audit Committee in October. There has been no change to the overarching risk score.

**Public engagement**  
The risk owner for this risk transferred to the Corporate Director following the restructuring of the CCG in September. The risk has been reviewed and largely rewritten and the overarching risk score increased to High 9. The increase has been driven by recognition that the CCG is not able to clearly demonstrate the impact of public engagement on commissioning plans and because it is not clear how the Joint Public Engagement Group is providing assurance to the CCG.

**Primary care**  
Further assurances and controls have been added to this risk. There has been no change to the overarching risk score.
Neighbourhoods
The risk owner has reviewed the detailed project plans and risks for this corporate objective and made significant changes to the description of the risk. The controls have been reviewed and updated across the whole overarching risk. The result of this is that the overarching risk score has been increased to High 12, driven by the absence of assurance that appropriate information sharing agreements and common information technology are in place.

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

### Heat Map

<table>
<thead>
<tr>
<th>Risk Matrix</th>
<th>Impact</th>
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</thead>
<tbody>
<tr>
<td>Likelihood</td>
<td></td>
</tr>
<tr>
<td>Rare</td>
<td>Negligible 1</td>
</tr>
<tr>
<td></td>
<td>Minor 2</td>
</tr>
<tr>
<td></td>
<td>Moderate 3</td>
</tr>
<tr>
<td></td>
<td>Major 4</td>
</tr>
<tr>
<td></td>
<td>Catastrophic 5</td>
</tr>
<tr>
<td>Unlikely</td>
<td>Quality 1</td>
</tr>
<tr>
<td></td>
<td>Financial Governance</td>
</tr>
<tr>
<td>Possible</td>
<td>Non Financial Governance</td>
</tr>
<tr>
<td></td>
<td>Public Engagement</td>
</tr>
<tr>
<td>Likely</td>
<td>Quality 2</td>
</tr>
<tr>
<td></td>
<td>Neighbourhoods</td>
</tr>
<tr>
<td>Almost certain</td>
<td>Primary Care</td>
</tr>
</tbody>
</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 October 2014.

### 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 help identify where 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.

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E-Mail:  graham.hewett@nhs.net  020 3049 3352
### Risk Scoring Matrix

<table>
<thead>
<tr>
<th>Risk Matrix</th>
<th>Impact</th>
<th>Moderate</th>
<th>Major</th>
<th>Catastrophic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rare</td>
<td>Negligible</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Unlikely</td>
<td>Negligible</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Possible</td>
<td>Negligible</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Likely</td>
<td>Negligible</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Almost Certain</td>
<td>Negligible</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

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.
Governing Body meeting on 13 November 2014

Report from the Chair of the Delivery Committee
Date of Meeting(s) reported: 23 October 2014
Author: Martin Wilkinson, Chair of Delivery Committee

1. Main Issues discussed

1.1 The meeting focused in detail on the top eight performance indicators identified by NHS England for 2014/15, quality indicators reported by FLaG and the CCG’s Finance Report for month 6.

1.2 The CCG has prioritised the use of central NHS monies and additionally invested from the CCG’s 2014/15 budget to targeted improvements to the RTT and A&E performance at Lewisham and Greenwich Trust. The agreed extra additional activity to improve RTT should be completed by December. A recovery trajectory to deliver 95% performance against the A&E 4 hour by March 2015 was agreed. Actual performance is off trajectory. FLAG and CQRGs are reviewing whether increased cancer waiting times are having an adverse quality impact.

2. Key achievements

2.1 At month six the CCG is reporting an overall underspend of £2.03m and is forecasting to deliver its £3.81m planned surplus. The CCG is maintaining this position by releasing its reserves.

2.2 The CCG is reporting that it will meet its QIPP target of £9.99m.

3. Key challenges addressed

3.1 Winterbourne View: There were 6 Lewisham residents in restricted environments outside of the borough at the end of September 2014. The Committee will track this routinely going forward.

3.2 IAPT Recovery Rates and Service Development Options - The access target is 15% out of the total population of need will access the service and enter treatment; the current access rate is 11%. The recovery target is 50% of patients who access the service will move to recovery; the current recovery rate is 43%. The introduction of triage assessments has resulted in an improvement to the recovery rate as a higher proportion of people who may benefit from the service are treated. Since July 2014 20% of patients have been referred out of the service. The Committee has requested scoping of additional service options for review in January 2015.

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

4.1 A&E: Lewisham and Greenwich Trust has the second worst quarterly performance in London. The Lewisham site narrowly missed the standard for Q2 at 94.8%.

4.2 Cancer: The focus is on GP referral to treatment time, for which the constitutional standard is that 85% of patients start their treatment within 62 days of a GP referral for cancer. The CCG
rolling year performance is 79.6%. The recovery trajectory has slipped from Q3 to Q4. The CCG is formally reviewing this through the Contract Management Board and the CQRG.

4.3 There has been significant improvement in the complaints response rate for LGT however they are still not meeting the 70% target for all complaints to have been addressed within 25 days.

4.4 There has been an increase in formal complaints at GSTT and KCH.

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

4.6 Sufficient assurance has not been received from SLaM on safeguarding training or CRB compliance.

4.7 The CQC report on the Blackheath Brain Injury Unit suggests that the unit is non-compliant in 5 of the 16 essential standards.

4.8 LAS performance has dropped and a recent staff survey revealed that 70% of staff would not recommend the organisation as a place to work.

4.9 A District Nursing Service Review progress report will be presented to the Governing Body meeting in November 2014.

4.10 The acute budget year to date is £2.03m over-spent and the forecast year end position is £4.11m over-spent.

4.11 Drawing on budgetary reserves to offset overspends impairs the CCGs ability to invest in year and for following years.

5. How did the meeting promote quality and safety?

5.1 Through the review of quality reports from FLaG and linking quality to financial and other performance metrics (see sections 3 and 4.2 to 4.9)

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 (see 4.1 and 4.2)
### Enclosure 9

**Month 6 Integrated Performance Report**

<table>
<thead>
<tr>
<th>RESPONSIBLE LEAD:</th>
<th>Tony Read, Chief Financial Officer</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AUTHOR:</strong></td>
<td>Mike Hellier, Head of System Intelligence</td>
</tr>
<tr>
<td></td>
<td>Tony Read, Chief Financial Officer</td>
</tr>
<tr>
<td></td>
<td>Alison Browne, Nurse Director</td>
</tr>
<tr>
<td></td>
<td>Nick Brown, Head of Financial Management and Planning</td>
</tr>
</tbody>
</table>

### RECOMMENDATIONS:

The Committee is asked to:

- Note the Quality Exceptions (Appendix 1)
- Note the summary of performance challenges reviewed by Delivery Committee captured in the cover sheet.
- Note the Finance Report for Month 6 (Appendix 2)

### SUMMARY:

The developing Delivery Committee Corporate Objectives metrics dashboard has been further populated since last month. This will form part of the assessment of our Corporate Objectives.

NHS England has identified Top 8 Performance indicators and expects these to be the primary performance focus of CCGs for 2014/15. The CCG’s corporate objectives already included recovery of poor performance in 3 of these indicators; RTT, A&E and cancer waiting times.

Additional investment has been agreed by the CCG aimed specifically at improving the RTT performance and providing resilience throughout winter. There are action plans in place to...
recover the RTT, A&E and cancer waiting times performance to standard. There is some reported slippage in meeting the trajectories for Lewisham and Greenwich Trust, and in the case of cancer waiting times the CCG is seeking to assess any potential adverse quality impact for those waiting the longest.

Activity and cost of emergency admissions is below plan. Elective hospital activity is significantly above plan and there is some correlation with slippage on some QIPP schemes (e.g. Referral Management Service). The net acute overspend is forecast to be Approximately £4m. Despite this the CCG is on target to achieve its financial duties at year end; achievable by the release of reserves and by deferring non recurrent investments. This will adversely impact upon the CCG’s 2015/16 financial plan.

**KEY ISSUES:**

**NHS England Top 8 Performance**

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>Current Issues and Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E</td>
<td>4 Hour Standard (95%)</td>
<td>Lewisham and Greenwich Trust has the second worst quarterly performance in London. The Bexley, Greenwich and Lewisham System Resilience Board has agreed £3.1m investment for winter 2014 and there is recovery trajectory to the standard, especially at QE. Many of the actions in the plan were due to come into effect on November 3rd 2014. There is further funding becoming available and a revised plan and actions is in the process of being agreed by the System Resilience Board. Currently, the Lewisham site narrowly missed the standard for Q2 at 94.8% following a large dip in performance in mid September 14.</td>
</tr>
<tr>
<td>Cancer waiting</td>
<td>62 days from GP referral to</td>
<td>CCG rolling year performance now red rated. See</td>
</tr>
<tr>
<td>times</td>
<td>treatment</td>
<td>below for detail and discussion.</td>
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<tr>
<td>-----------------------</td>
<td>-----------------------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>18 Weeks RTT</td>
<td>Three standards for admitted, non-admitted and incompletes.</td>
<td>The System Resilience Board has agreed funding with NHS England of £1.5m for Lewisham and Greenwich NHS Trust. A further tranche of £0.26m has been agreed for a limited amount of extra work outsourced to BMI Blackheath. Admitted performance is at risk until patients waiting a longer time are treated.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>By the end of August, patients waiting on the incomplete list over 36 weeks have fallen by 25% to 122 and over 42 weeks has fallen by 36% to 56 patients since June 2014.</td>
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<tr>
<td></td>
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<td>There are still 12 patients waiting longer than 52 weeks all at Kings College Hospital in August 2014.</td>
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<tr>
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<td></td>
<td>The extra work to treat longer waiting patients has caused the admitted performance to fall in August 2014 to 80%. Non admitted and incomplete pathway standards are being met.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The number of incomplete pathways (the waiting list) continues to increase 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.</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>6 week waits (99% of diagnostic waiting list within this standard)</td>
<td>CCG delivered this standard, of 99% within 6 weeks, in June and July, following an endoscopy “catch up initiative” at the Lewisham site. In August the CCG’s performance slipped to 97.7% as a result of people waiting for ultrasound at the Lewisham site. The Contract Management Board paper from the Trust indicates that this issue has been resolved.</td>
</tr>
<tr>
<td>Health visitors</td>
<td>Increased Numbers of health visitors.</td>
<td>NHS England is commissioner.</td>
</tr>
<tr>
<td>Improved Access to Psychological Therapies.</td>
<td>15 % of need by Q4 (i.e. 3.75%) Recovery rate 40%+</td>
<td>Quarterly IAPT review. Need measure is currently 3.0% for Q1. Recovery rate for August was 46%, which is a major improvement from last year, which was in the low 30% and this is above the CCG plan. Effectively, the service is now triaging those referred for IAPT services in order to identify those for whom the service would be most effective. A Delivery Committee Paper on the needs of those not identified for IAPT was received in October 2014</td>
</tr>
</tbody>
</table>
February with a further paper in February 2015 to identify any gaps in provision based on an audit of the triage process.

Dementia

Diagnosis rate of prevalence to 58% (NHS England expect 67%). This

The plan for improvement and a business case is in process of being agreed, especially a coding audit in general practice to ensure that all patients are coded to the Dementia Register.

Further work is required to identify the capacity and, hence, waits for the Memory Service.

Winterbourne View

Focus on people still in specialist services, especially those in services outside Lewisham. For these, there is also a focus on reviews in the last 6 months.

At the end of Q2, there were 6 CCG funded people in this cohort (1 less than the end of Q1). All 6 have been reviewed in the last 6 months. The plan is that a further 1 to 2 of these will have been moved by the end of Q3. There are a further 2 Lewisham people commissioned currently by NHS E. The CCG may, of course, have some new patients into this cohort in the next quarter.

Cancer Waiting Times

The focus for the NHS England Top 8 performance is on GP referral to treatment time, for which the constitutional standard is that 85% of patients start their treatment within 62 days of a GP referral for cancer. This standard has not been met in London.

Current rolling year performance for the CCG as a commissioner is 79.6%, which is red rated. It is also becoming consistently red (see run chart for last 12 months – last month is August 2014). In August 2014 there were 9 patients out of 34 waiting over 62 days, which is 4 patients above the threshold. The monthly data up to August 2014 is set out below:
FLAG has asked for an analysis of any increase in over 100 day waits on this pathway, as the CQRG for Lewisham and Greenwich has been tasked with understanding any clinical effect on patients for these very long waits.

The three Trusts in South East London have had visits from the Cancer Waits Intensive Support Team in the early part of 2014 and the Trusts all committed to delivering the recommendations by September 2014, so that this standard would be met in Quarter 3.

Reviews from each Trust have shown that most actions have been met; with Lewisham and Greenwich NHS Trust’s plan having many actions in September 2014.

The South East London overall review took place on 3rd October 2014 and it became apparent that while there are enhanced plans (e.g. a resource between Lewisham and Greenwich and GSTT to expedite tertiary referrals in a timely fashion), there are still risks to performance in Q3. It was agreed to move this meeting from quarterly to monthly during this quarter agreeing any remedial action as necessary. The next meeting is on 11th November 2014.

The Lewisham and Greenwich Trust Board received a report on 14 October that the standard will now be met at the end of Q3 (i.e. for Q4). At the Contract Management Board, the Trust stated that the Trust Board wanted to be assured that the Intensive Support Team identified actions are in place.

There is a clinical summit on cancer between Trust clinicians and GPs in mid-December 2014.

Outcomes
The Outcomes for Healthcare Acquired Infections are included in this paper with two MRSA infections above the zero tolerance level.

There have been 27 CDifficile infections for the first five months of 14/15 with a year to date plan of 15 and an annual plan of 33. There has been a meeting with the London lead to explain the challenge of producing Post Infection Reviews for the ‘community acquired cases’, given the challenges of gaining patient consent for access to medical records.

Other NHS 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. Lewisham people are at an amber rating year to date. 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. Further review by NHS England, the Trust Development Authority and LAS is in progress.

Finance summary

The finance report for Month 6 is at Appendix 2.

As at Month 6 the CCG is reporting an overall underspend of £2.03m against its issued budgets, representing a £0.12m favourable variance against plan.

Running cost budgets are presently reporting a £0.45m underspend.

The acute activity position is available up to July 2014 for Lewisham and Greenwich Trust and August for all other providers. The acute expenditure has been forecast, based on historical trends, and indicates a potential overspend of £4.11m.

At month 6 performance against the Better Practice payments Code is below plan. Recovery actions have been put in place by the Chief Financial Officer.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Plan/Target</th>
<th>Forecast Outturn</th>
<th>Forecast Variance</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Surplus</td>
<td>£3.81m</td>
<td>£3.81m</td>
<td>NIL</td>
<td>Green</td>
</tr>
<tr>
<td>QIPP Delivery</td>
<td>£9.99m</td>
<td>£9.99m</td>
<td>NIL</td>
<td>Green</td>
</tr>
<tr>
<td>Acute Expenditure</td>
<td>£204.87m</td>
<td>£208.98m</td>
<td>(£4.11m)</td>
<td>Amber</td>
</tr>
<tr>
<td>Total Expenditure</td>
<td>£381.38m</td>
<td>£381.38m</td>
<td>NIL</td>
<td>Green</td>
</tr>
<tr>
<td>Better Practice Payments Code</td>
<td>95%</td>
<td>95%</td>
<td>NIL</td>
<td>Amber</td>
</tr>
</tbody>
</table>
**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.

**PUBLIC SECTOR EQUALITY DUTY**

This report does not specifically address the public sector equality duty. However, 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:**
<table>
<thead>
<tr>
<th>Name</th>
<th>Email</th>
<th>Telephone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mike Hellier</td>
<td><a href="mailto:Mike.Hellier@nhs.net">Mike.Hellier@nhs.net</a></td>
<td>0207 206 3322</td>
</tr>
<tr>
<td>Nick Brown</td>
<td><a href="mailto:nick.brown1@nhs.net">nick.brown1@nhs.net</a></td>
<td></td>
</tr>
</tbody>
</table>
Quality Exceptions Report for Governing Body
November 2014

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<td>13</td>
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<tr>
<td>Prevent Further Deaths Reports</td>
<td></td>
</tr>
</tbody>
</table>

✓ Denotes success on a quality issue
## CQC Interventions

<table>
<thead>
<tr>
<th>Name of Provider</th>
<th>CQC Regulation Intervention Action Reported</th>
<th>Date of CQC Intervention</th>
<th>Description of Agreed Improvement Plan / Trajectory</th>
<th>Description of CCG Assurance Process (Note: Responsible Clinician &amp; Officer)</th>
</tr>
</thead>
</table>
| Lewisham and Greenwich Health Care NHS Trust | CQC visit 24 February – March 6th  
All sites visited except community services | May 9th 2014 | Trust Quality improvement plan is presented by:  
- Patient flow  
- Workforce  
- Safety  
- Organisational learning | Action plan is monitored through CQRG part B meeting with NHSE and TDA to chair  
All the actions have been triangulated to create the 5 year strategy. Metrics have been created to link in to the action, which will allow the divisions to monitor the actions.  
Metric score cards to be presented at next CQRG and commissioners have requested a written narrative to accompany the score cards around the impact of the actions. Exception Reports will be provided if actions are not meeting deadlines. |
### Lewisham and Greenwich Healthcare Trust (Acute)

<table>
<thead>
<tr>
<th>R A G</th>
<th>Quality Issue Identified</th>
<th>Commissioner Actions Taken and Planned</th>
<th>CCG Group with Oversight</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Quality concerns in District Nursing services</td>
<td>Improvement plan monitored through an improvement group which reports to Community Contract Group (which reports to Contract Monitoring Board). Healthwatch have been invited to attend. A new Head of Service for Community Services is now in post. A monthly Community Quality metrics dash board report goes to FLAG.</td>
<td>CQRG and FLAG Quality improvement group will oversee action plan on behalf of Contract Management Board (CMB)</td>
</tr>
<tr>
<td></td>
<td>Patient complaints</td>
<td>Despite additional resource and focus, the trust has had a fifth successive month of challenge to hit the 70% target for all complaints to have been addressed within 25 days. There has been significant improvement in the complaints response rate for the whole Trust but they are still at 50%. Monthly complaints reports are being taken to the CQRG and quarterly patient experience reports are going to FLAG.</td>
<td>FLAG CQRG</td>
</tr>
<tr>
<td></td>
<td>CIPS</td>
<td>Continued monitoring quality assurance will be sought through CQRG for any new CIPS and trust has been asked to provide a response on how the gap will be closed through their transformation project.</td>
<td>CQRG FLAG</td>
</tr>
<tr>
<td></td>
<td>Cancer 2 week waits and 62 days quality concerns</td>
<td>Although LGT is on trajectory to achieve both targets by April 2015, there remains concerns particularly with &gt;100 day waits and the impact of quality on these patients. The Cancer Locality groups used to pick up these issues and were disbanded following the dissolution of the PCTs. The CQRG are currently reviewing &gt;100 day breaches of the 62 day target for the quality impact. Capacity concerns around endoscopy and dermatology have been escalated to the Contract Monitoring Board. A Quality Summit is scheduled for 16th December.</td>
<td>HSG FLAG CQRG</td>
</tr>
</tbody>
</table>
### Quality Issue Identified

<table>
<thead>
<tr>
<th>RAG</th>
<th>Quality Issue Identified</th>
<th>Commissioner Actions Taken and Planned</th>
<th>CCG Group with Oversight</th>
</tr>
</thead>
<tbody>
<tr>
<td>62 day cancer waits</td>
<td>Commissioners requested that GST provide details of what actions the Trust was taking with regard to cancer 62 day waits. It was noted that there are separate regular meetings devoted to cancer 62 day performance, which an NHSE representative attends. This produces actions in relation to performance and the CQRG had previously agreed that this was the right forum for dealing with cancer waits as it had the right people attending, covered more than one Trust and therefore could address inter Trust referrals. This did not prevent issues being raised at CQRG, but the actions were not necessarily single Trust specific.</td>
<td>CQRG FLAG</td>
<td></td>
</tr>
<tr>
<td>Hospital Death Review</td>
<td>The Trust gave a verbal report in relation to how GST are reviewing deaths and learning lessons to improve care. GST as a large Trust has a significant number of deaths of about 90 per month even though the mortality rate overall is comparatively low. About two thirds of these occur in acute medicine, in general, geriatric and respiratory. Approximately 30% occur in patients that are in the critical care service at time of death. There are also clusters that occur, when data is aggregated, in areas such as cardiac and children’s services. The Trust is working on a template which is to be rolled out in stages and can be used at monthly reviews with different departments and services. The template needs adapting for different services, and will pull out whether the death was expected or not, and the underlying factors from which learning can be taken. This was not discussed at the meeting so an update will be requested.</td>
<td>CQRG FLAG</td>
<td></td>
</tr>
<tr>
<td>Complaints</td>
<td>There is an increase in formal complaints. GST has contacted other Trusts and it appears this is a general trend. It has been noted that there is a substantial rise in complaints attributed to staff behaviour and this is being investigated and addressed locally in directorates. There is a high compliance with staff appraisals and care and compassion featured in these appraisals. Communication can be an issue especially with the diverse population which the trust serves, and where English is a second language. The communication issues had been reported to the GST Risk and Quality Committee. GH had not detected any staff attitude or behaviour issues coming up in incident investigations generally.</td>
<td>CQRG FLAG</td>
<td></td>
</tr>
<tr>
<td>RAG</td>
<td>Quality Issue Identified</td>
<td>Commissioner Actions Taken and Planned</td>
<td>CCG Group with Oversight</td>
</tr>
<tr>
<td>-----</td>
<td>--------------------------</td>
<td>---------------------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td></td>
<td>Radiology</td>
<td>Radiology SIs: the previous backlog in radiology has potentially contributed to six serious incidents. Commissioners requested assurance that all potential SIs have been identified. Following an audit into all delayed films, six were escalated with potential harm but noting that two of these experienced less than a week delay. The audit has highlighted internal governance processes within the Trust, making it evident that the whole radiology process needs tightening with quicker response times and turnaround particularly in specific pathways e.g., IP and ED. To address this there will be a programme of work beginning in September to look at pathways. There is also a team working on reducing migration risk which is associated with the new IT process. No further discussions regarding this took place at the September CQRG.</td>
<td>Radiology</td>
</tr>
<tr>
<td></td>
<td>Urology</td>
<td>A meeting is being organised to discuss issues with the Urology pathway together with Lewisham CCG. The long term plan for this service is for GSTFT to take over the service from L&amp;GT. Preliminary conversations have taken place between the two Trusts, with a further meeting in the diary and an intention after that meeting to meet with wider stakeholders, including KCH, with a transfer concluded by end Dec.</td>
<td>Urology</td>
</tr>
<tr>
<td></td>
<td>A and E</td>
<td>The outcome performance data for the Emergency Department is being presented to the October CQRG to demonstrate both activity and quality indicators monitored by the Trust.</td>
<td>A and E</td>
</tr>
<tr>
<td></td>
<td>Complaints</td>
<td>A rise in complaints has been noted in both sites PRUH – 54 in July from 34 in June and Denmark Hill - 61. The number of complaints either open or not responded to within 25 working days remained static at 28 cases for the August position. Each Clinical Division has been asked to respond individually. However, it is felt there is a lack of proportionality in complaints response. New guidance, training and process is planned to address speedily simpler complaints and allow for a more detailed focus on complex and serious complaints. There is more of a focus on process and guidance for staff on how to deal effectively and efficiently with complaints. Themes and/or trends will be reported on in the Trust Quality reports.</td>
<td>Complaints</td>
</tr>
<tr>
<td>Falls</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Although there had been a decrease in Falls for 13/14 (1324) from 12/13 (1647) at Denmark Hill, there has been an increase in severity. It is difficult to compare with other trusts, but the KCH performance was similar to others in the Shelford group. Again a variety of actions had been drawn out similar to work on Pressure Ulcers but also including the ongoing exploration of care bundles across TEaM wards, development of a Band 3 pool for 1:1 nursing and improved use of Bed &amp; Chair Sensors. The Trust recognises that current training requires further improvement.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### South London and Maudsley NHS Foundation Trust and other mental health providers

<table>
<thead>
<tr>
<th>RAG</th>
<th>Quality Issue Identified</th>
<th>Commissioner Actions Taken and Planned</th>
<th>CCG Group with oversight</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Safeguarding reporting for adults and children</td>
<td>Reports generated by the trust do not give assurance of training or CRB compliance. Urgent action is being taken to rectify this by end of September so that we are sighted of a report. CAMHS safeguarding training is 100% at level 3 All polices currently being updated</td>
<td>HSG FLAG CQRG</td>
</tr>
</tbody>
</table>
|     | Increase in Suicides                          | Raised with SLaM concerns about increase in suicides. The Trust presented 2005-2011 Suicide data and action plan to improve figures to the CQRG in September. Key actions were;  
  • Changing risk assessment and processes  
  • Strengthening governance and clinical leadership  
  • Self-harm interventions  
  • Additional training in Adult Mental Health for high risk patients | FLAG CQRG                |

### Private Health Providers

<table>
<thead>
<tr>
<th>Quality Issue Identified</th>
<th>Commissioner Actions Taken and Planned</th>
<th>CCG Group with Oversight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thames Brain injury Unit, Blackheath</td>
<td>Following the release of the CQC report in early October pertaining to Blackheath Brain Injury Unit, a meeting will be arranged with NHS England, Lewisham Safeguarding Team, Joint Commissioners, CQC, Greenwich CCG and Lewisham CCG. The report suggests that the unit is non-compliant in 5 of the 16 essential standards.</td>
<td>HSG FLAG</td>
</tr>
<tr>
<td>Quality Issue Identified</td>
<td>Commissioner Actions Taken and Planned</td>
<td>CCG Group with Oversight</td>
</tr>
<tr>
<td>-------------------------</td>
<td>---------------------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Quality Alerts</td>
<td>Future Quality Alerts raised will include outcomes when identified by the Triage Nurse. Triaging of quality alerts continue to take place on a daily basis and FLAG receive a monthly summary of all Quality Alerts,</td>
<td>FLAG Delivery Group</td>
</tr>
</tbody>
</table>

Future Quality Alerts raised will include outcomes when identified by the Triage Nurse. Triaging of quality alerts continue to take place on a daily basis and FLAG receive a monthly summary of all Quality Alerts,
Other Providers

<table>
<thead>
<tr>
<th>Quality Issue Identified</th>
<th>Commissioner Actions Taken and Planned</th>
<th>CCG Group with Oversight</th>
</tr>
</thead>
<tbody>
<tr>
<td>London Ambulance Service (LAS)</td>
<td>Performance in LAS is down and the recent staff survey is poor. More information has been requested from the contracting CCG.</td>
<td>FLAG</td>
</tr>
</tbody>
</table>
1. Quality Alerts submitted over the last 12 months

<table>
<thead>
<tr>
<th>Provider</th>
<th>Proportion of LCCG’s total spend on health care (£)</th>
<th>Oct-13</th>
<th>Nov-13</th>
<th>Dec-14</th>
<th>Jan-14</th>
<th>Feb-14</th>
<th>Mar-14</th>
<th>Apr-14</th>
<th>May-14</th>
<th>Jun-14</th>
<th>Jul-14</th>
<th>Aug-14</th>
<th>Sep-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>LGNT – Lew Community Services</td>
<td>LGNT – Lew Community Services 22,275,692 -6.02%</td>
<td>11</td>
<td>15</td>
<td>11</td>
<td>14</td>
<td>14</td>
<td>18</td>
<td>10</td>
<td>5</td>
<td>7</td>
<td>4</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>LGNT – QEH + PRUH</td>
<td>0 2 1 4 2 5 1 1 0 1</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>GSTT</td>
<td>30,040,892 -8.11%</td>
<td>2</td>
<td>14</td>
<td>6</td>
<td>13</td>
<td>6</td>
<td>10</td>
<td>3</td>
<td>4</td>
<td>9</td>
<td>4</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>KCH</td>
<td>31237808 -8.44%</td>
<td>9</td>
<td>13</td>
<td>5</td>
<td>6</td>
<td>2</td>
<td>5</td>
<td>4</td>
<td>9</td>
<td>5</td>
<td>2</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>SLaM</td>
<td>55,478,660 -14.98%</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>6</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Other</td>
<td>NA</td>
<td>1</td>
<td>15</td>
<td>6</td>
<td>1</td>
<td>7</td>
<td>13</td>
<td>9</td>
<td>11</td>
<td>5</td>
<td>3</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>370,308,000</td>
<td>49</td>
<td>134</td>
<td>85</td>
<td>102</td>
<td>92</td>
<td>120</td>
<td>53</td>
<td>68</td>
<td>69</td>
<td>45</td>
<td>42</td>
<td>35</td>
</tr>
</tbody>
</table>

2. Quality Alerts submitted during Sep 2014

- Total of 35 QAs received
- 15 (43%) QAs concerned LGNT¹ - Lewisham site services
- 7 (20%) QAs concerned Lewisham Community services
- 1 (3%) QAs concerned an LGNT - Greenwich site service and 1 PRUH services
- 4 (11%) QAs concerned GSTT services
- 4 (11%) QAs concerned KCH services
- 2 (6%) QAs concerned SLaM services
- 2 (6%) “Other” QAs. The others concerned services provided by OPD Eye Clinic and GP WIC @waldron

Quality Exceptions October 2014
Page: 10 of 13
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Serious Incidents Reported by Lewisham Providers
01 April 2013 to 30 September 2014

The tables below show the number of Serious Incidents (SI’s) reported by Lewisham Providers for incidents that occurred under their services (including patients who are not registered or live in Lewisham).

### All incidents reported by Lewisham providers 2014/15 by month incident occurred.

<table>
<thead>
<tr>
<th>Date of Incident (Month)</th>
<th>Acute</th>
<th>Community</th>
<th>Mental Health</th>
<th>Child Protection</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>7</td>
<td>3</td>
<td></td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>May</td>
<td>4</td>
<td></td>
<td>1</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>June</td>
<td>6</td>
<td>1</td>
<td>2</td>
<td></td>
<td>9</td>
</tr>
<tr>
<td>July</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>August</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>September</td>
<td>7</td>
<td>2</td>
<td></td>
<td></td>
<td>9</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>30</td>
<td>9</td>
<td>9</td>
<td></td>
<td>48</td>
</tr>
</tbody>
</table>

LGT reported 9 incidents during September;
- 1 Slip / Trip / Fall
- 2 x Unexpected Admission to NICU
- 1 Communicable Disease and Infection Issue
- 4 Pressure Ulcer Grade 3 (3 Acute acquired in April, August and September and 1 Community acquired in August)
- 1 Pressure Ulcer Grade 4 (Community acquired in August)

Out of the 9 incidents reported, only 1 was reported within 2 working days.

SLaM reported 0 incidents for Lewisham throughout September. The Grade 2 incident reported last month was downgraded to a Grade 1 as the victim survived the attack.

### All incidents reported by Lewisham Providers 2013/14 by month incident occurred.

<table>
<thead>
<tr>
<th>Date of Incident (Month)</th>
<th>Acute</th>
<th>Community</th>
<th>Mental Health</th>
<th>Child Protection</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>13</td>
<td>14</td>
<td></td>
<td></td>
<td>27</td>
</tr>
<tr>
<td>May</td>
<td>7</td>
<td>8</td>
<td>1</td>
<td>1</td>
<td>17</td>
</tr>
<tr>
<td>June</td>
<td>5</td>
<td>9</td>
<td></td>
<td></td>
<td>14</td>
</tr>
<tr>
<td>July</td>
<td>6</td>
<td>8</td>
<td></td>
<td></td>
<td>14</td>
</tr>
<tr>
<td>August</td>
<td>7</td>
<td>5</td>
<td></td>
<td></td>
<td>12</td>
</tr>
<tr>
<td>September</td>
<td>2</td>
<td>12</td>
<td>1</td>
<td></td>
<td>15</td>
</tr>
<tr>
<td>October</td>
<td>5</td>
<td>12</td>
<td>2</td>
<td></td>
<td>19</td>
</tr>
<tr>
<td>November</td>
<td>9</td>
<td>8</td>
<td>1</td>
<td></td>
<td>18</td>
</tr>
<tr>
<td>December</td>
<td>4</td>
<td>10</td>
<td>1</td>
<td></td>
<td>15</td>
</tr>
<tr>
<td>January</td>
<td>8</td>
<td>10</td>
<td>2</td>
<td></td>
<td>20</td>
</tr>
<tr>
<td>February</td>
<td>5</td>
<td>4</td>
<td>2</td>
<td></td>
<td>11</td>
</tr>
<tr>
<td>March</td>
<td>6</td>
<td>1</td>
<td></td>
<td></td>
<td>7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>77</td>
<td>101</td>
<td>10</td>
<td>1</td>
<td>189</td>
</tr>
</tbody>
</table>
The table below shows the type and number of incidents reported by Lewisham & Greenwich NHS Trust from 1st April 2013 to 30th September 2014.

<table>
<thead>
<tr>
<th>Incident Type</th>
<th>No of SI’s 2013 / 2014</th>
<th>No of SI’s 2014 / 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adverse Media Coverage <em>(SLaM)</em></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Confidential Information Leak</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Communicable Disease and Infection Issue</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Confidential Information Leak <em>(SLaM)</em></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Delayed Diagnosis</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Maternity Services – Intrapartum Death</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Maternity Services – Maternal Death</td>
<td>1</td>
<td>1 (indirect)</td>
</tr>
<tr>
<td>Maternity Services – Maternal unplanned admission to ITU</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Maternity Services – Unexpected admission to NICU</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Maternity Services – Unexpected neonatal death</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Maternity Service</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>MRSA Bacteraemia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pressure Ulcer Grade 3</td>
<td>74* (131 reported)</td>
<td>20</td>
</tr>
<tr>
<td>Pressure Ulcer Grade 4</td>
<td>10* (18 reported)</td>
<td>6</td>
</tr>
<tr>
<td>Radiology / Scanning Incident</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Slips / Trips / Falls</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Suspected Suicide <em>(SLaM)</em></td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Attempted Suicide by Inpatient (in receipt) <em>(SLaM)</em></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Serious Incident by Inpatient (in receipt) <em>(SLaM)</em></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Serious Incident by Outpatient (in receipt) <em>(SLaM)</em></td>
<td>2 (Attempted Murder and Assault)</td>
<td>1 (Assault)</td>
</tr>
<tr>
<td>Suspected Arson <em>(SLaM)</em></td>
<td></td>
<td>1 (de-escalated)</td>
</tr>
<tr>
<td>Surgical Error (2 retained swabs)</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Unexpected Death (General)</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Unexpected Death of Inpatient (not in receipt) <em>(SLaM)</em></td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Unexpected Death of Inpatient (in receipt) <em>(SLaM)</em></td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>188</td>
<td>48</td>
</tr>
</tbody>
</table>

An Unexpected Death (General) at Lewisham & Greenwich NHS Trust has been de-escalated as no care or service delivery issues were identified.
Safeguarding adults and Children

Safeguarding Serious Case Reviews (SCR) and Multi agency reviews (MARS) update May 2014

Children’s Safeguarding – there were 2 multi-agency reviews (MARS) completed with action outstanding for general practice and Lewisham NHS Trust.

There is x2 SCRs lead by Lewisham which are still not complete or published, but the learning for health services has been implemented. One case has been to court and the parents both convicted. A communications strategy has been developed as there are health implications which will need to be addressed and monitored. So far there has been no media interest but there maybe once the SCR is published so the communication plan will need to be reviewed following that.

A further new case has been referred to the SCR panel for consideration in September

Adult Safeguarding – there is one MAR and the report is now complete but awaiting to be reported to the serious case review panel of the Lewisham Safeguarding Adults Board.

Domestic homicide reviews (DHRs) – we are currently on DHR no 5 and we are working with the borough to ensure compliance against the framework for investigation. Themes will emerge once the reports are published.

(Detailed reports will be sent quarterly to part 2 of the Governing Body.)

Status of Coroner’s Reports
There were no further Coroners cases this month
Finance Report
Month 6, period to 30th September 2014, and full year forecast.

1. Summary

At Month 6 the CCG is on target to deliver its financial duties at year end. However, this requires the release of £3.29m reserves (full year forecast) to offset overspending budgets; in particular acute contracts. This reduces the CCG’s non recurrent investment budget and in-year savings are, therefore, required to bring expenditure into line with budgets and restore investment funds.

Table 1 outlines the key headline measures.

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</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Surplus</td>
<td>£3.81m</td>
<td>£3.81m</td>
<td>NIL</td>
<td>Green</td>
</tr>
<tr>
<td>QIPP Delivery</td>
<td>£9.99m</td>
<td>£9.99m</td>
<td>NIL</td>
<td>Green</td>
</tr>
<tr>
<td>Acute Expenditure</td>
<td>£204.82m</td>
<td>£208.98m</td>
<td>(£4.11m)</td>
<td>Amber</td>
</tr>
<tr>
<td>Total Expenditure</td>
<td>£381.38m</td>
<td>£381.38m</td>
<td>NIL</td>
<td>Green</td>
</tr>
<tr>
<td>Better Practice Payments Code</td>
<td>95%</td>
<td>95%</td>
<td>NIL</td>
<td>Amber</td>
</tr>
</tbody>
</table>

2. Revenue Resource Limit and Start Budget

2.1. At Month 6 the CCG’s combined Revenue Resource Limits total £385.19m. This includes £7.23m for its running cost allowance (RCA).

2.2. In month 6 £1.43m has been received in relation to treatment for overseas visitors.

2.3. Table 2 shows the confirmed and anticipated 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>Programme £m</th>
<th>Running £m</th>
<th>Total £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notified Allocation at Month 5</td>
<td>376.53</td>
<td>7.23</td>
<td>383.76</td>
</tr>
<tr>
<td>Month 6 allocations</td>
<td>1.43</td>
<td></td>
<td>1.43</td>
</tr>
<tr>
<td>Notified Allocation at Month 6</td>
<td>377.96</td>
<td>7.23</td>
<td>385.19</td>
</tr>
</tbody>
</table>

Anticipated Allocations

| Specialised adjustment    | 2.30         |            | 2.30      |
| Winter funding            | 2.01         |            | 2.01      |
| Total Anticipated Allocation at M06 | 382.27 | 7.23 | 389.50 |
2.4. It should be noted that the previously anticipated £1.43m allocation deduction relating to legacy balances has not yet been adjusted by NHS England and is reported as an expenditure charge in Month 6.

3 Cash and Maximum Cash Drawdown

3.1 The CCG’s advised maximum cash drawdown is £380.65m for the year. As at Month 6 the CCG has drawn down £185.17m (48.6%).

4 Headline Financial Performance

4.1 At Month 6 the CCG is reporting an overall underspend of £2.03m against its issued budgets. This represents a better position, by £0.12m, against the planned 1% surplus (£1.91m at Month 6).

4.2 Programme budgets are forecast to be under-spent at year end by £3.20m and Running Cost budgets are forecast to be under-spent by £0.61m. 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>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Budget £m</td>
<td>Actual £m</td>
</tr>
<tr>
<td>Acute Contracts</td>
<td>101.16</td>
<td>103.20</td>
</tr>
<tr>
<td>Community Services</td>
<td>14.81</td>
<td>14.73</td>
</tr>
<tr>
<td>Joint Commissioning Adults</td>
<td>39.96</td>
<td>39.80</td>
</tr>
<tr>
<td>Joint Commissioning Children</td>
<td>0.87</td>
<td>0.85</td>
</tr>
<tr>
<td>Primary Care Budgets</td>
<td>18.10</td>
<td>18.10</td>
</tr>
<tr>
<td>Corporate Budgets</td>
<td>4.16</td>
<td>3.75</td>
</tr>
<tr>
<td>Other, Reserves and Financing</td>
<td>10.35</td>
<td>8.86</td>
</tr>
<tr>
<td>Planned Surplus</td>
<td>1.91</td>
<td>0.00</td>
</tr>
<tr>
<td><strong>Total CCG Budget</strong></td>
<td><strong>191.32</strong></td>
<td><strong>189.29</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Programme/ Running Cost Split</th>
<th>Year to Date</th>
<th>Annual</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Programme Budgets</strong></td>
<td>187.71</td>
<td>186.13</td>
</tr>
<tr>
<td><strong>Running Cost Budget</strong></td>
<td>3.61</td>
<td>3.15</td>
</tr>
<tr>
<td><strong>Total CCG Budget</strong></td>
<td><strong>191.32</strong></td>
<td><strong>189.29</strong></td>
</tr>
</tbody>
</table>

4.3 The CCG is forecasting to deliver its planned surplus of £3.81m at year end. The main risks to the CCG’s ability to achieve this are summarised in section 9.
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></th>
<th></th>
<th>Annual</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Budget</td>
<td>Actual</td>
<td>Variance</td>
<td>Budget</td>
<td>Actual</td>
<td>Variance</td>
</tr>
<tr>
<td>Lewisham and Greenwich NHS Trust</td>
<td>58.22</td>
<td>60.56</td>
<td>(2.34)</td>
<td>118.99</td>
<td>122.54</td>
<td>(3.56)</td>
</tr>
<tr>
<td>Guy’s and St Thomas’ NHS Foundation Trust</td>
<td>15.12</td>
<td>15.63</td>
<td>(0.51)</td>
<td>30.04</td>
<td>31.60</td>
<td>(1.56)</td>
</tr>
<tr>
<td>King’s College Hospital NHS Foundation Trust</td>
<td>15.62</td>
<td>16.82</td>
<td>(1.20)</td>
<td>31.24</td>
<td>34.19</td>
<td>(2.96)</td>
</tr>
<tr>
<td><strong>Total Local Acute Service Agreements</strong></td>
<td><strong>88.96</strong></td>
<td><strong>93.06</strong></td>
<td><strong>(4.05)</strong></td>
<td><strong>180.27</strong></td>
<td><strong>188.34</strong></td>
<td><strong>(8.08)</strong></td>
</tr>
<tr>
<td>External Service Agreements</td>
<td>8.33</td>
<td>8.35</td>
<td>(0.02)</td>
<td>16.67</td>
<td>16.75</td>
<td>(0.08)</td>
</tr>
<tr>
<td>Non Contracted</td>
<td>1.60</td>
<td>1.67</td>
<td>(0.07)</td>
<td>3.20</td>
<td>3.27</td>
<td>(0.07)</td>
</tr>
<tr>
<td>Other Acute</td>
<td>2.26</td>
<td>0.16</td>
<td>2.11</td>
<td>4.73</td>
<td>0.62</td>
<td>4.11</td>
</tr>
<tr>
<td><strong>Total Acute Contracts</strong></td>
<td><strong>101.16</strong></td>
<td><strong>103.20</strong></td>
<td><strong>(2.03)</strong></td>
<td><strong>204.87</strong></td>
<td><strong>208.98</strong></td>
<td><strong>(4.11)</strong></td>
</tr>
</tbody>
</table>

5.2 Lewisham and Greenwich Trust (£2.34m) – The reported position has been based on month 4 data due to issues affecting the Trust’s ability to reliably report May activity arising from the implementation of the Cerner patient administration IT system. Reporting is expected to return to normal for June data onwards. The main areas of variance are, therefore, in line with those reported in the CCG’s Month 5 financial position; Elective (£0.79m adverse) where additional activity is partly attributed to additional activity over contracted levels to reduce the number of patients waiting over 18 weeks for treatment, outpatients (£0.87m adverse) and A&E attendances (£0.52m). Emergency spells are below plan (£0.18m favourable).

5.3 The remaining year to date (YTD) position is based on Month 5 flex information, with a year-end forecast based on expenditure profiles seen in previous years.

5.4 King’s College Hospital (£1.20m) – The main causes of the YTD overspend position are critical care activity (£0.35m adverse), outpatient activity (£0.29m adverse) and elective activity (£0.38m adverse). The improvement in the position since Month 5 is due to the removal of activity for which Lewisham CCG is not the responsible NHS commissioner.

5.5 Guy’s and St Thomas’ (£0.51m) – This variance is mainly caused by outpatient activity (£0.25m adverse) and Critical Care (£0.32m adverse). The position has improved in month (by approximately £0.48m full year forecast) following an adjustment for activity for which NHS England is the responsible NHS commissioner.

6  Corporate Budgets
6.1 Expenditure against the CCG corporate budgets is in line with last year. As at Month 6 the CCG is forecasting to underspend its corporate budgets by £0.51m (and the running cost element by £0.61m).

6.2 This equates to forecast running cost expenditure of £22.65 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 £0.51m RCA underspend is being used in 2014/15 for patient treatments and care.

7 Other, Reserves and Financing

7.1 It is anticipated that £3.29m of reserves will need to be released to offset the forecast year end position unless in year expenditure reductions are delivered. This will adversely impact on the CCG’s ability to make new investments in 2014/15. It will also require additional recurring savings to be made from 2015/16, over and above the CCG’s future financial plans.

8 Prescribing and Other Primary Care Budgets

8.1 Following the national agreement of the 2014/15 community pharmacy funding arrangements, the CCG is forecasting an adverse impact of £0.29m, with a recurrent cost pressure of £0.55m. This forecast has been based on a national assessment of the likely impact and will be refined in coming months as actual costs are known.

9 Adult Joint Commissioning Budgets

9.1 The underspend against the adult Joint Commissioning budgets is mainly due to the Continuing Care position; a forecast £0.25m favourable variance at the year end.

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 6 the CCG is forecasting to be £0.15m 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 6 position for schemes relating to Lewisham and Greenwich have been based on Month 4 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 6 QIPP</th>
<th>201415 Plan</th>
<th>YTD Plan</th>
<th>YTD Actual</th>
<th>Forecast</th>
<th>Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000's</td>
<td>£000's</td>
<td>£000's</td>
<td>£000's</td>
<td></td>
</tr>
<tr>
<td>Integrated Care (Emergency Admissions)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Diabetes</td>
<td>451</td>
<td>226</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>- Heart Failure</td>
<td>259</td>
<td>130</td>
<td>79</td>
<td>177</td>
<td></td>
</tr>
<tr>
<td>- COPD</td>
<td>446</td>
<td>223</td>
<td>92</td>
<td>207</td>
<td></td>
</tr>
<tr>
<td>- Asthma</td>
<td>50</td>
<td>25</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>- Other Emergency Admissions</td>
<td>33</td>
<td>17</td>
<td>619</td>
<td>1,706</td>
<td></td>
</tr>
<tr>
<td>Total Integrated Care</td>
<td>1,239</td>
<td>620</td>
<td>790</td>
<td>2,091</td>
<td></td>
</tr>
<tr>
<td>Primary and Planned Care Programme</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Outpatient Referrals</td>
<td>1,517</td>
<td>309</td>
<td>143</td>
<td>1,000</td>
<td></td>
</tr>
<tr>
<td>- Physiotherapy - Local Tariff Adjustment</td>
<td>279</td>
<td>140</td>
<td>140</td>
<td>279</td>
<td></td>
</tr>
<tr>
<td>- A&amp;E (Reviewing the current configuration of urgent and emergency care)</td>
<td>300</td>
<td>150</td>
<td>0</td>
<td>150</td>
<td></td>
</tr>
<tr>
<td>- Contract Metrics</td>
<td>823</td>
<td>412</td>
<td>412</td>
<td>823</td>
<td></td>
</tr>
<tr>
<td>Total Primary and Planned Care Programme</td>
<td>2,919</td>
<td>1,010</td>
<td>694</td>
<td>2,252</td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Shifting focus to Community Care</td>
<td>1,000</td>
<td>500</td>
<td>500</td>
<td>1,000</td>
<td></td>
</tr>
<tr>
<td>Total Mental Health</td>
<td>1,000</td>
<td>500</td>
<td>500</td>
<td>1,000</td>
<td></td>
</tr>
<tr>
<td>Older Adults</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Reduction in Emergency Admissions</td>
<td>520</td>
<td>0</td>
<td>166</td>
<td>372</td>
<td></td>
</tr>
<tr>
<td>- AQP Continuing Care</td>
<td>480</td>
<td>240</td>
<td>240</td>
<td>480</td>
<td></td>
</tr>
<tr>
<td>Total Older Adults</td>
<td>1,000</td>
<td>240</td>
<td>406</td>
<td>852</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Maternity</td>
<td>858</td>
<td>429</td>
<td>429</td>
<td>858</td>
<td></td>
</tr>
<tr>
<td>- Anti Coagulation</td>
<td>74</td>
<td>7</td>
<td>0</td>
<td>37</td>
<td></td>
</tr>
<tr>
<td>- Improving prescribing and patient concordance</td>
<td>2,300</td>
<td>1,150</td>
<td>1,022</td>
<td>2,300</td>
<td></td>
</tr>
<tr>
<td>- Other Trust Guarantee</td>
<td>600</td>
<td>300</td>
<td>267</td>
<td>600</td>
<td></td>
</tr>
<tr>
<td>Total Other</td>
<td>3,832</td>
<td>1,886</td>
<td>1,718</td>
<td>3,795</td>
<td></td>
</tr>
<tr>
<td>Month 6 QIPP Performance</td>
<td>9,990</td>
<td>4,255</td>
<td>4,107</td>
<td>9,990</td>
<td></td>
</tr>
</tbody>
</table>
12 Risk and Mitigation

12.1 The key identifiable risks that could impact upon delivery of the CCG’s financial duties are summarized below:

- Specialised Services Misattribution adjustment - The CCG requires £2.3m to be returned from NHS England in 2014/15 onwards linked to an acute contract variation to correct an activity misattribution identified in 2013/14. Currently signed contracts are in line with where funding sits. This risk can be fully mitigated by signing the contract variation only after confirmation of the corresponding revenue resource limit adjustment.

- The CCG’s Lewisham and Greenwich Trust position (which represents 32.8% of the CCG’s total programme spend) has been based on Month 4 data due to reporting delays during the implementation of the new Cerner (patient record) system at Queen Elizabeth Hospital. Whilst this issue is expected to be rectified for activity reported in Month 6, the current lower level of confidence in the reported position reduces the confidence in the CCG’s forecast year end position. This will be closely monitored in October and confidence levels reported back to the Delivery Committee.

- QIPP delivery is directly related to the CCG’s acute activity levels and therefore expenditure. The acute activity areas presenting the largest risk to the CCG’s financial position are:
  - Emergency activity, where the present underspend is forecast to continue to the year end. Given the limited scope of the data this requires careful monitoring.
  - Outpatient activity and the impact of the RMS. The RMS is being rolled out, with the forecast impact of this based on a risk assessment of the figures identified within the business case.

Taken together these represent a £2.19m risk to the reported position.

13 Creditors and Debtors

13.1 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 6 is below required standard. Remedial action is being taken to speed up the processing of invoice payments. Current month and cumulative performance are shown.
Table 6: Better Practice Payments Code

<table>
<thead>
<tr>
<th></th>
<th>Sept-14</th>
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<th>Cumulative</th>
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<td>NHS</td>
<td>Non-NHS</td>
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<td>NHS</td>
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<td>% of Invoices Paid within Target (Count)</td>
<td>92.46%</td>
<td>90.83%</td>
<td>91.41%</td>
<td>92.92%</td>
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<td>% of Invoices Paid within Target (Value)</td>
<td>99.71%</td>
<td>86.23%</td>
<td>99.07%</td>
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13.2 Table 7 below outlines the aged debt position for 30th September 2014.

Table 7: Aged Debt

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<tr>
<td>AR not yet due amount</td>
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<tr>
<td>AR overdue 1-30 days</td>
<td>0.008</td>
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<tr>
<td>AR overdue 31-60 days</td>
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<tr>
<td>AR overdue 61-90 days</td>
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</tr>
<tr>
<td>AR overdue 91-120 days</td>
<td>Nil</td>
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<tr>
<td>AR overdue 121-180 days</td>
<td>0.026</td>
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<tr>
<td>AR overdue 181-360 days</td>
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Aged Debt Summary

AR = accounts receivable

Tony Read
Chief Financial Officer
October 2014
### Appendix 1: Revenue Resource Limit

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<tr>
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<th>Admin £’000s</th>
<th>Programme £’000s</th>
<th>Total £’000s</th>
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<tr>
<td><strong>Opening Allocations</strong></td>
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<tr>
<td>2014-15 Opening Baseline</td>
<td>7.23</td>
<td>370.31</td>
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<td>2013-14 Surplus Carry Forward</td>
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<td><strong>Board Approved Budget</strong></td>
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<td><strong>In Year Allocation</strong></td>
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<td>2013-14 Change in Surplus</td>
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<tr>
<td><strong>Total Allocation at Month 2</strong></td>
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<td><strong>Total Allocation at Month 3</strong></td>
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<td><strong>Total Allocation at Month 5</strong></td>
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<td>2014-15 CEOV and non rechargeable services</td>
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<td><strong>Total Allocation at Month 6</strong></td>
<td>7.23</td>
<td>377.96</td>
<td>385.19</td>
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ENCLOSURE 10
UPDATE ON SYSTEM RESILIENCE IN LEWISHAM, GREENWICH AND BEXLEY

CLINICAL LEAD: David Abraham
Post: Senior Clinical Director

MANAGERIAL LEAD: Martin Wilkinson
Post: Chief Officer

AUTHOR: Tom Bunting
Post: Urgent Care Project Manager
(Lewisham, Greenwich & Bexley CCGs)

RECOMMENDATIONS:
The Committee is asked to note the update on system resilience planning from the Lewisham, Greenwich and Bexley System Resilience Group.

SUMMARY:
• This update consists of a summary of the key work streams and activity being overseen by the Lewisham, Greenwich and Bexley System Resilience Group, and undertaken by the various organisations within its membership, in 2014/15.
• This work is focused primarily on delivering an improvement in performance and bolstering resilience across the system to ensure that both Lewisham Hospital and Queen Elizabeth Hospital consistently deliver the 95% national standard for A&E and that patients’ experience of urgent and emergency care services is optimised.
• This paper also includes a summary of how the System Resilience Group is utilising and monitoring the winter resilience funding that has been distributed by NHS England to support challenged health economies over the winter months.
• Finally, the paper sets out the risks (across the local health economy system) that the System Resilience Group is faced with and how these are being mitigated to ensure that services will work in tandem to ensure that the system is able to stand up to the demands on it on a sustainable basis.

KEY ISSUES:
Background:
NHS England (NHSE) published its plans for operational resilience in June 2013. These marked a shift change in the way that NHSE envisages pressures across local health systems are managed and set a framework by which health economies can more effectively balance elective and non-elective workloads. The guidance proposed that Urgent Care Working Groups (UCWG) evolved into System Resilience Groups (SRG) which as well as having a remit to look at unscheduled care, would also lead on demand and capacity, the coordination and integration of services and be responsible for achievement of both the 95% Accident and Emergency (A&E) standard and Referral to Treatment (RTT) times.
A&E performance:

University Hospital Lewisham has traditionally been a strongly performing site, though performance was missed in Q3 and Q4 2013/14 and Q1 and Q2 in 2014/15. The primary reasons for missing the target were staffing issues and sub-optimal patient pathways. An analysis performed on a specialty by specialty basis demonstrated a shortfall of 29 beds for at University Hospital Lewisham on expected activity in Q3 and Q4. Silver Command was put in place in February which helped identify areas for improvement. These were implemented in spring 2014 which led to stronger performance, although the site narrowly missed the 95% standard in Q2.

In October 2013, following the merger of Lewisham Healthcare NHS Trust and Queen Elizabeth Hospital from the dis-established South London Healthcare NHS Trust, performance trajectories were set for Queen Elizabeth Hospital which deviated from the national standard, in recognition of the specific challenges the site faced. The trajectory was met throughout Q3, but as attendances, admissions and Length of Stay increased in late January and February performance deteriorated. On a weekly basis throughout Q4 of 2013/14 and Q1 and Q2 of 2014/15 performance has consistently been below the 95% target. The failure to meet performance targets has been caused by capacity constraints, (the demand and capacity analysis reference above indicated an 82-bed shortfall based on current demand, which has adversely affected patient throughput and performance), as well as suboptimal patient pathways and staffing issues within A&E.

In line with the NHS England guidance on Operational Resilience, and in response to the issues above, a new System Resilience Group was formed in Lewisham, Bexley and Greenwich to ensure joined up working across the health economy. It oversees a number of primary areas, which are listed below. These are contained in the System Resilience Plan, a summary of the plan is contained in Appendix A.

- **Demand and Capacity** – for both sites a number of plans were put in place to close the capacity shortfalls, taking effect between November 2014 and February 2015.
- **Staffing** – Extensive recruitment drive is under way to reduce vacancy rates both at home and abroad. These have been successful, with 140 nurses from the Philippines due to join between December 2014 and February 2015. However, due to staff turnover, progress to date has been limited.
- **Reducing admissions and extending out of hospital provision** – Increased community capacity planned across the system with a new 40 bedded Community Hospital due to open in Greenwich in January 2015. Improving ambulatory care services at both hospitals, supported by integrated discharge teams to provide health and social care assessment.
- **Improving flow and Length of Stay** – Creating dedicated CDU and RAT areas at Queen Elizabeth Hospital to improve flow and reduce A&E breaches and ambulance offload delays. Improving internal productivity across both sites to reduce length of stay with transformation team in place.
- **Improvements in DTOCs** – Bed days lost to delays in transfers of care were unacceptable; with February’s figure of 1449 an all-time high. Joint working and increased scrutiny applied to reduce this figure and support length of stay reduction initiatives.
Winter resilience funding:
The tranche 1 allocation for the System Resilience Group was £5.184m. These bids have been approved by NHSE and confirmed with providers, who have implemented the vast majority of schemes. On 26 September NHSE confirmed that additional winter monies would be available to support Trusts across London. For this second tranche bids the System Resilience Group was awarded £6.7m by NHS England. The main priority areas for schemes across both allocations are for enhancement of seven-day working across the system, processes to minimise delayed discharge, rapid response/admissions avoidance, and the provision additional physical capacity in and out of hospital. A summary of the tranche 1 and tranche 2 schemes allocations per provider is attached as Appendix B.

Expected impact of resilience plans in totality:
The Lewisham site is expected to meet the 95% overall for Q2, Q3 and Q4 noting that should there be any slippage against target in a given week, this will need to be compensated over the quarter as a whole.

The Queen Elizabeth Hospital site is expected to meet the 95% target consistently from February. The trajectory has been plotted based on when additional capacity opens, and also factoring in incremental performance improvements due to pathways being reshaped to ensure that additional capacity is best used, increases in staff numbers and their growing familiarity with processes and procedures, and the overall embedding of the significant changes being planned.

Monitoring:
The initiatives within the core system resilience plan and the winter resilience funding are monitored at the System Resilience Group. In addition, regular meetings are held with the regional tripartite panel on progress of the plans and mitigating any slippage.

CORPORATE AND STRATEGIC OBJECTIVES

1. Commission high quality care services today

CONSULTATION HISTORY INCLUDING MEMBERS ENGAGEMENT:
Lewisham, Greenwich and Bexley System Resilience Group
LCCG Delivery Committee (Monthly updates)

PUBLIC ENGAGEMENT
Lewisham Healthwatch representation at the Lewisham, Greenwich and Bexley System Resilience Group
Healthier Communities Select Committee, Lewisham Borough Council (21.10.14)
Health & Well Being Board, Lewisham Borough Council (23.09.14)

HEALTH INEQUALITY DUTY
System Resilience will address delivery of the constitutional standards and therefore will support in reducing inequalities. For example reducing referral to treatment times (RTT) will have a positive and direct impact on patients.

PUBLIC SECTOR EQUALITY DUTY
<table>
<thead>
<tr>
<th>RESPONSIBLE MANAGERIAL LEAD CONTACT:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name: Martin Wilkinson</td>
</tr>
<tr>
<td>E-Mail: <a href="mailto:martinwilkinson@nhs.net">martinwilkinson@nhs.net</a></td>
</tr>
<tr>
<td>Telephone: 020 7206 3371</td>
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</table>

<table>
<thead>
<tr>
<th>AUTHOR CONTACT:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name: Tom Bunting</td>
</tr>
<tr>
<td>E-Mail: <a href="mailto:tom.bunting@nhs.net">tom.bunting@nhs.net</a></td>
</tr>
<tr>
<td>Telephone: 07960403228</td>
</tr>
</tbody>
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Appendix A: Overview of System Resilience Plans – Bexley, Greenwich and Lewisham

1. Purpose of the paper

To provide a brief summary of the System Resilience Plan, and clarify the key actions that are due to take place over the next few months. The described actions are intended to improve performance and resilience and ensure that both Lewisham Hospital (UHL) and Queen Elizabeth Hospital (QEH) consistently deliver the 95% national standard for A&E. This paper seeks to clarify what key initiatives are due to take effect and what their expected impact will be.

2. Background

LGT has experienced challenging performance at both UHL and, in particular, at QEH. Following the merger of the two sites it has become clear that there is a significant mismatch in demand and capacity at QEH, and that pathways, both in and out of the hospital, needed improving. An analysis performed on a specialty by specialty basis demonstrated a shortfall of 82 beds for QEH on expected activity in Q3 and Q4, and a smaller shortfall of 29 beds at UHL. The following actions are thus being taken to address the identified issues.

2.1 Stroke Unit transferred from QEH to UHL

**Context:** The CQC report in January 2014 stated that the emergency care pathway was ‘inadequate’ with a ‘lack of bed capacity at the hospital despite escalation wards being utilised’. In order to ensure that patient safety is maintained at QEH, acute bed capacity urgently needed to be released. Given that extensive construction work to create capacity is not a viable option in the short term, stroke is the only viable service that could be moved from the QEH site. It has thus been agreed that the stroke unit move to a new ward at the UHL site for several months on safety grounds.

**Impact on QEH:** Release of 24-28 beds. It is noted that whilst the Stroke unit is technically a 28 bedded ward, on occasions medical outliers have been placed on the ward, thus marginally reducing the total bed saving.

**Impact on UHL:** Whilst work will transfer to UHL, this will be to a new 24 bedded ward (Maple) so there is no net gain or loss of beds. It is also considered that the greater efficiencies and staff availability that the consolidated unit will offer will improve efficiency, particularly in regard to the timely repatriation of patients from HASUs.

**Date of Impact:** November 3rd

2.2 Elective work moves from Queen Mary’s Sidcup (QMS) to UHL

**Context:** As part of the longer term Trust vision, it was always intended for elective surgery currently performed at QMS to be centralised at the UHL site. This move would allow for greater efficiencies in the surgical pathway and also release beds at QMS which, through a series of other moves, would allow for Foxbury ward to be reinstated for use by QEH. To allow for this to happen, an escalation ward at UHL (Linden) will be utilised as a surgical unit. Linden is a 20 bedded unit, which is in excess of what is currently used at QMS. If possible therefore, a Surgical Assessment Unit will also be created.

**Impact on QEH:** Not directly, but allows for space to be created at QMS for Foxbury to be reinstated

**Impact on UHL:** Loss of an escalation ward, but because of the layout and staffing this had
not been used unless essential and only for low dependency patients. In addition, a new escalation ward is being created. Net effect is thus that 16 beds worth of activity moves to a 20 bedded ward leading to a 4 bed surplus which is hoped to be used for an SAU. These projections are before any further efficiencies or reductions to length of stay are applied.

Date of Impact: November 3rd

2.2 Foxbury Ward reopens at QMS for use by QEH

Context: Foxbury, a 22 bedded ward, was successfully utilised last year by QEH as a low-acuity medical ward. Whilst it was not fully utilised initially, once the criteria and staffing profile was adjusted it was fully occupied from February onwards, predominantly for Bexley patients. Due to building work at QMS, the ward had to close in April, but will be available again from the start of November.

Impact on QEH: Net increase of 22 beds
Impact on UHL: None
Date of Impact: November 3rd

2.3 Additional escalation ward opens at UHL

Context: A previously mothballed paediatric ward, Sapphire, is being renovated for use as an escalation ward that will be open and available throughout winter at UHL. This will replace Linden.

Impact on QEH: No impact
Impact on UHL: Net increase of 20 beds
Date of Impact: November 3rd

2.4 Opening of Eltham Community Hospital

Context: The new Eltham Community Hospital will see the transfer of patients from the Bevan Unit into a new purpose build centre, housing GP practices, out-patient services, a day surgery theatre and 40 intermediate care sub-acute beds. Crucially the unit will have Acute Consultant Geriatrician support to allow for avoidance of hospital admissions and readmissions, support reductions in length of stay at QEH by earlier transfers, and allow a higher acuity of patients to be transferred to ensure better utilisation of community beds. As an interim measure however, Greenwich are commissioning 14 additional beds from 3rd November which will also move in to Eltham when ready.

Impact on QEH: 14 additional community beds, but should allow for higher utilisation of community facilities than currently achieving
Impact on UHL: Would also support transfers of Greenwich patients from UHL, though it is considered that the vast majority would be from QEH given patient flows
Date of Impact: 3rd November for interim arrangements, with Eltham due to open on 26th January.

2.5 Hospital at Home service

Context: Building on work done by other local providers, notably King’s, who have successfully used Medihome to provide home based care packages to support early discharge. The Trust and Medihome have done a joint audit of the numbers of patients able to be supported (who are outside of the remit of current community packages of care) with results indicating that the equivalent of 18 beds would be saved through reduced length of stay. A business case has been produced, but discussions are ongoing regarding funding sources for this initiative.
Impact on QEH: Based on the audit 18 beds would be released.
Impact on UHL: None initially – the pilot would be for QEH with further expansion possible depending on outcomes
Date of Impact: There would be a reasonable lead in time needed but should negotiations be rapidly concluded, the service would be able to start by mid-February at the latest.

2.6 Opening of a Clinical Decision Unit (CDU) at QEH

Context: A cause of significant breaches at the QEH site is the lack of a dedicated Clinical Decision Unit (CDU) and an observation area to provide longer periods of assessment for patients who do not require an acute admission or who are waiting on diagnostic results before discharge. The area currently improvised as a CDU is also used to undertake Rapid Assessment and Treatment (RAT) and the competing priorities mean that both services are negatively impacted at times of surge. By relocating the Fracture Clinic the winter estate programme will create a CDU with 12 beds and 6 chairs in a dedicated location freeing up space to continue RAT for all new LAS arrivals.

Impact on QEH: Whilst the CDU technically adds 12 beds, these have not been included in the overall bed base, as they are not intended as inpatient capacity. However, the CDU will help decompress A&E and the ring-fencing of the RAT space should significantly reduce offloading breaches.

Impact on UHL: The opening of the CDU, together with the other initiatives described for early November will allow the interim changes to ambulance catchment areas which saw a higher proportion of ambulance patients from Greenwich to be directed to UHL to finish

2.7 Other Initiatives

In parallel to the work progressing on capacity, it is important to note that there are several other strands of work underway, details of which are fully explained in the System Resilience Plan. These include:

- 6 key work streams on reduction in length of stay and improvements to patient care, each with a Clinical and Managerial lead. These include Front Door, Ambulatory and Short Stay, Internal Patient Flow, External Patient Flow, Winter Resilience and Stroke Consolidation
- Continued progression of admission avoidance schemes, including increased primary care support to care homes, extension of palliative care services, and community based ambulatory care services
- Working with ECIST to run two ‘Perfect Weeks’. The focus of these weeks will be on making the best of the new capacity, improving utilisation of community services, and provide rapid learning and process change to boost efficiency and performance. These weeks will be actively supported by all organisations within the SRG.
- The UCC at QMS is now run by the Hurley Group, with OOH services co-located. The QMS UCC is the hub, with Erith Urgent Care Centre opening at the beginning of October as a spoke site. These changes are being well publicised through local communications and with patient groups. These services should support a reduction in A&E attendances, and a revised ACP has been agreed with LAS that is intended to increase utilisation of the UCC and support a reduction in ambulance conveyances.
In collaboration with LAS a Project Manager is being employed to work with all ACP holders and with ambulance crews to standardise the ACP criteria to ensure better utilisation by crews. Feedback has indicated that whilst Bexley, Greenwich and Lewisham have a wide range of ACPs available, the different inclusion and exclusion criteria has caused confusion for crews resulting in them defaulting to A&E. A hospital liaison offer is also in place at QEH who will work proactively with crews to ensure all conveyances are appropriate and advise on community alternatives.

Staff recruitment continues apace with successful recruitment drives in Portugal and the Philippines. Staff are expected to be in post during Q3.

Robust programme management both within the Trust and across the whole system, with a newly created Head of System Resilience post currently being recruited to. System oversight will be led by the Chief Officer of Bexley as Chair of the SRG.

A subgroup of the SRG is also being established to focus on system wide measures to be implemented for the first two weeks of January – a traditionally difficult period – to ensure no slippage against planned trajectories.

3. Expected impact

QEH is expected to meet the 95% target consistently from March. The trajectory has been plotted based on when additional capacity opens, and also factoring in incremental performance improvements due to pathways being reshaped to ensure that additional capacity is best used, increases in staff numbers and their growing familiarity with processes and procedures, and the overall embedding of the radical changes being planned. The Lewisham site is also expected to meet the 95% overall for Q2, Q3 and Q4 noting that should there be any slippage against target in a given week, this will need to be compensated over the quarter as a whole.
Report from the Chair of the Strategy & Development Committee
Date of Meeting(s) reported: 2\textsuperscript{nd} October 2014
Author: Dr Marc Rowland

Main Issues discussed

The main agenda items covered update reports from the CCG’s Public Engagement Group (PEG) and the Joint Public Engagement Group (JPEG), progress and proposals for joint commissioning intentions for integrated care, revised equalities objectives for the CCG, further development of the CCG strategic communications framework, and mechanisms for maintaining feedback from the South East London Clinical Leadership Groups (CLGs).

Key achievements

The Committee agreed the joint commissioning priorities for 2015/16-2016/17 for further development, approved changes to the CCG equalities objectives, and signed off the communications framework including its workplan and stakeholder analysis.

Key challenges addressed

Discussion of the proposals for the joint commissioning intentions identified the challenges of achieving transformational change required to improve services while operating within the total budgets available. Culture change within provider organisations was highlighted as a particular influencing factor for achieving commissioning priorities.

Key risks (include assurances received positive and negative)

Further development of plans to support the proposed commissioning intentions will be required to ensure affordability within financial resources.

How did the meeting promote quality and safety?

Continuous improvement in quality of care is included as one of the expectations of providers in the proposed commissioning intentions, and the committee was advised that this would be monitored through patient experience, and NHS, Public Health, and Adult Social Care Outcomes Frameworks.

How did the meeting help address inequalities and fairness?

The proposed commissioning intentions highlighted population health needs and inequalities which would be addressed through the main priority areas and supporting actions.
The agreed equalities objectives will help to address priority issues identified that impact on different population groups.

**How did the meeting promote and draw on public engagement?**

The report from PEG highlighted plans to establish a patient reference group for the CCG to support public involvement in decision-making.

Discussion on the proposed commissioning intentions included the key requirements for effective public engagement.
ENCLOSURE 12

Joint Commissioning Intentions for Integrated Care

CLINICAL LEAD: Dr David Abraham  
Post: Senior Clinical Director

MANAGERIAL LEAD: Susanna Masters  
Post: Corporate Director

JOINT AUTHOR:  
Dee Carlin  
Post: Head of Joint Commissioning
Susanna Masters  
Post: Corporate Director

RECOMMENDATIONS:

The CCG’s Governing Body is asked to:

1. approve the draft Joint Commissioning Intentions for Integrated Care for 2015/16 and 2016/17 which is shown at Appendix A.
2. approve the proposed approach to public and stakeholder engagement during November and December 2014, which will inform the development of the CCG’s Operating Plan for 2015/16 and 2016/17.
3. note the Health and Wellbeing Board’s specific responsibilities regarding the CCG’s commissioning plans.
4. note the proposed next stages to develop and agree the Operating Plan and contracts for 2015/16

Summary

The purpose of this report is to provide the Governing Body with an overview of the key contents of the draft Joint Commissioning Intentions, the proposed public and stakeholder engagement and the formal involvement of the Health and Wellbeing Board.
1. Background

1.1 The draft Joint Commissioning Intentions for Integrated Care provides a two year framework for how commissioners intend to commission local health and care services for 2015/16 and 2016/17.

1.2 These joint Commissioning Intentions cover the whole of Lewisham’s adult population with a particular focus on:

- frail and vulnerable people
- adults with complex needs and disabilities
- older people
- people with long term conditions and/or mental health problems
- people with alcohol problems
- pregnant women

1.3 Also these draft Joint Commissioning Intentions include the interface with children and young people’s services which are commissioned by the local health service. The detail of the Children and Young People’s plan (2012–2015) - ‘It’s everybody’s business’ can be found at www.lewisham.gov.uk/myservices/socialcare/children/Documents/CYPP2012-15.pdf

1.4 It is a single plan with one set of priorities. This is the first time that the collective resources available to Lewisham Council (Adult Social Care and Public Health) and NHS Lewisham Clinical Commissioning Group (CCG) have been brought together into a single commissioning plan. The aim is to use these resources, of nearly £490 million, to their best effect to reshape the advice, support and care services provided across health and social care, working together with our public and partners, to improve health and care and reduce health inequalities.

2. Draft Joint Commissioning Intentions – challenges and priorities for action

2.1 The draft Joint Commissioning Intentions summarises the 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
improvements only. This means the solution is to work together to change what we do and how we do it.

2.2 These challenges are common across all health and care systems, as recently highlighted in NHS Five Year Forward view (October 2014) and the report of the London Health Commission ‘Better Health for London’ (October 2014).

2.3 The approach in Lewisham to address these fundamental challenges is to commission person-centred care that through early intervention and integrated care pathways, helps Lewisham residents – from birth and throughout life - to enjoy a good quality of life, to make choosing healthy living easier and to support local people and neighbourhoods to do more for themselves and one another.

2.4 Only a limited number of six priorities for action have been proposed, of which five align with the Better Care Fund submission; the sixth relates to Children and Young People. These priorities are:

- 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

2.5 These proposed priorities for action build on and embed the work of previous health and care plans, including the Health and Wellbeing strategy, which have been informed by our Joint Strategic Needs Assessment and the views of local people in Lewisham.

3. Draft Joint Commissioning Intentions – Commissioners’ ambition

The draft joint Commissioning Intentions also set out the commissioners’ ambition for system wide change for 2015/16 and onwards.

3.1 The commissioners’ ambition is to achieve better outcomes than we do now for Lewisham residents by:

- making choosing healthy living easier - providing people with the right advice, support and care, in the right place, at the right time to improve their health and wellbeing and help people live independently.

- providing the most effective personalised care and support where and when it is most needed, so giving all adults control of their own care and supporting them to meet their individual needs.
• helping to build engaged, resilient and self-directing communities - enabling and assisting local people and neighbourhoods to do more for themselves and one another.

3.2 The commissioners’ ambition is to deliver the following system wide changes across health and social care, working together with the people of Lewisham and partners by:

• commissioning advice, support and care services for the whole population using techniques of risk stratification, patient segmentation and evidence based care to ensure our collective, limited resources are most effectively used to meet the local health and care needs and challenges.

• using a person centred approach to commissioning to ensure that advice, support and care is personalised, delivered earlier and more effectively resulting in:
  o consistent high quality of care and patient experience whenever and wherever care is provided.
  o reduced variation and inequalities in health and care outcomes.
  o increased focus on proactive, preventative care.
  o better outcomes for the Lewisham residents.

• working in partnership with Lewisham residents to empower users of services to help reshape their services to achieve better outcomes.

• shifting the focus of resources to invest in joined up primary care, social care and community care, for both physical and mental health, so that people receive the support they need when they need it and to reduce the growth in demand for acute (hospital based) services.

• spending our collective resources wisely to deliver better outcomes and avoid waste by working collaboratively with current and future providers to develop the local market and to identify the procurement approach most suitable to achieve and secure the above system wide transformation.

3.3 The Commissioners’ ambition is to commission from a wide range of statutory, voluntary and independent sector providers to support us to deliver the proposed priorities and plans as set out in these Commissioning Intentions and to transform systems and organisations to deliver integrated advice, support and care across Lewisham.

3.4 The commissioners want to work in partnership with all our local providers to support them to:

• embed, within their organisations, systems and processes to ensure that the views of users of the service are listened to and acted on in order to achieve continuous
improvement in the quality of care, which is proactive, self-monitoring and managed -
as an effective organisational response to the Francis recommendations\(^1\) and the
Winterbourne View report\(^2\).

- use the opportunities to develop services that help people to live well in all aspects of
  their lives and to have strong, effective leadership at every level throughout the
  organisation, to lead the cultural change in the way in which care is delivered across
  the health and care system.

- demonstrate to Lewisham residents that local services provide good value for money
  and are efficient and effective, but also ‘add value’ and are financially sustainable.

3.5 The draft Joint Commissioning Intentions requires further work to make sure that it is
readily accessible to Lewisham people by being written in plain English and asking the most
appropriate consultation questions. A readers’ panel has been set up to provide advice on
the language and presentation of the joint Commissioning Intentions and a short, summary,
public-facing version of the Joint Commissioning Intentions which is being prepared.

The Governing Body is asked to approve the draft Joint Commissioning Intentions for
Integrated Care for 2015/16 and 2016/17, shown at Appendix A

4. Public and stakeholders engagement

4.1 The full Joint Commissioning Intentions will be a public document, accompanied by a
simple summary public-facing report for wider engagement with the public and local
stakeholders. There will be a six week, specific engagement programme and communication
plan during November – December 2014, to further test whether the Joint Commissioning
Intentions is focused on the right plans for action to deliver the maximum benefits to
Lewisham people over the next two years.

4.2 The findings of this engagement exercise will be considered by the Public
Engagement Group in January 2015 and will inform the ‘translation’ of the joint
Commissioning Intentions into the Operating/Commissioning Plans across health and social
care for 2015/16 and 2016/17.

4.3 During the development of the Better Care Fund plan and draft Joint Commissioning
Intentions there has been on-going discussion with the main acute, community and mental
health providers about the implications of the emerging plans for individual providers.
Individual letters have been sent to each local provider to notify them of our high level
Commissioning Intentions at the end of September. A further letter will follow later in
November, providing further details of specific contractual changes expected in 2015/16.

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\(^1\) Francis Report – see Glossary of Terms, Appendix F
\(^2\) Winterbourne View report – see Glossary of Terms, Appendix F
The Governing Body is asked to note the proposed approach to public and stakeholders engagement during November and December 2014, which will inform the development of the CCG’s Operating Plan for 2015/16 and 2016/17.

5. Health and Wellbeing Board

5.1 The Health and Social Care Act 2012 places a specific duty on the CCG to include the relevant Health and Wellbeing Board in the preparation of their commissioning plans and when making significant revisions to those plans. The Health and Wellbeing Board must be provided with a draft commissioning plan and the CCG must consult the Board as to whether it considers the plan takes proper account of the Health and Wellbeing Strategy.

5.2 Legislation also requires that the Health and Wellbeing Board’s opinion on the final plan must be published within the Operating Plan. Health and Wellbeing Boards can refer plans to NHS England if they do not think the joint Health and Wellbeing Strategy has been taken into proper account.

5.3 Members of the Health and Wellbeing Board are being asked to review the draft Joint Commissioning Intentions for Integrated Care, to consider whether these draft Joint Commissioning Intentions have taken proper account of the Health and Wellbeing Strategy and to provide a formal opinion at its next meeting on 25th November 2014.

The Governing Body is asked to note the Health and Wellbeing Board’s specific responsibilities regarding the preparation and finalisation the CCG’s commissioning plans.

6. Summary of the process for developing the Operating Plan

The process by which the draft Joint Commissioning Intentions has been developed with the involvement of Members, the Governing Body and the Health and Wellbeing Board is shown diagrammatically opposite. Also shown is the proposed next stages to develop and agree the Operating Plan and contracts for 2015/16.

The Governing Body is asked to note the proposed next stages to develop and agree the Operating Plan and contracts for 2015/16.

Appendix A – draft Joint Commissioning Intentions for Integrated Care 2015/16 and 2016/17.
Develop context for CI 2014/15 as part of BCF

Approve process

Develop draft high level CI through S&D Committee

Refine CI through S&D and AJSCG

Public Engagement on CI

Develop Operating Plan

Finalise Operating Plan

Share detailed CI with providers & develop contract negotiation strategy

Contract Negotiations

Sign Contract

Preparation for implementing business cases

Develop business cases

Develop high level QIPP

Develop detailed QIPP

Key

AJSCG – Adult Joint Strategic Commissioning Group
BCF – Better Care Fund
CI – Commissioning Intentions
Del Com – Delivery Committee
GB – Governing Body
HWB – Health and Wellbeing Board
QIPP – Quality, Innovation, Productivity and Prevention
S&D Com – Strategy and Development Committee
CORPORATE AND STRATEGIC OBJECTIVES

Corporate Objective 2 – ensure robust governance arrangements are in place. In accordance with the CCG’s Constitution, the Governing Body has responsibility for signing off the annual Commissioning Intentions.

CONSULTATION HISTORY (including Members’ engagement):

Members of the Governing Body, Public Health and providers have participated in workshops to develop and agree the 2014/15 and 2015/16 Operating Plan which has informed this work.

Adult Joint Strategic Commissioning Group on 10th June 2014 agreed the scope and process to develop joint Commissioning Intentions to be the framework for the Better Care Fund.

Health and Wellbeing Board on 3 July 2014 noted that the Adult Joint Strategic Commissioning Group (AJSCG) was co-ordinating the development of joint Commissioning Intentions, as a key aspect of the adult integrated care programme.

Membership Forum on 13th August the views of Members were sought on the emerging priorities for the Commissioning Intentions.

Adult Joint Strategic Commissioning Group workshop 21st August 2014 – reviewed evidence base and benchmarking information to identify the potential opportunities.

Adult Joint Strategic Commissioning Group workshop 28th August 2014 – discussed and agreed priority areas.

Health and Wellbeing Board on 23rd August noted the progress in developing the joint Commissioning Intentions, aligned with the Better Care Fund submission on 19th September.

Strategy and Development Committee on 4th September 2014, on behalf of the CCG’s Governing Body received a presentation on the emerging priorities and plans for action and endorsed the proposed process and timeline to produce the Commissioning Intentions.

CCG’s Governing Body 11th September 2014 noted the emerging Commissioning Intentions priority areas and endorse the approach to finalise the Commissioning Intentions.

Strategy and Development Committee on 2nd October (am) noted the progress and agreed that the Adult Joint Strategic Commissioning Group will complete the outstanding work to finalise the Commissioning Intentions.

Governing Body workshop on 2nd October (pm) discussed the priorities for action in 2015/16. Membership Forum on 8th October summarise the work that has been undertaken to develop the draft joint Commissioning Intentions for Integrated Care and specifically sought Members’ views on the proposed priorities and plans for 2015/16 and 2016/17.
Adult Joint Strategic Commissioning Group on 9\textsuperscript{th} October 2014 finalised the draft Joint Commissioning Intentions

**PUBLIC ENGAGEMENT**

An engagement programme and communication plan will be put in place during November – December 2014, to further test that the Commissioning Intentions are focused on the right priorities and actions to deliver the maximum benefits to Lewisham people over the next two years – more details are provided in section 3 above.

**HEALTH INEQUALITY DUTY**

**PUBLIC SECTOR EQUALITY DUTY**

The draft Joint Commissioning Intentions includes an ambition from all providers to developing robust systems to monitor user experiences of services, including those who are unlikely to complain or voice their views, with specific consideration of people with protected characteristics, triangulated with other quality information - see section 6.3 of the draft Joint Commissioning Intentions.

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   4.2 Lewisham Residents’ views of our service
   4.3 Performance of our services
   4.4 Financial position over the next two years

5 Proposed commissioning priorities and plans for 2015/16 – 2016/17
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   5.2 GP practices and primary care
   5.3 Neighbourhood community care for adults
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6. Commissioners’ ambition for 2015/16 and 2016/17
   6.1 Commissioners’ ambition for Lewisham residents
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Appendix A – Alignment of plans
Appendix B – Map of Lewisham four neighbourhoods and GP Practices
Appendix C – How the views of Lewisham people have an impact on developing the action plans for 2015/16 and 2016/17
Appendix D – Key Performance Indicators to measure progress
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Appendix F – Glossary of Terms
1. Executive summary

This document sets out our draft Joint Commissioning Intentions for Integrated Care. It is a framework for how we intend to commission local health and care services for 2015/16 and 2016/17. It covers the whole of Lewisham’s adult population with a particular focus on:

- frail and vulnerable people;
- adults with complex needs and disabilities;
- older people;
- people with long term conditions and/or mental health problems;
- people with alcohol problems;
- pregnant women.

The draft Joint Commissioning Intentions includes the interface with children and young people’s services that are commissioned by the health service. The Children and Young People’s plan (2012–2015) - ‘It’s everybody’s business’ - sets out the strategic aims and the detailed priorities and plans for all agencies working with children and young people across Lewisham.1

It is a single plan with one set of priorities. This is the first time we have brought together the collective resources available to Lewisham Council (Adult Social Care and Public Health) and NHS Lewisham Clinical Commissioning Group (CCG). We aim to use these resources, of nearly £490 million, to their best effect to reshape the advice, support and care services provided across health and social care, working together with our public and partners, to improve health and care and reduce health inequalities.

It sets out how our population’s physical, mental and social care needs will be better met through coordinated advice, support and care. Our approach is to commission person-centred care, that through early intervention and integrated care pathways helps Lewisham residents – from birth and throughout life - to enjoy a good quality of life, to make choosing healthy living easier, and to support local people and neighbourhoods to do more for themselves and one another.

It is an ambitious commissioning plan. We believe that by transforming systems and organisations we will be able to respond effectively to the following significant challenges facing health and social care in Lewisham:

- people are living longer.
- more people have one or more long term conditions.
- deprivation is increasing.
- too many people die early from deaths that could have been prevented by healthier lifestyles.
- people’s experience of care is very variable.
- services are under increased strain due to a rising level of demand and limited resources.

• people’s expectation of services and the cost of services are increasing.
• there is an affordability gap which cannot be addressed by efficiency and productivity improvements only.

We have chosen six priorities which align with the Better Care Fund submission:

1. prevention and early intervention (section 5.1)
2. GP practices and primary care (section 5.2)
3. Neighbourhood community care for adults (section 5.3)
4. Enhanced care and support for adults (section 5.4)
5. Children and young people’s care (section 5.5)
6. Supporting enablers (section 5.6)

The proposed action plans for these priorities will allow us to achieve our ambition and are realistic and feasible to deliver within the expected resources.

These proposed priorities build on and embed the work of previous health and care plans (see box below) all of which have been informed by our Joint Strategic Needs Assessment\(^2\) and the views of local people in Lewisham.

**Relevant Lewisham Strategic and Operational Plans**

- Health and Wellbeing Strategy
- Children’s and Young People’s Plan 2012-2015
- CCG’s Commissioning Strategy 2013-18
- Last Years CCG’s Commissioning Intentions 2014/15 – 2015/16
- CCG’s Operating Plan 2014/15-2015/16
- Draft south east London commissioning strategy

The relationship between these different plans is shown at Appendix A

A financial gap remains between the draft action plans, as set out in these draft Commissioning Intentions, and the resources we expect to have for the next two years. Given these significant challenges, these draft joint Commissioning Intentions are part of a continuing journey of planning, engaging, prioritising and reviewing how best we use our joint resources, of nearly £490 million, to provide quality care with improved health and care outcomes for all in Lewisham. It is part of our ongoing dialogue with the Lewisham people and partners together to determine the way integrated care will be provided in Lewisham. We remain committed to fully engage in an open and transparent way with the public and our providers to discuss the way we can best meet the serious challenges that face statutory health and social care organisations in Lewisham

We know we can find local solutions to the significant challenges we face, today and in the future, by continuing to:

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\(^2\) [www.lewishamjsna.org.uk](http://www.lewishamjsna.org.uk) and see Glossary of Terms, Appendix F
• work in partnership with Lewisham residents.
• work effectively with the CCG’s member practices, both as local commissioners and providers of services.
• work collectively with other CCGs and NHS England, across the south east London health economy as a whole, on the elements of our strategy that cannot be addressed at a Lewisham borough level alone.
• work collaboratively with our local providers, including voluntary and community organisations, to support them to integrate care across organisational boundaries and respond effectively to our commissioning expectations as set out in section 6.

Thus, it is vitally important that we the local health and care commissioners, the CCG’s members, Lewisham residents and local providers continue to work together to effectively reshape future health and care systems and organisations locally in Lewisham.

Aileen Buckton
Executive Director for Community Services
London Borough of Lewisham

Dr Danny Ruta
Director of Public Health,
London Borough of Lewisham

Dr Marc Rowland
Chair,
NHS Lewisham CCG

Martin Wilkinson
Chief Officer,
NHS Lewisham CCG
2. Who we are

NHS Lewisham Clinical Commissioning Group (CCG) and the London Borough of Lewisham (LBL) are responsible for commissioning (planning, buying and monitoring) the majority of health and care services in Lewisham. LBL and Lewisham CCG have co-terminus boundaries.

Residents access acute and community health care mainly from Lewisham and Greenwich NHS Trust and mental health care from South London and Maudsley Foundation Trust. Health and care work together in four geographical neighbourhoods as shown at Appendix B.

NHS Lewisham Clinical Commissioning Group (CCG) is a membership organisation made up of the GP practices in the borough. NHS Lewisham CCG commissions most of the healthcare services for Lewisham residents, including:

- hospital care
- rehabilitation care
- urgent and emergency care
- most of community health services
- mental health
- learning disability services

NHS England commission primary care services such as GPs, pharmacists, dentists and opticians and some other specialist services.

London Borough of Lewisham (LBL) commissions and in some areas provides a wide range of services including:

- adult social care, community and cultural services, public health
- children’s social care - targeted and early intervention services for children and young people
- housing and homeless
- education; environment and waste
- planning economy and regeneration
- finances for payment of council tax and benefits

Health and Wellbeing Board – NHS Lewisham CCG and the London Borough of Lewisham work in partnership with other stakeholders, as members of Lewisham’s Health and Wellbeing Board. The Health and Wellbeing Board is a statutory committee of the London Borough of Lewisham (LBL). It promotes greater integration to improve health and wellbeing in Lewisham and produces the joint strategic needs assessment (JSNA). The Council, the CCG and partners use this information to develop strategies to meet the identified needs of Lewisham people. The Health and Wellbeing Board oversees the Adult Integrated Care Programme, and works alongside the Children and Young People’s Strategic Partnership to deliver the priorities in the Children and Young People’s Plan:

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3 Health and Wellbeing Board’s membership – see Glossary of Terms, Appendix F
• The Children and Young People’s Strategic Partnership (CYPSP) brings together all organisations working with and for children and young people in Lewisham, so that services are well placed to deliver our vision that - ‘Together with families, we will improve the lives and life chances of the children and young people in Lewisham’.

• The Adults Integrated Care Programme (AICP)\(^4\) covers all adults in Lewisham. It is a whole system approach covering most services and activities across the health and care sector, including public health. It is aligned with universal services such as Supporting People, housing, employment, adult education, culture and leisure and is underpinned by joint commissioning, local pooled budgets (section 75 agreements)\(^5\) and Better Care Funding.

**South East London** - the six CCGs in south east London are working together with NHS England commissioners (specialised services and primary care), the six London Boroughs and the public to deliver 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. There is a public consultation process underway for the south east London commissioning strategy\(^6\) - ‘Our Heathier South East London’. Appendix A shows how the different strategic plans fit together.

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\(^4\) Adult Integrated Care Programme – see Glossary of Terms, Appendix F  
\(^5\) Section 75 Agreements – see Glossary of Terms, Appendix F  
3. Our vision for health and care in Lewisham

Lewisham’s vision is to deliver joined up and co-ordinated health and social care to all residents in the borough.

Our overall ambition for adults is for adults to be more in control of their care, to understand what services are available to them and know how to access urgent support. People who use services experience person-centred support and care provided closer to home by joined up teams of staff, working proactively, to reduce the need to attend or be admitted to hospital in an emergency.

<table>
<thead>
<tr>
<th>Our vision for adult health and care in Lewisham</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Better Health</strong> – to make choosing healthy living easier - providing people with the right advice, support and care, in the right place, at the right time to improve their health and wellbeing.</td>
</tr>
<tr>
<td><strong>Better Care</strong> - to provide the most effective personalised care and support where and when it is most needed - giving all adults control of their own care and supporting them to meet their individual needs.</td>
</tr>
<tr>
<td><strong>Stronger Communities</strong> – to build engaged, resilient and self-directing communities - helping local people and neighbourhoods to do more for themselves and one another.</td>
</tr>
</tbody>
</table>

Our overall ambition for children and young people is that together with families, we will improve the lives and life chances of the children and young people in Lewisham. We will target support to the children, young people and families who need it most, intervening early so that their needs do not escalate and outcomes are improved. We will achieve this through effective joint commissioning and the better alignment of resources across different agencies to deliver the partnership’s shared outcomes across health, social care and education.

<table>
<thead>
<tr>
<th>Our vision for children and young people is underpinned by three shared values:</th>
</tr>
</thead>
<tbody>
<tr>
<td>We will put children and young people first every time.</td>
</tr>
<tr>
<td>We will have the highest aspirations and ambitions for all our children and young people.</td>
</tr>
<tr>
<td>We will make a positive difference to the lives of children and young people.</td>
</tr>
</tbody>
</table>
4. Local challenges

Local challenge in Lewisham:

- changes in our population’s health and social care needs
- Lewisham residents’ views of their service is that greater improvement is required
- performance of our current services
- financial position over the next two years

4.1 Population trends and health and social care needs

Key population and ethnicity profile change

Lewisham is a diverse inner London borough with a growing population, projected to increase from 286,000 to 318,000 by 2021. Lewisham is the 15th most ethnically diverse local authority in England - 46% of the population are from black and ethnic minority groups. Lewisham’s population is relatively young, with one in four aged under 19 years.

Lewisham’s population is projected to grow across all age groups over the next five years. In this period the largest will be in the 20-64 year old age group. The ethnic profile of those aged 20-64 will be increasingly diverse with a greater proportion of people from black and ethnic minority groups.

However, over the next fifteen years the greatest percentage increase will be in the 65+ age group. The ethnic profile of the older population which had been previously predominantly white will also change.

Challenge – people are living longer

Around 26,000 residents in Lewisham are above 65 years of age and over 3,400 are aged over 85 years. In 2012/13 almost 8000 Lewisham people aged 65 years and over had an emergency admission to hospital. The most common diagnosis for admission for those aged over 65 years was pneumonia, urinary tract infections (UTI) and COPD.

There have been improvements in the health of Lewisham residents. However Lewisham people still have significantly worst health outcomes than the rest of London and England.
Deprivation

Deprivation is increasing in Lewisham. The Index of Multiple Deprivation 2010 ranks Lewisham 31st of 326 districts in England and 9th out of 33 London boroughs.

The areas of the highest deprivation are found in Evelyn (the most culturally diverse ward in the borough) and Whitefoot and Bellingham (wards with the highest proportion of older people). Even within wards there can be very wide and potentially increasing variation in the wellbeing and life chances experienced by residents.

Mortality

Life expectancy has been improving. The life expectancy at birth was 76.7 years for women and 72.3 years for men in 1991-93; in 2008-10 it had increased to 81.3 years and 78.8 years respectively, however, for both men and women life expectancy remains lower than the England average. Also there are even greater differences in life expectancy rates in different wards within the borough. Life expectancy is 6.6 years lower for men and women in the most deprived areas of Lewisham than in the least deprived areas.

Challenge – too many people die early from deaths that could have been prevented by healthier lifestyles

Cancer is now the main cause of death (28.3%), followed by circulatory disease (28.1%), respiratory disease (13.8%) and dementia (9%) in Lewisham.
A fifth (21%) of Lewisham population smoke, which is more than the national average. About a third of adults in the borough are overweight or obese, compared to just under a quarter in England as a whole. Lewisham also has a high level of childhood obesity - over 25% of Reception children and 37% of Year 6 are overweight or obese. Alcohol related harm is significant and increasing in Lewisham.

### The main health risks by age group

<table>
<thead>
<tr>
<th>Children</th>
<th>Young people</th>
</tr>
</thead>
<tbody>
<tr>
<td>• premature delivery</td>
<td>• mental health issues, often as a consequence of exposure to toxic stress during early development</td>
</tr>
<tr>
<td>• low birth weights of babies</td>
<td>• sexual ill-health - high levels of teenage pregnancy and rates of sexually transmitted infections (STIs)</td>
</tr>
<tr>
<td>• high levels of obesity</td>
<td>• high levels of obesity</td>
</tr>
<tr>
<td>• exposure to toxic stress</td>
<td>• tobacco, alcohol and cannabis use also adversely affect young people's health in Lewisham</td>
</tr>
<tr>
<td>• the level of child poverty in Lewisham is significantly worse than the England average</td>
<td></td>
</tr>
<tr>
<td>• the rate of family homelessness is also worse than the England average</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Adults</th>
<th>Older people</th>
</tr>
</thead>
<tbody>
<tr>
<td>• increasing numbers of people diagnosed with long term conditions and their management, in particular, diabetes, COPD, CVD and hypertension</td>
<td>• the likelihood of having a long term condition increases with age, with over 50% of those aged 75+ having two or more long term conditions.</td>
</tr>
<tr>
<td>• level of mental health needs for both common and severe mental illness is significantly higher for adults in Lewisham than comparative borough</td>
<td>• dementia as it increases markedly with age and the level of diagnosis is low (see Adults section)</td>
</tr>
<tr>
<td>• Lewisham is only identifying 52.9% of people with dementia; increasing the low diagnosis is a national challenge</td>
<td>• accidental falls - the rate of emergency hospital admissions for accidental falls is significantly higher in Lewisham than the England average, at 3,367 per 100,000 in 2012/13</td>
</tr>
<tr>
<td>• high levels of drug and alcohol misuse</td>
<td></td>
</tr>
</tbody>
</table>

Further information is available from Lewisham’s Joint Strategic Needs Assessment.7

### 4.2 Lewisham residents’ views of our service

There has been an ongoing dialogue with the people of Lewisham and local providers about our proposed commissioning priorities and plans through a wide programme of engagement, including the Quality Summit8, joint workshops on integrated care9, focus groups10, online surveys11 as well as a range of consultation.

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7 [http://www.lewishamjsna.org.uk/](http://www.lewishamjsna.org.uk/)
8 Quality in Health and Social Care – a People’s Summit – 29th March 2014
9 Joint Integrated Workshops have been held to map care pathways; review information and advice and develop neighbourhood community vision during 2014
events. We have worked closely with Lewisham Healthwatch and with the many voluntary organisations and community groups in Lewisham to capture the views of local people about their local services, which are summarised at Appendix C.

This engagement work has confirmed that the people in Lewisham support the key priorities of the Adult Integrated Care Programme including:

- individuals making choices and decisions for themselves -which requires better information to support people to have greater confidence to make choices and take control of the management of their own care.
- individuals looking after themselves more and a willingness to self-manage their health and wellbeing – but again this requires better information and advice which is personalised and access to the right support.
- better co-ordination and joined up health and care services which includes the voluntary sector.
- personalised care which is holistic – where the user of the service is in control, supported with individual care planning and shared decision making.

This engagement work has confirmed that further improvements are required in local services. Lewisham Healthwatch recently provided an overview of the key messages from Lewisham people during 2013-14, which was reinforced at the People’s Quality Summit in March 2014, as summarised in the box below:

<table>
<thead>
<tr>
<th>How to improve health and care outcomes -</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Summary feedback from local residents:</strong></td>
</tr>
<tr>
<td><strong>More information</strong> – Lewisham residents want greater information on:</td>
</tr>
<tr>
<td>o how to access services and activities - to know how to access services out of hours and weekends; more information on how services are performing against standards</td>
</tr>
<tr>
<td>o how to do more self-care and manage their own care; there is a strong willingness to self-manage and support for ‘every contact counts’; people want more information about their medication and discharge information</td>
</tr>
<tr>
<td>o how to get involved in community activities.</td>
</tr>
<tr>
<td><strong>Caring staff</strong> – local people who use services want competent staff who are courteous and compassionate and treat the person as an individual; who listen and keep the user, carers and family members informed throughout the planning, care and treatment</td>
</tr>
<tr>
<td><strong>Better coordinated services</strong> – Lewisham residents strongly supported joined up health and social care, specifically improving the coordination between district nurses, care workers and other agencies</td>
</tr>
</tbody>
</table>

Source: Healthwatch Lewisham (July 2014); People’s Quality Summit (March 2014)

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10 Focus Groups with different specific groups (reflecting our seldom heard and equalities protected characteristics) as part of developing the CCG’s Commissioning Strategy
11 Online survey of the CCG’s Commissioning Intentions – January 2014
The above views of Lewisham residents have informed the development of the proposed implementation plans for 2015/16 and 2016/17 as summarised in Section 5.

See Appendix C for more information which shows the Lewisham people have informed the development of specific action plans for 2015/16 and 2016/17.

4.3 Performance of our services

We have seen improvements in services already during 2013/14 with the alignment of acute and community health and care teams and the pilot of an integrated multi-disciplinary team in one neighbourhood:

- people with long term conditions feel more supported.
- emergency admissions for chronic conditions have reduced.
- 87% of the people who were supported through Enablement Care Services were able to remain in the community at the end of the service provision.
- although our older people population has risen, there has been a decrease in the numbers entering residential or nursing care. Therefore more people have remained in their own homes also the number of emergency admissions has reduced for people over 65 years.
- mothers who smoke at time of delivery has decreased from 8.7% in March 2012 to 4.4% in March 2014. This is significantly lower than the average in England at 12%.
- the number of Looked After Children (LAC) who have completed annual health assessments rose from 80.9% in March 2012 to 92.8% as at August 2014, and 100% of Looked After Children aged 0-4 have had annual health checks.
- percentage of LAC who received intervention for substance misuse is 100%, exceeding the target of 80%.

There are many examples of excellent services in Lewisham; but we have not succeeded in rolling out best practice and innovation uniformly across the borough, and some unacceptable variation in services and outcomes remains, for example:

- the NHS Constitutional standard that Lewisham residents should start their consultant led treatment within a maximum of 18 weeks from GP referral for non-urgent conditions is not being met fully – in August 2014 the overall performance was 89%.
- some Lewisham people have difficulty in accessing primary care services.
- a high proportion of children in Lewisham are not being vaccinated, especially the uptake of the pre-school booster and the MMR2 by the age of five remain below target.
Given the rising pressure on health and care services, we need to ensure that a consistent high quality care is provided within the finite resources.

The cost of providing care is getting more expensive. The health service can now treat illnesses that previously were undiagnosed or were simply untreatable. People with more complex conditions can be supported in the community due to better drugs, equipment and skilled staff. It is good that more people are receiving health and care, but we cannot afford to keep treating more and more people. We need to work together to improve the performance of some services, but also provide services in a different way in the future.

4.4 Financial position over the next two years

NHS Lewisham Clinical Commissioning Group (CCG) receives around £384m (2014/15) to commission most of the healthcare services in Lewisham which we allocate as follows:

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**Challenge – people's experience of care is very variable**
Reduce the current variation in the quality of care and experience for all Lewisham residents

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**Challenge – increasing pressure on services**
Maintain high quality services which are safe when services are under increased strain due to a rising level of demand and limited resources

---

**Challenge – rising expectations of people and increasing cost of services**
The cost of delivering health and care services is increasing - we need to work together to improve the performance of some services, but also provide services in a different way in the future.
53% of the CCG’s budget is spent on acute hospital care equivalent to £205 million.

If NHS 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 £27.5 million between 2015/16 and 2016/17.

<table>
<thead>
<tr>
<th>NHS Lewisham CCG</th>
<th>2014/15 (this year)</th>
<th>2015/16 (year 1)</th>
<th>2016/17 (year 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net spend budget</td>
<td>£377.826 million(^{12})</td>
<td>£391.633 million</td>
<td>£398.595 million</td>
</tr>
<tr>
<td>Savings required</td>
<td>£9.990 million</td>
<td>£13.557 million</td>
<td>£13.964 million</td>
</tr>
</tbody>
</table>

Source: NHS Lewisham CCG’s Governing Body March 2014

This estimate is made taking into account current expected productivity improvements and the expected annual out-turn expenditure in line with contracts, and assumes that the health budget will remain protected in real terms and is based on national guidance\(^{13}\).

**Lewisham Council** has a net spend budget of £268 million in 2014/15. It needs to make £85 million savings over the next three years due to reduced government

---

\(^{12}\) As at March 2014, since then additional budget adjustments have been made.

\(^{13}\) ‘Everyone Counts: Planning for Patients 2014/15 - 2018/19’ – see Glossary of Terms – Appendix F
funding – as shown below. The Council is engaging with Lewisham residents on how these savings can be made as part of the ‘Lewisham’s Big Budget Challenge’.¹⁴

<table>
<thead>
<tr>
<th>Lewisham Council</th>
<th>2014/15 (this year)</th>
<th>2015/16 (year 1)</th>
<th>2016/17 (year 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Savings required</td>
<td>£39.0 million</td>
<td>£26.0 million</td>
<td>£20.0 million</td>
</tr>
</tbody>
</table>

Source: Healthier Communities Select Committee, 21st October 2014, item 5, Lewisham Futures Programme

Lewisham Council’s Adult Social Care (ASC) has a net budget of £84.57 million. The majority (87%) of the ASC’s budget is spent on the provision of care to individuals, either in their own homes or in community settings – as shown below. As the largest service area, adult social care will be required to make a substantial contribution to the Council savings programme over the next two years.

Lewisham Council’s Public Health budget is £20 million in 2014/15. It is currently a ‘ring fenced budget’ so this money has to be invested in Public Health. The main areas of Public Health expenditure are

Integrated care has delivered some efficiency savings and reshaped some services already. But improved productivity and efficiency savings alone will not be sufficient action to address the significant financial pressures and to respond to increases in the level and complexity of demand.

**Challenge – affordability gap**

Greater efficiency and productivity improvements will not be sufficient to address the significant financial challenges Lewisham faces.

This means the solution is to work together to change what we do and how we do it.
5. Proposed commissioning priorities and plans for 2015/16-2016/17

This section describes the six proposed commissioning priorities for 2015/16-2016/17 to deliver integrated care across Lewisham, which is centred around the individual, their family and their carers:

1. prevention and early intervention (section 5.1)
2. GP practices and primary care (section 5.2)
3. Neighbourhood community care for adults (section 5.3)
4. Enhanced care and support for adults (section 5.4)
5. Children and young people’s care (section 5.5)
6. Supporting enablers (section 5.6)

5.1 Prevention and early intervention

<table>
<thead>
<tr>
<th>Our aim for prevention and early intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>To connect people to services and communities across the borough to promote wellbeing; where people recognise their personal strength and abilities as well as those of their families, friends and communities.</td>
</tr>
<tr>
<td>To encourage people to stay independent longer and to find creative solutions to individual and collective challenges.</td>
</tr>
</tbody>
</table>

What actions do Lewisham commissioners intend to implement over next two years?

The proposed action plan for Prevention and Early Intervention is to:

- establish a Single Point of Access to improve the coordination and provision of information and advice, borough wide, with a single phone number for social care and health, to provide more detailed information about services available and advice on how to stay healthy.

- provide a borough wide information and advice gateway to provide specialist advice and signposting for carers. This information will support self-help and self-care and be the access point for care accounts, as required by the Care Act 2014.

- promote healthy lifestyles to support Lewisham people to have greater engagement in and control of their own health and care by:
provision and access to preventative services, low level equipment and rehabilitation and reablement of people following a fall, to reduce the number of falls.

- increasing the support to people to enable them to stay in their own homes by investing in minor housing improvements such as those achieved through “warm homes” and handyperson schemes, low level equipment and telecare.

- integrating health improvement services with the neighbourhood community networks so that interventions and services can facilitate and support life style and behaviour changes - to reduce smoking, alcohol and drug misuse; promote mental and emotional wellbeing healthy eating, exercise and cancer screening - through making ‘every contact count’.

- extend Lewisham’s Community Connections project to connect people to local support and activities, reduce isolation and improve wellbeing for the people who use services and carers.

- Children and Young People:
  - promote emotional wellbeing of our young people through delivery of our Headstart programme and submission to The Big Lottery for further work in 2015.
  - implement the expansion of health visitors and transfer of responsibilities to Local Authorities.
  - reduce preventable childhood illness by promoting the uptake of infant and child vaccinations and a wider model of intervention.

### 5.2 GP practices and primary care

#### Our aim for GP practices and primary care

| To provide strong GP practices and primary care<sup>15</sup> focused on delivering continuity of care which is proactive, co-ordinated and accessible to deliver improved outcomes, working in partnership with patients and in collaboration with other practices and neighbourhood community teams. |

### What actions do Lewisham commissioners intend to implement over next two years?

The proposed action plan for GP practices, working with neighbourhood community teams, supported by local improvement funding, is to:

<sup>15</sup> Primary Care services includes GP practices, community pharmacists, general dental practitioners and optometrists
• increase the level of proactive, preventative care focused on ‘every contact counts’; health checks, promoting immunisation and vaccination, to promote better health.

• increase earlier identification, diagnosis and intervention for people over 75 - diabetes, Cardiovascular-disease (CVD), chronic-obstructive pulmonary-disease (COPD), dementia and cancer, to improve health outcomes.

• provide greater support to patient self-management of long term conditions, to increase individual choice and control.

• ensure that patients have collaborative care plans, identify people who will benefit from continuity of care and ensure that these people have a named professional accountable for their care.

• reduce variation in care between GP practices by supporting GP practices:
  o make appropriate outpatient referrals by improving the pathways of care and evaluating the Referral Support Service pilot$^{16}$.
  o effective medication reviews and prescribing of medicines.
  o address quality standards, diagnosis and management of disease as highlighted in neighbourhood population profiles.
  o improve the patient’s experience with better access in hours and out of hours and continuity of care, using the information gained from the public about the barriers to accessing GP services.
  o support NHS England’s consultation on the London draft standards and specifications for primary care.

• improve the quality and accessibility of urgent care by redesigning current services, like ‘walk in centres’$^{17}$, to make them simpler to navigate, with a common specification and with the roll out of NHS 111 In Lewisham working with neighbouring CCGs.

• enhance access to Mental Health Specialist advice and support to primary care via neighbourhood link workers and consultants supporting the seamless and effective transition of individuals with mental health needs into primary care.

• support specialist provision within primary care to provide enhanced treatment for drug and alcohol problems with a particular focus on increasing and higher risk drinkers.

• support the implementation of End of Life - “One Chance to Get it Right” and the opportunities of better care with Coordinate My Care.

• take forward the potential opportunities of primary care co-commissioning including developing the appropriate governance arrangements, working collaboratively across south east London.

$^{16}$ Referral Support Service – see Glossary of Terms – Appendix F
$^{17}$ Walk in centres in Lewisham - see Glossary of Terms – Appendix F
support GPs to continuously improve the quality of services they provide by implementing an education and training programme.

increase the co-ordination of care working with the wider primary care team – with community pharmacists for minor illnesses, general dental practitioners and optometrists.

5.3 Neighbourhood community care for adults

<table>
<thead>
<tr>
<th>Our aim for neighbourhood community care for adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>To provide co-ordinated support and care, by locally based multi-disciplinary teams, for people with long term physical and/or mental health conditions and vulnerable people, with their carers, families and communities to effectively manage their own care, where possible, and maintain their independence.</td>
</tr>
</tbody>
</table>

What actions do Lewisham commissioners intend to implement over next two years?

The proposed action plan for Neighbourhood Community Care is to:

- embed and enhance the effectiveness of the Neighbourhood community teams which are aligned to General Practice (GP) clusters with the integration of mental health workers to co-ordinate both physical and mental health care. These multi-disciplinary teams have already brought together district nurses, all therapies, social workers and care workers. The core neighbourhood community teams are linked with the wider neighbourhood community network. The functions of the neighbourhood community teams are to provide:
  - preventative care through the early identification of risks and deterioration.
  - admission avoidance using local multidisciplinary teams (MDTs) centred around person centred care and collaborative care plans.
  - support following hospital discharge to remain well and supported in the community.
  - short-term enablement support to enhance independent living skills.
  - joint medication policy and medication reviews to optimise the use of medication.
  - increase people’s confidence and motivation to manage their condition by extending peer support and self-management.
  - provision of ‘hub’ services for drug and alcohol misusers in the community.

- Take a shared approach to care management across health and social care, including:
  - same approach to risk stratification to identify those people at higher risks of a deterioration in their health.
  - sharing of information, resulting in individuals only having to tell their story once.
• single assessment and co-produced health and social care records.
• single reviews undertaken by trusted reviewers on behalf of health and social care whenever possible.
• personal budgets are offered to all to adults and children who are eligible for NHS Fully Funded continuing healthcare.

- workforce training to ensure that all staff have the appropriate capability, capacity and engagement to ensure an equitable service for all users of services, including strengthening working practices through leadership and supervision to health and care staff who work in people’s homes and in isolation.

- realignment of care packages for people with learning and/or physical disabilities to meet their needs in the most cost effective way. This will include potentially taking forward preliminary work to develop new integrated personal commissioning for people with complex needs, working with people who use these services, their families and the voluntary sector.

- give equal status to mental health with physical health, by enhancing the range of community mental health services and interventions that are tailor-made to the needs of individuals and their aspirations for long term recovery and provide support to reduce relapse and need for hospital re-admission.

- support the development of Lewisham’s Maternity Care Model to promote normalised child birth and improve continuity of care for mothers.

- review of current services and procurement approaches for community based services:

  - review community health services to ensure that the delivery of these services are fully integrated with the neighbourhood community teams and to identify areas for potential future market testing, which is likely to include diabetes, pressure ulcer and tissue viability services.
  - Review acute services to ensure that the delivery of these services are fully integrated across health and social care to identify areas for potential innovative contractual models which is likely to include the care pathway for musculoskeletal, direct access physiotherapy, dermatology and cardiology.
  - review of talking therapies services in the borough to inform future service development.
  - review mental health voluntary contracts to increase the opportunity for community support for people with mental health problems and reducing the reliance on secondary care services.

18 MSK – Musculoskeletal - see Glossary of Terms Appendix F
5.4 Enhanced care and support for adults

Our aim for enhanced care and support for adults

To refocus and redesign the current community based intermediate tier of services to better provide enhanced care to support people to continue to live at home and to prevent people requiring a hospital admission and ensuring effective structured discharge to avoid re-admission.

What actions do Lewisham commissioners intend to implement over next two years?

The proposed action plan for enhanced care and support is to:

- provide additional community based support by responding rapidly to changes in circumstances and providing alternative services to acute hospital care, to maximise the opportunity for people to remain in their own home or within a community setting.

- refocus and reshape existing community based care services that contribute to admission avoidance across Lewisham’s health and care sector to improve their responsiveness, application and outcomes. This will include redesigning access to and pathways through such services. New approaches will be piloted over the winter period and, where successful, new contracts for services will be put in place from 2015/16 with a focus on enhancing ‘step up’ facilities.

- review, develop and enhance support available to and within care homes to ensure that unplanned admissions from such settings can be reduced.

- improve the structures around discharge planning and its associated services to reduce unnecessary delay and readmission. This covers assessments of need, home preparation services and night sitting services.

- streamline the process and application for the Disabled Facilities Grant to ensure that it is used to best effect to maximise the benefits for residents working with housing services.

- work in partnership with Housing – to deliver alternative service models to support people to live longer in the community
  - Implement new model for extra care housing including remodelling existing sheltered assets developed jointly with Lewisham Homes
  - Explore alternative models of housing and support for vulnerable groups including people with learning disabilities and mental health problems

- review and evaluate the implementation of the adult Mental Health model to ensure that it is improving outcomes for services users and reducing the reliance on bed based care.

- improve continuing healthcare (CHC) processes for assessment and case management by:

19 Community Based ‘Step up’ services – see Glossary of Terms Appendix F
• reviewing the CHC process from checklist/referral to decision making in order to improve processes.
• reviewing placement activity (AQP via spot purchasing vs home care packages) in order to identify current trends and projections for future demand.
• developing a joint funding policy with the London Borough of Lewisham for patients who do not meet the eligibility criteria for NHS Fully Funded Continuing Care but have significant health care needs.

• recomission our nursing home contracts to ensure that we have access to sufficient high quality cost effective which offer choice to service users and their families.

• review the provision of specialist continuing care services for older adults with severe mental health problems to ensure that these specialist services are commissioned in the most clinically appropriate and cost effective way.

• End of Life – to ensure the NHS London Strategic Clinical End of Life Network Guidance on Commissioning Intentions is implemented locally

• Neuro-rehabilitation to ensure that Lewisham residents have access to a range of neuro-rehabilitation services including specialist bed based, currently commissioned by NHS England, lower acuity bed based services, slow stream rehabilitation and community based neuro-rehabilitation

• re-commission the existing domiciliary care framework to move from a model which delivers care in a ‘time and task ‘ approach to one which focuses on delivering outcomes which are important to individuals and their families’.

• explore the opportunities for supporting people who have both physical and mental health problems and who need a hospital admission by developing a different model of care between acute care and mental health focusing on rapid assessment and discharge planning (RAID).

5.5 Children and young people’s care

<table>
<thead>
<tr>
<th>Our aim for children and young people’s care</th>
</tr>
</thead>
<tbody>
<tr>
<td>To provide integrated care pathways that provide high quality support – with choice and control for children, young people and their families at the right time, in the right place for all our children and young people, ensuring that needs do not escalate.</td>
</tr>
</tbody>
</table>

What actions do Lewisham commissioners intend to implement over next two years?
The proposed action plan for Children’s and Young People is to:
- shape the development of regional health service provision through the south east London Clinical Commissioning Strategy – ensuring that our existing areas of good practice are emphasised and replicated.
- deliver high quality and integrated care pathways in the community to ensure that all children receive excellent and complementary care from different services, partners and providers - including children's community nursing, school nurses, therapies, and special needs nursing.
- develop the process and mechanisms through which to deliver personal health budgets to children, including those with Education, Health and Care Plans.
- secure high quality community health services through re-modelled and effective service delivery with commissioned providers, including school nurses, therapies, and special needs nursing.
- Commission a new drug and alcohol treatment service for Children and Young People up to the age of 25

5.6 Supporting enablers

<table>
<thead>
<tr>
<th>Our aim for supporting enablers</th>
</tr>
</thead>
<tbody>
<tr>
<td>To ensure that the necessary tools and infra-structure are in place to achieve the cultural changes and working practices required to support integrated care, including public communication and engagement, Information Technology, commissioning tools, estates utilisation</td>
</tr>
</tbody>
</table>

What actions do Lewisham commissioners intend to implement over next two years?

The proposed action plan for Supporting Enablers is to:
- improve the communication with the public to promote system wide change in the way advice, support and care is provided.
- implement a joint workforce development plan to support the ambition of integrated care and the proposed action plans set out in the Commissioning Intentions:
  - new ways of working, - different skill mix, new generic roles; new competencies.
  - different relationship with patients - a cultural change in the relationship with people who use our services and carers supporting empowerment and independence.
• maximise the potential of technological advances to support people who use our services and professionals, specifically the delivery of Connect Care\textsuperscript{20}, to provide health and care professionals with more complete information about a person’s needs and to support and facilitate, amongst other things, joint assessments, joint care planning and swifter interventions.

• use different commissioning, procurement and contractual tools to secure the potential benefits of integrated care:
  o sharing of risks and incentives between commissioners and providers;
  o joint procurement.
  o the opportunities of Payment by Results (PbR)\textsuperscript{21} flexibilities.
  o the commissioning of support service using the opportunities to buy from the Commissioning Support Lead Provider Framework\textsuperscript{22}.

• provide programme support for Adult Integrated Care Programme\textsuperscript{23} to ensure implementation is paced and mainstreamed and evaluations are undertaken and learning shared

• better utilisation of our collective estates by statutory and voluntary organisations – to work with providers to undertake a review of estates in Lewisham Borough to maximise their effective.

\textsuperscript{20} Connect Care – see Glossary of Terms, Appendix F
\textsuperscript{21} Payment by Results - see Glossary of Terms, Appendix F
\textsuperscript{22} Commissioning Support Lead Provider Framework – see Glossary of Terms, Appendix F
\textsuperscript{23} Adult Integrated Care Programme - see Glossary of Terms, Appendix F
6. Commissioners’ ambition for 2015/16 and 2016/17

6.1 Commissioners’ ambition for Lewisham residents

As commissioners we intend to bring together the collective resources available to Lewisham Council (Adult Social Care and Public Health) and NHS Lewisham Clinical Commissioning Group (CCG), of nearly £490 million, to use them to the maximum benefit to support people to live well in all aspects of their lives. Our ambition is to achieve better outcomes than we do now for Lewisham residents by:

- making choosing healthy living easier - providing people with the right advice, support and care, in the right place, at the right time to improve their health and wellbeing and help people live independently.

- providing the most effective personalised care and support where and when it is most needed, so giving all adults control of their own care and supporting them to meet their individual needs.

- helping to build engaged, resilient and self-directing communities - enabling and assisting local people and neighbourhoods to do more for themselves and one another.

6.2 Commissioners’ ambition for system wide change

Our ambition is to deliver the six system wide changes across health and social care, summarised below, working together with the people of Lewisham and partners, to achieve improved health and care and reduced inequalities.

<table>
<thead>
<tr>
<th>Commissioners’ ambition for system wide change in 2015/16 and 2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Commission advice, support and care services for the whole population using techniques of risk stratification, patient segmentation and evidence based care to ensure our collective, limited resources are most effectively used to meet the local health and care needs and challenges.</td>
</tr>
<tr>
<td>2. Use a person centred approach to commissioning to ensure that advice, support and care is personalised, delivered earlier and more effectively resulting in:</td>
</tr>
<tr>
<td>• consistent high quality of care and patient experience whenever and wherever care is provided.</td>
</tr>
<tr>
<td>• reduced variation and inequalities in health and care outcomes.</td>
</tr>
<tr>
<td>• increased focus on proactive, preventative care.</td>
</tr>
<tr>
<td>• better outcomes for the individual.</td>
</tr>
<tr>
<td>3. Work in partnership with Lewisham residents to empower users of services to help reshape their services to achieve better outcomes.</td>
</tr>
<tr>
<td>4. Shift the focus of resources to invest in joined up primary care, social care and</td>
</tr>
</tbody>
</table>
community care, for both physical and mental health, so that people receive the support they need when they need it and to reduce the growth in demand for acute (hospital based) services.

5. **Spend our collective resources wisely** to deliver better outcomes and avoid waste by working collaboratively with current and future providers to develop the local market and to identify the procurement approach most suitable to achieve and secure the above system wide transformation.

6.3 **Commissioners’ ambition for all providers**

We wish to commission from a wide range of statutory, voluntary and independent sector providers to support us to deliver the proposed priorities and plans as set out in these Commissioning Intentions and to transform systems and organisations to deliver integrated advice, support and care across Lewisham.

We want to work in partnership with all our local providers to support them to embed, within their organisations, systems and processes to ensure that users of the service views are listened to and acted on in order to achieve continuous improvement in the quality of care, which is proactive, self-monitoring and managed - as an effective organisational response to the Francis recommendations and the Winterbourne View report.

We would like to work together with our providers to support them to use the opportunities to develop services that help people to live well in all aspects of their lives and to have strong, effective leadership at every level throughout the organisation, to lead the cultural change in the way in which care is delivered across the health and care system.

Finally, we are keen to demonstrate to Lewisham residents that not only do we commission services that provide good value for money and are efficient and effective, but also ‘add value’ and are financially sustainable.

**Commissioners’ ambition for all local providers in 2015/16 and 2016/17**

1. **Continuous improvement in quality of care for all** – “getting the basics right every time” monitored and reported publicly:
   - **Safety** – have robust systems in place to protect people from abuse and avoidable harm, with an open culture to learn when mistakes do occur.
   - **User experience** – develop robust systems to find out about the experiences of all people who use our services, including those who are unlikely to complain or voice their views, triangulated with other quality information.

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24 Francis Report – see Glossary of Terms, Appendix F
25 Winterbourne View report – see Glossary of Terms, Appendix F
• **Effectiveness** – have a programme of audits to test that advice, support and care achieves good outcomes, promotes good quality of life and is based on the best available evidence; working towards real time information.

• **Workforce** – ensure care is provided by staff who are caring, compassionate and understand the importance of language and cultural differences; staff who are supported to be confident, engaged, motivated, knowledgeable and properly skilled; staff who have shared values and are empowered to be innovative, creative and to learn.

2. **Strong leadership at every level throughout the organisation** to support the culture and practice in the way in which care is delivered across the health and care system:

• **Person centred** – where the ‘person is in control’; the professional is focused on the total needs of the individual, which empowers the individual to be independent, make informed choice and take control; a behavioural change in the relationship between the person and the professional.

• **Proactive, preventative care focused on better outcomes and reducing inequalities** provided in the community setting, supporting health and wellbeing.

• **Provided in cooperation and collaboration** with other professions and coordinated across organisations (health, social care and the voluntary sector) so that it is seamless to the user, supported by Connect Care26.

• **Co-produced with people who use the services and the public**, with specific consideration to engage with people from protected characteristics, to proactively reduce inequalities of access and outcomes.

• **Supports learning and innovation**.

3. **Added Value**

• **Increasing value for money** – demonstrate good value for money, efficiency and effectiveness compared to similar services and avoid waste.

• **Move towards an integrated performance management approach** that focuses on improving ‘value’, for example, by using a scorecard of outcome metric that relate to safety and effectiveness, patient experience and costs.

• **Develop financially sustainable services** working with commissioners.

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26 Connect Care – see Glossary of Terms, Appendix F
7. Measuring the benefits of integrated care

We wish to use the National Voice “I statements”\(^\text{27}\) to make sure that we are measuring what Lewisham residents consider to be the most important benefits to achieved by joined up, integrated care. We want to work with the people of Lewisham to build on the initial work undertaken as part of the CCG’s Annual General Meeting (AGM) – see table below – as a basis for further engagement.

<table>
<thead>
<tr>
<th>Summary of the prioritised “I statements” from NHS Lewisham CCG AGM</th>
</tr>
</thead>
<tbody>
<tr>
<td>• I have an understanding and know what is in my Care Plan</td>
</tr>
<tr>
<td>• I have the information, and support to use it, that I need to make decisions and choices about my care and support</td>
</tr>
<tr>
<td>• I have the information, and support to use it, that helps me manage my condition</td>
</tr>
<tr>
<td>• I tell my story once</td>
</tr>
<tr>
<td>• I want to be involved in discussions and decisions about my care, support and treatment</td>
</tr>
<tr>
<td>• I know in advance where I am going, what I will be provided with and who will be my main point of professional contact</td>
</tr>
<tr>
<td>• Taken together, my care and support help me to live the life I want to the best of my ability.</td>
</tr>
</tbody>
</table>

Source: National Voices A narrative for person-centred coordinated (‘integrated’) care - ‘I statements’ 2012

Also we will use the NHS, Public Health and Adult Social Care outcomes frameworks and the local communities’ feedback to measure success. The majority of these measures are included within the Health and Wellbeing Board Performance Dashboard which is monitored by the Health and Wellbeing Board on a regular basis – See Appendix D.

\(^{27}\) National Voice ‘I Statements’ – see Glossary of Terms, Appendix F
8. Engagement process

This draft Joint Commissioning Intentions for Integrated Care sets out our proposed priorities and accompanying draft action plans for local services for 2015/16 and 2016/17, which commissioners consider are most feasible and realistic within the collective, expected resources and best addresses the local challenges we face in Lewisham.

These joint Commissioning Intentions and proposed action plans, however, only partially address the financial challenges that face Lewisham health and care system. A ‘financial gap’ still remains. The exact size of the remaining ‘gap’ is difficult to determine precisely, but it will become clearer in January 2015 when it is expected that further national guidance will be available.

![The challenge continues:]

A financial gap still remains between the proposed action plans as set out in these draft joint Commissioning Intentions and the collective resources we expect to have for the next two years

Therefore it is vitally important that the Council, CCG’s members, the public and local providers continue to work together to effectively reshape future health and care systems and organisations locally in Lewisham. Only together will we be able to make sure that the local health and care services are financially sustainable.

We are committed to build on our good communication and engagement to date and to engage fully with you, the public and our providers, to discuss openly and transparently the way we can best meet the serious challenges that face the statutory health and social care sector, to find jointly local innovative solutions. We are putting in place a programme of engagement events, working with Lewisham Healthwatch, to seek your views and comments during the November and December 2014.

We would welcome your views on the following three issues:

<table>
<thead>
<tr>
<th>Three engagement Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Are these the best action plans to deliver the priorities within the limited resources available, for 2015/16 and 2016/17, as set out in section 5?</td>
</tr>
<tr>
<td>2. Do you agree that the most important ‘I Statements’ for us to achieve as a result of joined up, integrated care are those set out in section 7? Or are there other important issues you wish to highlight, from the Lewisham Healthwatch and the Quality Summit summary (section 4.2)</td>
</tr>
<tr>
<td>3. Do you support the commissioners’ ambition for whole system and providers</td>
</tr>
</tbody>
</table>

The challenge continues:

A financial gap still remains between the proposed action plans as set out in these draft joint Commissioning Intentions and the collective resources we expect to have for the next two years.
changes, as set out in section 6?

*Discuss with communications how best to phrase these engagement questions*

Please contact XXXXXXXXX with your views before 31st December 2015.
APPENDIX A

National Planning Guidance
‘Everyone Counts: Planning for Patients 2014/15-2018/19’

Borough-specific issues, challenges and plans

Lewisham JSNA
Population health needs

Areas with need for collective action

Strategic Planning
5 Year

Operational Planning
2 Year

Health & Wellbeing Strategy

CCG Strategy

Delivery plan

Commissioning Intentions

Operating plans

Adult Integrated Care Programme Workstreams

CCG programmes

Clinical Leadership Group Workstreams

Children’s and Young People’s Partnership

SEL commissioning strategy

Years 1 & 2 outcomes and ambitions

Draft Joint Commissioning Intentions for Integrated Care

Page 33
GP Practices in Lewisham

North Lewisham Practices
1. Morningside
2. Queens Road
3. Kingfisher MC
4. Clifton Rise
5. New Cross Health Centre
6. Grove Medical Centre
7. Vesta Road
8. Amersham Vale Training Practice
9. Deptford Surgery
10. Dr Batra Surgery
11. Deptford Medical Centre

Central Lewisham Practices
12. Belmont Hill
13. Lewisham Medical Centre
14. Burnt Ash Surgery
15. Morden Hill
16. St John's Medical Centre
17. Lee Road
18. Brockley Road
19. Hilly Fields Medical Centre
20. Honor Oak
21. Triangle
22. Rushey Green
23. Woodlands Health Centre
24. Nightingale
25. Hurley Group Practice

South East Lewisham Practices
26. South Lewisham
27. Tidman Road
28. Barling Road
29. ICO Moorside Clinic
30. Downham Family Practice
31. Winlaton
32. ICO Chinnbrook
33. Parkview
34. ICO Marvels Lane Health Centre
35. Muirkirk Road
36. ICO Boundfield Road Medical Centre
37. Oakview

South West Lewisham Practices
38. Jenner
39. Sydenham Green
40. Woolstone Medical Centre
41. Sydenham Surgery
42. Wells Park
43. Bellingham Green
44. Vale Medical Centre
## How the views of Lewisham people have an impact on developing the action plans for 2015/16 and 2016/17

<table>
<thead>
<tr>
<th>Priority</th>
<th>Local service issues</th>
<th>Public Feedback on local issues</th>
<th>Action planned to be implement during 2015/16 and 2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prevention and Early Intervention</strong></td>
<td>Information and advice on staying healthy and well.</td>
<td>Strong view that individuals should be making choices and decisions for themselves. This requires better information to give people confidence to make choices and take control of the management of their own care. Clear and consistent information to support health promotion and self-management in appropriate format.</td>
<td>Establish a Single Point of Access to improve the coordination and provision of information and advice, borough wide with a single phone number for social care and health, to provide more detailed information about services available and advice on how to stay healthy.</td>
</tr>
<tr>
<td></td>
<td>Information and advice on accessing services</td>
<td>Improve the information about accessing services - how to access services out of hours and weekends especially about changes to access to GP out of hours and emergency services;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Information and advice on accessing community activities</td>
<td>Want to be able to find out how to get involved in communities activities and co-produce new services;</td>
<td>Extend Lewisham’s Community Connections project to connect people to local support and activities, reduce isolation and improve wellbeing for service users and carers.</td>
</tr>
<tr>
<td></td>
<td>Access to performance data about local services</td>
<td>More information about how services are performing which is transparent and easy to access.</td>
<td>Commissioners’ Ambition for all Local Providers to work in partnership with all local providers to support them to embed, within their organisations, systems and processes to ensure a continuous improvement in quality of care for all – “getting the basics right every time” - monitored and reported publicly.</td>
</tr>
<tr>
<td>Health Promotion - general</td>
<td>Strong support for ‘every contact counts’ ethos; strong willingness to self-manage (eg health trainers);</td>
<td>Integrating health improvement services with the neighbourhood community networks so that interventions and services can facilitate and support life style and behaviour changes - to reduce smoking and alcohol misuse; promote mental and emotional wellbeing healthy eating, exercise and cancer screening - through making ‘every contact count’</td>
<td></td>
</tr>
<tr>
<td>Health promotion – mental health</td>
<td>There should be increased awareness about mental health and more done to prevent the onset of mental health;</td>
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<tr>
<td>General Practice - access</td>
<td>Primary Care access continues to be difficult and frustrating, particularly telephone access and for certain groups of the population including carers, young persons, older people and people who do not speak English as a first language;</td>
<td>Reduce variation in care between GP practices by supporting GP practices to improve the patient’s experience with better access in hours and out of hours and continuity of care, using the information gained from the public about the barriers to accessing GP services.</td>
<td></td>
</tr>
<tr>
<td>General Practice - quality</td>
<td>Improve the continuity of care from general practice</td>
<td>Support GPs to continuously improve the quality of services they provided by implementing an education and training programme</td>
<td></td>
</tr>
<tr>
<td>Wider Primary Care - quality</td>
<td>Improve the service and communication from practice staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community based care – quality</td>
<td>Positive feedback about community pharmacy and the services it provides</td>
<td>Increase the co-ordinating care working with the wider primary care team – with community pharmacists, general dental practitioners and optometrists</td>
<td></td>
</tr>
<tr>
<td>Neighbourhood Community Care</td>
<td>Improve the quality of district nurses and social work provision; Better coordination between district nurses, care workers and other agencies; Poor experience for mental health users; seem to</td>
<td>Embed and enhance the effectiveness of the Neighbourhood community teams which are aligned to General Practice (GP) clusters with the integration of mental health workers to co-ordinate both physical and mental health care, linked with the wider neighbourhood community network</td>
<td></td>
</tr>
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</table>
### Integrated community based care

<table>
<thead>
<tr>
<th>Enhanced Care and Support</th>
<th>Enhanced care and support - quality</th>
<th>Enhanced care and support - Inequality</th>
</tr>
</thead>
<tbody>
<tr>
<td>be not treated with the same priority as people with physical health needs</td>
<td>Give equal status to mental health with physical health, by enhancing the range of community mental health services and interventions that are tailor made to the needs of individuals and their aspirations for long term recovery and provide support to reduce relapse and need for hospital re-admission.</td>
<td>Implement a shared approach to care management across health and social care including:</td>
</tr>
<tr>
<td>Integrated community based care</td>
<td>Strong support for better co-ordinated, joined up health and social care including involving and supporting the voluntary sector; but need to make sure that person who uses the service understand who is responsible;</td>
<td>- Same approach to risk stratification to identify those people at higher risks of a deterioration in their health</td>
</tr>
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<td></td>
<td>Lewisham residents want personalised care across all settings which is holistic – with individual care planning, shared decision making and patients in control;</td>
<td>- sharing of information, so that individuals tell their story only once</td>
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<tr>
<td></td>
<td>Service users want greater empowerment by being given more information about their care and medication without use of technical language;</td>
<td>- single assessment and co-produced health and social care records</td>
</tr>
<tr>
<td></td>
<td>Adequate time and information needs to be given to support patient understanding and role in decision making;</td>
<td>- single reviews undertaken by trusted reviewers on behalf of health and social care whenever possible</td>
</tr>
<tr>
<td></td>
<td>Review, develop and enhance support available to and within care homes to ensure that unplanned admissions from such settings can be reduced.</td>
<td>- personal budgets to adults and children rolled out to those who receive continuing healthcare</td>
</tr>
<tr>
<td>Enhanced care and support - quality</td>
<td>Reduce the variability of quality of care provided in hostels and care homes;</td>
<td>Undertake an equalities impact assessment of our joint Commissioning Intentions for Integrated care</td>
</tr>
<tr>
<td>Enhanced care and support - Inequality</td>
<td>Emerging concerns about equity and equality for some specific groups eg HIV, Substance Misusers, people living in hostels, people in care</td>
<td></td>
</tr>
<tr>
<td>Enhanced care and support – discharge planning</td>
<td>Users, carers (unpaid) and family members want better inclusion in care planning and process and discharge planning. Improve the discharge particularly for vulnerable groups e.g. hostel residents and mental health patients.</td>
<td>Improve the structures around discharge planning and its associated services to reduce unnecessary delay and readmission. This covers assessments of need, home preparation services and night sitting services.</td>
</tr>
<tr>
<td>Children’s and Young People</td>
<td>Positive feedback continues about Lewisham’s birthing unit (Ref 1). Young people want to engage with health dialogues to influence services and make sure their needs are understood. Mental Health services – improve the access to MH and CAHMs; Greater focus on the transition (16-25 years).</td>
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</tbody>
</table>
| Public's future expectations | Users experience of care is variable and could be made better
Strong desire for improved communication from staff - with improved interpersonal skills, where staff are caring, courteous and compassionate; service users are treated with dignity and respect and listened to | Commissioners’ Ambition for all Local Providers to work in partnership with our local providers to support them to embed, within their organisations, systems and processes to ensure continuous improvement in quality of care, which is proactive, self-monitoring and managed: to have strong, effective leadership at every level, throughout the organisation, to lead the change in the culture and practice in the way in which care is delivered across the health and care system. |
APPENDIX D

Key Performance Indicators to measure progress

Improved health and care outcomes - to improve outcomes and reduce the gap of equality of opportunities:

- Potential years of life lost from causes amenable to healthcare
- Life expectancy at birth – including inequality in life expectancy at birth
- Premature mortality - under 75 Mortality Rates from CVD, cancer, respiratory disease, Lung Cancer, serious mental illness
- Infant Mortality (under 1 years)
- Children in Poverty (Under 16s)

Prevention and Early Intervention

- Low birth weight of all babies
- Uptake rates of Immunisation for infants and children
- Cancer screening coverage - breast cancer, cervical cancer, bowel cancer
- Proportion of physically active and inactive adults
- Uptake of Influenza vaccine in those over 65 years of age
- Number of practitioners skilled in identifying those at risk from alcohol harm and delivering brief interventions
- Smoking
  - Level of smoking in the population (18+)
  - 4 week smoking quitters
  - Number of 11-15 year-olds who take up smoking
  - Number of children in smoke free homes
  - Smoking at time of delivery
- Mental Health
  - Level of Serious Mental Illness, dementia, depression in the population
  - Suicide rates
- Sexual Health
  - Rate of chlamydia diagnoses per 100,000 young people aged 15 to 24
  - Level of diagnosed HIV infection in the population
  - Percentage of people presenting with HIV at a late stage of infection
  - (Legal Abortion rate for all ages
  - Teenage conceptions

Better User Experiences

- Long Term Conditions - increase the number of people who feel supported to manage their condition;
- Patients with Long-Term conditions actively engaged in self-care
- Primary Care Access - ease to speak to someone on the phone – CCG Dash Board
- Friends and Family test- hospitals, maternity, GPs mental health and communities – CCG Dash board
- Breastfeeding Prevalence 6-8 weeks
• Self-reported well-being - people with a low happiness score
• Proportion of people using social care who receive self-directed support, and those receiving
direct payments
• End of life – people dying in their usual place of residence – CCG Dash board

Changes in the way people can obtain advice care and support – provide more community based services and reduce unnecessary hospital admissions

• Reduction in avoidable emergency admission using three measures:
  o Reducing unplanned hospitalisation for chronic ambulatory care sensitive conditions
  o Reducing emergency admissions that should not usually be admitted to hospital
  o Emergency readmissions within 30 days of discharge from hospital
  o unplanned hospitalisation for asthma, diabetes and epilepsy in children
  o emergency admissions for children with lower respiratory tract infection
  o Alcohol related admissions
• Increase in the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
• Delayed transfers of care from hospitals
• Improved access to psychological therapists – CCG Dash Board
• Two week wait referrals for cancer services
• Early diagnosis of cancer
### How will we know we have achieved out ambition of integrated care – National Voices “I Statements”

<table>
<thead>
<tr>
<th>Category</th>
<th>“I” Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overall</strong></td>
<td>I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me.</td>
</tr>
<tr>
<td><strong>Goals and outcomes</strong></td>
<td>All my needs as a person are assessed.</td>
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<tr>
<td></td>
<td>My carer/family have their needs recognised and are given support to care for me.</td>
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<tr>
<td></td>
<td>I am supported to understand my choices and to set and achieve my goals.</td>
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<tr>
<td></td>
<td>Taken together, my care and support help me live the life I want to the best of my ability.</td>
</tr>
<tr>
<td><strong>Care Planning</strong></td>
<td>I work with my team to agree a care and support plan.</td>
</tr>
<tr>
<td></td>
<td>I know what is in my care and support plan. I know what to do if things change or go wrong.</td>
</tr>
<tr>
<td></td>
<td>I have as much control of planning my care and support as I want.</td>
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<tr>
<td></td>
<td>I can decide the kind of support I need and how to receive it.</td>
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<td></td>
<td>My care plan is clearly entered on my record.</td>
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<tr>
<td></td>
<td>I have regular reviews of my care and treatment, and of my care and support plan.</td>
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<tr>
<td></td>
<td>I have regular, comprehensive reviews of my medicines.</td>
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<tr>
<td></td>
<td>When something is planned, it happens.</td>
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<tr>
<td></td>
<td>I can plan ahead and stay in control in emergencies.</td>
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<tr>
<td></td>
<td>I have systems in place to get help at an early stage to avoid a crisis.</td>
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<tr>
<td><strong>Communication</strong></td>
<td>I tell my story once.</td>
</tr>
<tr>
<td></td>
<td>I am listened to about what works for me, in my life.</td>
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<tr>
<td></td>
<td>I am always kept informed about what the next steps will be.</td>
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<td></td>
<td>The professionals involved with my care talk to each other.</td>
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<tr>
<td></td>
<td>We all work as a team.</td>
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<tr>
<td></td>
<td>I always know who is coordinating my care.</td>
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<tr>
<td></td>
<td>I have one first point of contact. They understand both me and my condition(s). I can go to them with questions at any time.</td>
</tr>
<tr>
<td></td>
<td>I have the information and support to use it, that I need to make decisions and choices about my care and support.</td>
</tr>
<tr>
<td></td>
<td>I have information, and support to use it, that helps me manage my conditions.</td>
</tr>
<tr>
<td></td>
<td>I can see my health and care records at any time. I can decide who to share them with. I can correct any mistakes in the information.</td>
</tr>
<tr>
<td>Information</td>
<td></td>
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<tr>
<td>------------------------------------------------</td>
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</tr>
<tr>
<td>I am given information to me at the right times. It is appropriate to my condition and circumstances. It is provided in a way that I can understand.</td>
<td></td>
</tr>
<tr>
<td>I am told about the other services that are available to someone in my circumstances, including support organisations.</td>
<td></td>
</tr>
<tr>
<td>I am not left alone to make sense of information. I can meet/phone/email a professional when I need to ask more questions or discuss the options.</td>
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</table>

<table>
<thead>
<tr>
<th>Decision making</th>
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</thead>
<tbody>
<tr>
<td>I am as involved in discussions and decisions about my care, support and treatment as I want to be.</td>
</tr>
<tr>
<td>My family or carer is also involved in these decisions as much as I want them to be.</td>
</tr>
<tr>
<td>I have help to make informed choices if I need and want it.</td>
</tr>
<tr>
<td>I know the amount of money available to me for care and support needs, and I can determine how this is used (whether it’s my own money, direct payment, or a ‘personal budget’ from the council or NHS).</td>
</tr>
<tr>
<td>I am able to get skilled advice to understand costs and make the best use of my budget.</td>
</tr>
<tr>
<td>I can get access to the money quickly without over-complicated procedures.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Transitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>I can get access to the money quickly without over-complicated procedures.</td>
</tr>
<tr>
<td>When I move between services or settings, there is a plan in place for what happens next.</td>
</tr>
<tr>
<td>I know in advance where I am going, what I will be provided with, and who will be my main point of</td>
</tr>
<tr>
<td>I am given information about any medicines I take with me – their purpose, how to take them, potential side effects.</td>
</tr>
<tr>
<td>If I still need contact with previous services/professionals, this is made possible.</td>
</tr>
<tr>
<td>If I move across geographical boundaries I do not lose me entitlements to care and support.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Emergencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>I could plan ahead and stay in control in an emergency.</td>
</tr>
<tr>
<td>I had systems in place so that I could get help at an early stage to avoid crisis.</td>
</tr>
</tbody>
</table>
Appendix F

Glossary of Terms

Adult Integrated Care Programme
Lewisham’s Adult Integrated Care Programme (AICPB) builds on work undertaken within the borough since November 2011 to develop and deliver an integrated health and social care model. This work brought together teams of district nurses, all therapies, social workers and care workers. Building on this, further integration took place through the establishment of multi-disciplinary teams to align with GP neighbourhoods. Subsequently, members of the Health and Wellbeing Board agreed to increase the scale and pace of integration.

Better Care Fund
The Better Care Fund (BCF) was announced as part of the 2013 Spending Round and is a core element of the ‘Everyone Counts’ planning guidance. The national policy guidance stated that ‘the Government will introduce a £3.8 billion pooled budget for health and social care services, shared between the NHS and local authorities, to deliver better outcomes and greater efficiencies through more integrated services for older and disabled people, with the resultant reduction in unnecessary hospital admissions and inappropriate lengths of stay.

Care Act (2014)
The Care Act has created a single law that makes it clear what kind of care people should expect. The Care Act consolidates previous adult social care legislation and sets out a number of new duties, including:

- A duty on Councils to consider the physical, mental and emotional wellbeing of individuals in need of care;
- A duty to provide preventative services to maintain people’s health and to support them to live independently for as long as possible;
- A cap on care costs of £72,000 and monitoring an individual’s progress towards the cap;
- New rights for carers, who will be put on the same legal footing as the people they care for, with extended rights to assessment and rights to support if eligible;
- The provision of information and advice about care and support services to help people navigate the system and make the best choices

Commissioning Support Lead Provider Framework
NHS England has developed a new framework agreement for commissioning support services – the Lead Provider Framework – that enables CCGs, NHS England and other customers to source some or all of their commissioning support needs, ranging from back office support services to more bespoke services that support local and large scale transformational change projects.

Chronic conditions
Chronic conditions require ongoing management over a period of years and cover a wide range of health problems, such as heart disease, diabetes and asthma. These
conditions require a complex response over an extended time period that involve coordinated inputs from a wide range of health and care professionals and access to essential medicines and monitoring systems.

Connect Care
Connect Care, previously known as the Virtual Patient Record, allows patient information to be shared across organisations. It pulls together patient data from acute, community and primary care providing organisations in Lewisham with a read only record at the point that clinical decisions are made.

Enablement care services
Enablement is about helping people become more independent and improve their quality of life. It focuses on helping patients relearn how to do everyday tasks, such as making a meal, getting out of bed and personal care for themselves rather than having someone else doing the tasks for them.

Everyone Counts is planning guidance from NHS England that outlines the ambition, priorities and financial planning requirements for the NHS in England.

Francis Report (2013)
The Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry 2013 (The Francis Report) chaired by Robert Francis QC made 290 recommendations to the Secretary of State for Health to improve patient safety in the NHS. All NHS organisations have been required by NHS England to respond to the “Francis Report” and to publish an action plan detailing how the recommendations will be implemented.

Health and Wellbeing Board
Health and Wellbeing Boards bring together key leaders from the NHS, public health, adult social care, children’s services and Healthwatch, to plan how best to meet the needs of their local population and tackle local inequalities in health. Its main functions are to undertake a Joint Strategic Needs Assessment, develop the Joint Health and Wellbeing Strategy and encourage integrated health and social care.

Integrated Personal Commissioning (September 2014)
NHS England, the Local Government Association, Think Local Act Personal and the Association of Directors of Adult Social Services are formally inviting health and social care leaders to help build a new integrated and personalised commissioning approach through an Integrated Personal Commissioning (IPC) programme which will, for the first time, blend comprehensive health and social care funding for individuals, and allow them to direct how it is used.

Lewisham’s Joint Strategic Needs Assessment
Our Joint Strategic Needs Assessment pulls together information about local health and social care needs and is a vital tool to help us plan future services. It explores how Lewisham compares with other areas locally, regionally and nationally. It also
examines what services we are currently providing, what works well and what could be improved.

**MSK**

MSK is shorthand for Musculoskeletal. MSK disorders cover any injury, disease or problem relating to our muscles, bones or joints.

**National Voice “I” statements**

“*I*” statements are indicators for measuring people’s experience of integrated care and support. National Voices developed these statements through consultations with patient and user organisations, and from patient experience indicators. They tested and refined them in two workshops involving system leaders, patients, people who use services, carers and patient organisations.

**NHS 111**

NHS 111 is a new national service aimed at making it easier to access local NHS healthcare services in England. People can dial 111 when they need medical help fast but it's not a 999 emergency. NHS 111 is available 24 hours a day, 365 days a year. At the moment, NHS 111 is being rolled out in different parts of England but is not fully ‘live’ in Lewisham, Lambeth and Southwark.

**NHS Constitution (2013)**

The NHS constitution brings together in one place details of what staff, patients and the public can expect from the National Health Service. It also explains what you can do to help support the NHS, help it work effectively, and help ensure that its resources are used responsibly.\(^\text{28}\)

**Payments by Results**

Payments by Results (PbR) is the payment system in England under which CCGs pay healthcare providers for each patient seen or treated, taking into account the complexity of the patient’s healthcare needs. PbR currently covers the majority of healthcare in hospitals. For example, £119 for an outpatient attendance in obstetrics or £5,323 for a hip operation.

**Referral Support Service**

Lewisham’s Referral Support Service is a two year pilot to support the GP referral process from referrer to the patient’s first outpatient appointment. It offers patients a choice of location, date and time for their appointment, using the electronic referral system ‘Choose and Book’.

**Section 75 Agreement**

An agreement made under section 75 of National Health Services Act 2006 between a local authority and an NHS body in England. Section 75 agreements can include arrangements for pooling resources and delegating certain NHS and local authority health-related functions to the other partner(s) if it would lead to an improvement in the way those functions are exercised.

‘Step up’ and ‘step down’ services
‘Step up’ is a short term provision of up to six weeks provided to prevent an admission into a hospital bed. ‘Step down’ is a provision to speed up discharge from a hospital bed by helping the patient to return to their own home.

Walk in Clinics in Lewisham
The New Cross GP Led Walk-in Centre is a medical practice whose services are available to all, whether they are registered as a patient or not. Patients are able to walk-in, sign in at reception and see the next available clinician. The service offered to patients using the walk-in centre is limited to immediate or same day treatment only and is not suitable for on-going treatment for chronic conditions.

The report sets out steps to respond to failings following the abuse revealed at Winterbourne View hospital. The report lays out clear, timetabled actions for health and local authority commissioners working together to transform care and support for people with learning disabilities or autism who also have mental health conditions or behaviours viewed as challenging.
ENCLOSURE 13
SOUTH EAST LONDON 111 PROCUREMENT STRATEGY

CLINICAL LEAD: Patrick Harborow  
MANAGERIAL LEAD: Diana Braithwaite

AUTHOR: Niamh Wilson

RECOMMENDATIONS:
The Governing Body is asked to discuss and agree the approach to re-procurement of NHS 111 proposed in this paper, particularly agreeing the recommendations in section 2 of this paper.

SUMMARY:
The purpose of this document is to summarise the outputs of the South East London commissioner workshop on the 13th May 2014 and subsequent discussions and detail the key elements and process for the re-procurement of 111.

KEY ISSUES:
In 2012/13, the new NHS 111 service was launched in London, where it was agreed to pilot it for two years. The new service was specified by the Department of Health and commissioned locally through a tender process. SEL now needs to re-procure 111, and there is an opportunity to re-commission 111 as an enabler for SEL’s five-year strategy to improve urgent care pathways.

The SEL NHS 111 Programme Board plans to:
- Develop the local service specification including developing controls for quality and improved patient outcomes. Two workshop events have been set for October 2014.
- Consult with the market in November 2014 and publish an invitation to tender early in 2015.
- Review the options of developing outcome-based commissioning for the new service specification. This will require resources and a timeline to allow the necessary analyses and clinical engagement.
- Provide assurance to SEL CCGs and NHS England.

To support CCGs, NHS England has developed an ‘NHS111 Procurement Guidance’ document and checkpoints process (created by South London Commissioning Support Unit) to enable CCGs and NHS England the appropriate assurance in the process.

Bromley CCG, lead commissioner for NHS 111 in South East London will undertake a mini procurement to appoint the most appropriate service to undertake 111 procurement. The new procurement service will work very closely with the programme team to ensure that good
models of practice are in place.

<table>
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<tr>
<th>CORPORATE AND STRATEGIC OBJECTIVES</th>
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<tbody>
<tr>
<td>1. Commission high quality care services today</td>
</tr>
<tr>
<td>4. Strong Primary Care focused on population based commissioning and developing improved outcomes</td>
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There is an opportunity to re-commission 111 as an enabler for the SEL’s five-year strategy to improve urgent care pathways.

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<tr>
<th>CONSULTATION HISTORY INCLUDING MEMBERS ENGAGEMENT:</th>
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<tbody>
<tr>
<td>• SEL 111 Clinical Governance Group</td>
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<tr>
<td>• SEL 111 Programme Board</td>
</tr>
<tr>
<td>• SEL Clinical Scrutiny Committee</td>
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<tr>
<td>• SEL CCG’s Governing Bodies</td>
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<th>PUBLIC ENGAGEMENT</th>
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<td>SEL 111 Clinical Governance Group is attended by patient representatives who also sit on the SEL 111 Patient Engagement Group.</td>
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<th>HEALTH INEQUALITY DUTY</th>
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<td>The SEL clinical governance forum has reviewed the ethnicity and age breakdown of 111 callers, and this has illustrated that more vulnerable patient groups are not accessing 111. A review of the SEL service specification will also be an opportunity to review equality of access and work with 111 providers to improve access for the elderly, disabled and local ethnic minorities.</td>
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SEL commissioners need to consider local targeted marketing initiatives in conjunction with new ways to access 111, to support the promotion of 111.

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<td>Name: Diana Braithwaite</td>
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<tr>
<td>E-Mail: <a href="mailto:diana.braithwaite@nhs.net">diana.braithwaite@nhs.net</a></td>
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<th>AUTHOR CONTACT:</th>
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<tr>
<td>Name: Niamh Wilson</td>
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<td>E-Mail: <a href="mailto:niamh.wilson@nhs.net">niamh.wilson@nhs.net</a></td>
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<td>Telephone: 020 30499927</td>
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1. SEL vision for 111

Commissioners in south east London, in partnership with key stakeholders, have been developing plans for urgent and unscheduled care. Their vision for the future 111 service is;

1.1 NHS 111 is the key enabler to ensure that people with urgent care needs are given the right advice first time, to ensure they then seek care in the setting most appropriate for their needs.

1.2 NHS 111 is at the centre of an integrated care network and should be enhanced for patients as the ‘smart call to make,’ creating a 24-hour personalised priority contact point with access to patient records.

2. Recommendations for the CCG Governing Body

The Lewisham CCG Governing Body is asked to agree the key points and principles listed below, that will underpin the 111 procurement strategy for South East London (SEL) for 2014/15;

2.1 South East London CCG 111 Programme Board will oversee the re-commissioning of NHS 111 within the timescales outlined. The SEL CCG 111 Programme Board will be accountable for overseeing the projects/work streams to deliver SEL procurement for 111.

2.2 The recommendations in section 5 that will shape patient outcomes will form the basis for commissioning a new 111 service. These recommendations will provide the market with an opportunity to propose service models that will improve patient outcomes in line with SEL’s five-year commissioning strategy.

2.3 The new specification will include the recommendations in section 6 to improve access and capacity in 111 receiver services for unscheduled care (Directory of Services capacity).

3. Purpose

3.1 The purpose of this document is to summarise the outputs of the South East London commissioner workshop on the 13th May 2014 and subsequent discussions and detail the key elements and process for the re-procurement of 111. A draft timeline for procurement is provided in section 8. This paper has already been presented to the CSC and agreed by that committee.

4. Background and current position

4.1 Strategic fit for NHS 111

One of the key recommendations in the Emergency and Urgent Care Review is to ensure that people with urgent care needs are given the right advice in the right place, first time, to ensure they then seek care in the setting most appropriate for their needs, rather than defaulting to A&E. In order to achieve this, it is recommended that CCGs use NHS 111 as a key enabler for their urgent and unscheduled care strategies. It is also possible to enhance NHS 111 services, for
example, advertising the service as the ‘smart call to make,’ and creating a 24-hour personalised priority contact point with access to patient records. The report also notes the benefits of NHS 111 being at the heart of an integrated care network.


As part of the South East London five-year strategy, CCGs in South East London and the Clinical Leadership Group (CLG) for Urgent and Emergency Care has included the NHS 111 service as an essential part of urgent and out-of-hours access for patients in the future.

This multi-professional group, which includes members of the public, regards NHS 111 as the potential ‘glue’ between the different services and also as a mechanism to better develop self-management and access to community services for the population. Having better access to special patient notes (e.g. for Co-ordinate My Care) and a fuller and more thorough Directory of Services should help the population get the right care in the right setting.

As detailed below, making fuller use of NHS 111 and advertising it to the population of South East London is a key element of urgent and emergency care.

4.2 NHS 111 Implementation to date

In 2012/13, the new NHS 111 service was launched in London, where it was agreed to pilot it for two years. The new service was specified by the Department of Health and commissioned locally through a tender process. Nationally almost a million calls were answered by NHS 111 providers in June 2014 and latest NHS 111 providers’ service satisfaction survey data show that almost 90% of users of NHS 111 are satisfied with the service they received.

NHS Direct was successful in tendering for the joint SEL contract that went live in March 2013 from a location in Beckenham in South East London. (This service was also successful in bidding for NHS 111 services to Merton and Sutton and part of East London). However, in June 2013 NHS Direct indicated that they would exit the market following significant service and financial failure nationally, caused by the lack of viability of their business model.

In line with other parts of the country that also used NHS Direct to deliver NHS 111 services, urgent arrangements were made for a step-in provider to take over the service. In November 2013, London Ambulance Service (LAS) went live as the South East London 111 provider, following a restricted procurement process involving local London 111 providers as potential emergency step-in providers. At the time of this emergency re-procurement, many national and local NHS 111 providers were subject to rectification plans and were having difficulty in delivering 111 services to nationally specified standards.

SEL now needs to re-procure 111, and there is an opportunity to re-commission 111 as an enabler for SEL’s five-year strategy to improve urgent care pathways.
4.3 Strategic context SEL five-year commissioning strategy

Urgent and emergency care has been selected as a priority work stream of South East London’s five-year commissioning strategy. It is proposed to develop and use NHS 111 as a single point of access to direct patients to the right place, first time across the urgent care system by providing:

- access to relevant patient information at the right time.
- advice on the appropriate service for patient symptoms, or if appropriate, advice on self-care.
- an up-to-date Directory of Services to enable 111 call handlers to direct or book patients in to the right service for their symptoms.

In terms of the SEL vision to improve patient care, 111 will support joined-up care and rapid access to ensure patients consistently gain early access to the right care and appropriate self-care advice. This will be achieved by commissioning the right patient outcomes to ensure that a quality service is provided for patients. This approach will support smooth integration across the urgent care providers, including a reduction in the number of stages in the patient journey (otherwise known as patient ‘handoffs’). The 111 and out of hours services will increase the number of ‘right place, first time’ episodes.

111 is a young service which is likely to develop as a result of NHS England pilots and in learning from feedback and incidents. This means the future service needs to be adaptable and amenable to change with appropriate interfaces built into the 111 programme delivery to ensure that the new 111 has the capacity to adapt to an environment that will be changing over the next five years. We will need to consider:

1. Recommendations from the NHS 111 London Learning Programme and also the outputs from the current 111 pilot funded by NHS England will inform the next version of the NHS 111 commissioning standards due to be published in the autumn of 2014.

2. Clinical leadership groups have set the vision for the next five years. The business cases are in development and SEL is in consultation with stakeholders.

3. Local implementation of new models of primary care.
4.4 Re-procurement process

The SEL NHS 111 Programme Board plans to;

- Develop the local service specification including developing controls for quality and improved patient outcomes. Two workshop events have been set for October 2014.
- Consult with the market in November 2014 and publish an invitation to tender early in 2015.
- Review the options of developing outcome-based commissioning for the new service specification. This will require resources and a timeline to allow the necessary analyses and clinical engagement.
- Provide assurance to SEL CCGs and NHS England.

To support CCGs, NHS England has developed a ‘NHS111 Procurement Guidance’ document and checkpoints assurance process (created by SLCSU) to support CCGs and NHS England assure the process. The first assurance checkpoint will include evidence of:

- local service specification includes all key elements from the NHS 111 Commissioning Standards and embedding NHS111 into the local urgent care strategy;
- appropriate procurement process and documentation used;
- assurance of appropriate skills and 111 experience has been appointed to undertake the procurement process from commencement to pre-contract award and mobilisation.

Bromley CCG, lead commissioner for NHS 111 in South East London will undertake a mini procurement to appoint the most appropriate service to undertake 111 procurement. The new procurement service will work very closely with the programme team to ensure that good models of practice are in place.

5. Achieving the procurement strategy – recommendations for commissioning 111

5.1. This section lists the priority areas to develop the 111 service to support delivery of SEL’s urgent care strategy.

5.2. Section 6 lists areas outside the scope of 111 that commissioners need to take the lead on to ensure NHS 111 is effective as the ‘front end’ of urgent care and run parallel to ensure development of the 111 service;
- Developing the capacity of other services in the unscheduled care system to take direct 111 referrals;
- Providing 111 with access to patient records to support patient urgent care pathways.

5.3. Commissioning for patient outcomes

SEL would like to develop a set of patient outcomes and invite providers to propose options for service models that will improve patient outcomes. This approach will
encourage providers to develop partnerships and innovate to deliver an integrated urgent care experience.

This approach will require significant GP resource and stakeholder engagement across a wider urgent care system to develop the specification for procurement that will incentivise the right behaviours and monitor for unintended consequences. SEL will commission a 111 provider that can demonstrate a robust system of continuous monitoring and service improvement in order to improve patient experience and ensure that we achieve value for money. This will be demonstrated by staff education and support, patient engagement, patient outcomes and clinical audits.

Some examples are listed below where commissioning outcomes for patients could deliver a better patient experience and improve efficiency in the urgent care system by increasing the number of patients directed to the right place, first time.

- Reduce referrals to acute services to avoid hospital admissions - an audit of 111 referrals to LAS showed that around half were not clinically appropriate. SEL referrals to LAS are low compared to other 111 providers, but there may be scope to reduce these further.
- A recommendation from the London Learning Programme suggested increased access to patient records and special patient notes (SPNs) may reduce referrals to ED.
- Commissioners can use 111 to ensure utility of new services in line with commissioners’ strategy, for example, 24-hour access to home wards and sub-acute rapid access response services or direct all non-blue light flow to urgent care centres rather than EDs.
- Increase self-care advice - the future procurement specification should include incentives to increase the number of patients with a ‘self-care disposition’ that is handled within the 111 service. Currently, in SEL 6% of 111 callers reach a self-care disposition, and this is 11% in south west London. The impact of setting a stretch target of 20% to 25% should be explored to reduce onward referrals when it is clinically appropriate.
- Ensure patients referred to GP out-of-hours services (OOH) for a face-to-face or telephone assessment are appropriate to facilitate direct booking into OOH for face-to-face visits.

5.4. The service will be commissioned to ensure 111 call handlers and clinicians use the Directory of Services (DoS) and service access instructions to direct patients to an appropriate service in line with local commissioning intentions. This will ensure 111 is responsive to changes in local service provision where urgent care pathways are changed. For example, patients should be encouraged to visit pharmacies for repeat prescriptions in line with changes in commissioning.

5.5. Reducing the number of patient interactions/triage points in the patient journey

Review of the current 111 service data highlights opportunities to scale down the triage from three to two points to improve the patient experience. For example, 50% of patients currently speaking to a 111 clinician are then passed on to a GP.
These calls could be directed straight to a GP provider or a GP within the 111 service.

SEL would like to commission a service that encourages providers to reduce inefficiencies where a patient may wait for a clinical call back only to be told they need to wait for a GP to call back. Another option requiring further analysis is the clinical assessment of GP dispositions from 111 by OOH providers. In SEL OOH services are triaging calls from 111 to validate the see or speak to disposition; is this good use of GP time?

5.6. Extending the use of 111 infrastructure

CCGs have already invested in sophisticated infrastructure for 111 and could utilise the resources to increase the scope of 111 to increase value for money. For example, 111 could:

- provide an access point for extended hours for GP services;
- a single point of access for a patient to access community services or mental health services;
- co-location of Single Points of Access under one location, where appropriate and possible.

5.7. Increase digital access to 111 and utilise technology to improve the patient experience and improve access for self-management

- Increase access to 111 and OOH through advancing the digital agenda with apps, use of web-based conference apps and symptom checker, enabling direct referral into 111 and OOH services, particularly engaging the younger age groups of patients using A & E.
- Explore options for web-based requests for call backs for advice from 111.
- Direct access to dental services is limited to a telephone call or fax from 111, resulting in the patient waiting up to 10 minutes to be transferred for an appointment. Trial direct bookings from 111 into dental services.
- On line/text cancellation of appointments by patients given by 111, if no longer required, to reduce the number of Did Not Attends (DNAs) in OOH and Urgent Care.

6. Achieving the overall urgent and emergency care strategy – recommendations for commissioners to improve efficiency and effectiveness of 111

In order to optimise 111 as an enabler to transform urgent care pathways, work will need to continue in parallel on commissioning other services in SEL to improve capacity and access for 111 receiver services.

6.1. Review access and capacity of other services for unscheduled referrals from 111

Optimising the services that can take direct referrals from 111 may reduce inappropriate referrals to acute services, for example, chronic asthma and blocked catheters referred to ED. All options to re-direct 111 callers into primary care services will need to be explored, especially current and planned services.
for chronic disease management, in order to deliver the benefits of 111. The services below have been highlighted through the SEL clinical governance forum as requiring more work to increase 111 referrals.

1. Community – in SEL only 1% of calls are being referred to community services. It is expected that the rapid response teams, joint social care teams and others should receive a direct referral from 111 as appropriate, and any capacity issues should be resolved at the CCG level.

2. Mental Health – use of mental health specialist services within the 111 service or through a joint approach with other areas to enable 24-hour support.

3. Pharmacies – working with pharmacies to support future enhancements to provide primary care for seven days from eight am to eight pm on weekdays and eight am to six pm on weekends.

4. Dental – CCGs need to work with NHS England to resolve the OOH’s dental service gap that has been increased since the decommissioning of the NHS Direct nurse-led dental service.

6.2. Integration of patient pathways and commissioning across 111, 999, UCC and OOH

1. CCGs to lead on bringing data together from different providers to enable a comprehensive picture of a patient journey from accessing urgent care in 111 through to the service they are referred to. This will provide transparency on the full impact of commissioning decisions in terms of outcomes and cost.

2. Review patient pathways and outcomes from 111 referrals to urgent care providers to improve the Directory of Services and identify gaps in provision.

3. Improve integration between 111, 999 and urgent care contract management and clinical governance through joint meetings and steering groups.

6.3. Increased access to patient records

The NHS 111 Commissioning Standards of June 2014 state that access to the existing summary care records must be the minimum standard. Commissioners should encourage providers to develop wider sharing of records across the health system.

Patient experience will be greatly improved when NHS 111, 999 and providers delivering services in the OOH period have access to GP records and care plans to enable appropriate advice and organisation of appropriate support to complement current treatment advice.

The current landscape with the Coordinate My Care’s end-of-life register (CMC), Special Patient Notes (SPNs) and other emergency care records is challenging because it is not always clear who is responsible for updating records, and the
burden falls to GPs. Exploring access to the GP clinical record system and reviewing current adherence to policies for end-of-life records and special patient notes to improve compliance will need to be addressed as part of this programme of work.

6.4. Equal access to 111 services

The SEL clinical governance forum has reviewed the ethnicity and age breakdown of 111 callers, and this has illustrated that more vulnerable patient groups are not accessing 111. A review of the SEL service specification will also be an opportunity to review equality of access and work with 111 providers to improve access for the elderly, disabled and local ethnic minorities.

SEL commissioners need to consider local targeted marketing initiatives in conjunction with new ways to access 111, to support the promotion of 111.

7. Recommendations

The Lewisham CCG Governing Body is requested to;

Discuss and agree the approach to re-procurement of NHS 111 proposed in this paper, particularly agreeing the recommendations in section 2 of this paper.
8. **Procurement timescales**

The proposed timescale has allowed time for the work required to develop the service specification and explore the recommendations listed in section 4.

### 111 Procurement Key Milestones

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## 9. 111 Procurement risks

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<tr>
<td>1</td>
<td>Beckenham 111 centre lease expires in June 2016, and landlord will not renew.</td>
<td>• Identify TUPE and premises issue early in engagement with potential providers&lt;br&gt;• Include premises questions and mobilization of new premises within ITT</td>
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<td>Start-up costs in year for a new location and accommodation fit are likely to be significant</td>
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<td>2</td>
<td>Contract variations to support changes to local strategies affecting call volumes and service developments</td>
<td>• A strong contract detailing process for local variation to support changes expected&lt;br&gt;• Current 111 Commissioning Standards will be updated at least once a year in the future and may result in contract variations during the term of the contract to meet new requirements.</td>
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<td>3</td>
<td>Risk of perverse incentives: Around 111 streamlining to OOH due to a difference in tariff where 111 and OOH is provided by the same provider.</td>
<td>• The contract model and KPIs will be required to mitigate for this scenario including call audits.&lt;br&gt;• Clinical outcomes are based on specific responses from patients, and it would be difficult for a provider to manipulate the patient flow at scale.</td>
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<td>4</td>
<td>Lambeth, Lewisham and Southwark GPs Opt-in for OOH provision.</td>
<td>• Engage with the GP practice consortium and commissioners in June to discuss procurement and requirements&lt;br&gt;• Include GP membership on steering group</td>
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<td>5</td>
<td>Impact of primary care strategy. Extension of GP hours could reduce the 111 call volume.</td>
<td>• 111 call demand modelling needs to include the trajectory for the impact of extended GP hours.&lt;br&gt;• Where there is a risk of business viability, other options should be explored, e.g., 111 to provide a call handling service for extended GP hours.</td>
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<td>6</td>
<td>Outcome-based commissioning is a risk for providers and may reduce the market.</td>
<td>• Engage with the market and negotiate risk share in contract model</td>
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Niamh Wilson  
111 Contract Manager / Service Redesign Manager
A meeting of the Governing Body
13th November 2014

Enclosure 14
Lessons learnt and progress update on District Nursing

RESPONSIBLE LEAD: Alison Browne, Nursing and Quality Director

AUTHOR: Alison Browne, Nursing and Quality Director

RECOMMENDATIONS:

The Committee is asked to:

- Note for information the headline lessons learnt for the CCG from the issues raised by membership on local District Nursing Services.
- Note for information the progress update

KEY ISSUES:

At the April Delivery Committee it was agreed that an internal review would be undertaken to identify the CCG lessons from District Nursing services. A meeting involving the Chief Officer (MW), Nursing and Quality Director (AB), Senior Clinical Director lead for Quality (FM) and the CSU’s Head of Contracting for LGT (NS) was held on the 12th August. This paper reports back on the key reflections and lessons from the CCG’s management of the issues raised by the membership on local district nursing (DN) services.

Background:-

Although there were ongoing concerns for local GP practices during the PCT days, DN services were more formally raised by Membership GP practices through Quality Alert (QA) system within the shadow CCG around the end of 2011. These were raised with the Trust at the time and were mainly about communication between DN, GPs and patients with appointments not being kept either because of miscommunication between practices and DN service or the re-prioritisation of DN workload without communication with practices or patients. There were very few formal patients complaints direct to the Trust with patients often informally raising with practices who in turn would raise a QA. Clinical issues included missed blood taking, dressings, insulins, blood pressure checks and flu immunisations not being done or in a timely manner from GP practice perspective. Work to tackle these issues were taken forward by FLAG with direct discussions between CCG and Trust colleagues with signs of improvement over the summer of 2012 with appointment of an interim DN manager.
The QA were down which was used to give a level of assurance. Communications improved with GP practices by the Trust, albeit management issues were not identified when warning signs were there, for example the poor support to the overnight DN pilot (which agreed to stop early in Jan/Feb 2013). This improvement slipped back either because it was not embedded or the CCG took false assurance from the low QAs, which in fact may have been low across the board as the CCG later encouraged QA reporting via the Clinical Engagement Local Improvement Scheme.

The issue was placed on the public risk register which was a lever with the Trust.

DN service improvement was led by Dr Marc Rowland in his Clinical Director capacity working with the Trust and Council as the providers developed the beginnings of the neighbourhood community team. CCG management resource at that time did not align with this until much later through the work of AB and Prof Ami David.

Work on the audit was agreed with the Trust in February 2014 and started in March 2014. The report was received in April 2014 highlighting significant improvement areas.

Over the period 2012/13, other quality concerns being managed included improving safeguarding systems and assurances and local maternity services (CQC report and supervisory issues for local midwives).

The DN issues can be seen as a ‘rising tide’ issue as there were no significant clinical or safety triggers like complaints or SIs that escalated the issue.

Headline lessons:-

1 Robust community contract management – now established a separate community commissioning group with LGT under the Contract Management Board to ensure appropriate contract management focus on community services. There is also work to refresh specifications (in view of integration work), reporting and associated metrics, including a dashboard report for future Delivery Committees.

2. Development of community data and metrics to underpin commissioning with more clinically based, outcome oriented rather than process measures – this in part is being taken forward as above. A formal information development plan to be agreed as part of contract documentation and is there any learning from further afield?

3. Levels of assurance – as for the BAF, FLAG to develop reporting into Delivery Committee and Governing Body so levels of assurance strength to aid clarity of assurance so that clearer if assurance is based on one metric which may vary in its quality and /or can be triangulated with other sources (relates to avoid potential for false assurance and spot ‘rising tide’ issues)

4. Quality alert and feedback loops – improvements have already been made including
introducing a clinical triage of all QAs and with a view to further develop the QA reporting process so there is a direct relationship with the provider with reporting back to the CCG.

5. Greater use of clinical audit programmes and staff feedback and views as source of investigation and assurance - clinical audit is now part of the contracts and FLAG have identified staff feedback and wellbeing measures as part of their developing dashboard.

6. Work with LGT to ensure appropriate leadership and culture of community based services innovation is enhanced – AB has attended a number of nurse management interview panels at the request of the Trust. Trust developed a Nursing Strategy and enhanced the practice development resource to the DN service. Further consideration with the Trust would be beneficial.

Progress to date – October 2014

Workforce and Recruitment

The 8c senior manager for community nursing post has been appointed to and Beth Williams took up this post from the 6th of October.

The 8a posts have been interviewed and there 2 posts are under offer. The structure for the senior nurse team is that there will be 4 8a posts, one to lead each team across the borough, reporting to the 8c post.

General recruitment for junior bands of staff is on-going in accordance with the trust wide recruitment drive. The current vacancies are 6 posts at Band 5 and 4 posts at Band 6 closing dates for applications are the 23rd of October 2014. Establishment figures are approximately 140 nurses and HCAs, including matrons and community support nurses.

Developing a Multidisciplinary approach to leg ulcer care

The first joint MDT meeting, Neighbourhood 3 Domiciliary Wound Care Case Conference, which will have representation from foot health, tissue viability and district nursing, has been held on the 9th of October. This was the first meeting of its kind to progress joint care planning and streamline care for this cohort of patients. The next step will be to replicate this model to the leg ulcer clinic. The CCG have commissioned an audit of leg ulcer care to be undertaken.

Single point of access and Neighbourhood 1 pilot

The IT interface has now been resolved and the move to Laurence house has been finalised. The day to day operational management will be done by a senior administrator from social care that will be based there. The staff based in the current call centre at Sydenham Green are anticipated to move in the middle of October. This will allow time to introduce the new referral form which has been agreed with partners in social care to the wider stakeholder
group including General Practitioners.

Once the single point of access has moved the pilot will be launched. A directory of services has been shared with all GPs. Neighbourhood 1, based at the Waldron Health Centre, will host a group of District nurses, social workers and therapists. This neighbourhood covers 15 GP surgeries. Co-location of the multidisciplinary team is key to the success of this programme and premises are being identified to accommodate teams prior to the launch.

A Standard operating policy will be developed in a workshop which will include multiagency contribution and representation.

IT solutions

Further to exploring a seamless communication stream, the contract for the community IT system is currently going through the procurement process. The outcome of this will be known within the next 2 weeks and will then inform the IT solution to be developed.

Stakeholder meeting

The stakeholder meeting was held on the 25th of September 2014. Dr Appleby from St John’s medical centre attended the meeting as well as colleagues from Healthwatch. The members of the meeting agreed the Terms of Reference. Healthwatch offered to work in collaboration to develop a patient questionnaire. The first contact form and the domain classification was discussed and further details will be sent to the group for comment. Foot health would like to explore utilising the single point of access to be the initial line of contact for referrals to their service.

Education and Training

On the 15th of October 2014 Alice Chingwaru will be joining the Transformation team to lead and be responsible for the Educational and Developmental needs of the team. An education and training programme has been developed and is underway.

The Band 7 nurses have embarked on a leadership programme.

The remainder of the nursing workforce are participating in a programme of structured support and development. Some of the specific areas are wound management, infection control and diabetes care.

CORPORATE AND STRATEGIC OBJECTIVES

Supports both the ‘High quality for all today’ and ‘developing integrated neighbourhood care networks’ objectives and securing appropriate community based services through commissioning.
CONSULTATION HISTORY INCLUDING MEMBERS ENGAGEMENT:

Lessons learned at Delivery Committee

A Protected Learning Time session between the CCG, membership and LGT was held on 19th August to discuss the improvements made so far and planned for the future DN service with GP practices.

Monthly updates to GPs are placed on GPI.

PUBLIC ENGAGEMENT

Housebound patients receiving DN services were interviewed following the DN audit by Healthwatch and found that patients valued clear communication and nurses keeping to their appointments. There were no specific quality concerns raised about services.

HEALTH INEQUALITY DUTY

This report does not specifically address the health inequality duty as deals with lessons learnt from a management process.

PUBLIC SECTOR EQUALITY DUTY

This report does not specifically address the public sector equality duty as deals with lessons learnt from a management process.

STAKEHOLDER INVOLVEMENT INCLUDING MEMBERS ENGAGEMENT

Commissioning Support Unit

Lewisham and Greenwich Trust provide the DN service and taking forward subsequent improvement action plan

RESPONSIBLE LEAD CONTACT:

Name: Alison Browne E-Mail: Alison.browne@nhs.net

Telephone: 020 3049 2639
HSCA 2012 Statutory Obligation (Participation Duties)

The London CCG Engagement Leads Networks have worked collaboratively to develop a template to support their organisations statutory participation obligations reporting requirements. (Please return by 30th September 2014)

<table>
<thead>
<tr>
<th>Name CCG:</th>
<th>Lewisham</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name person completed this report:</td>
<td>Lorna Hughes</td>
</tr>
<tr>
<td>Internal sign off obtained from:</td>
<td>Diana Robbins, Governing Body Lay Member</td>
</tr>
<tr>
<td>Healthwatch statement completed by:</td>
<td>Miriam Long</td>
</tr>
<tr>
<td>Date submitted to regional team:</td>
<td></td>
</tr>
</tbody>
</table>

Please note the report covers the period- 1st April 2013 to 31st March 2014

SECTION ONE – Context Setting – (demographics, vision, resources)

Lewisham Clinical Commissioning Group serves a large diverse population in south east London. Our population of approximately 284,000 people is relatively young, with one in four residents aged under 19 years. The population aged 60 years and over represents one in eight people in the borough. Males comprise 49% of Lewisham’s population, females 51%.

Between 2001 and 2011, the population of Lewisham grew by 17,000, or 10%, and has grown by a further 9,000 between 2011 and 2013. Between 2013 and 2018 the population is expected to grow by a further 15,000, or 5%.

Lewisham is the 15th most ethnically diverse local authority in England, and two out of every five residents are from a black and minority ethnic background. The largest BME groups are Black Caribbean and Black African: Black ethnic groups are estimated to comprise 30% of the total population of Lewisham.

Lewisham is the 31st most deprived Local Authority in England. Relative to the rest of the country Lewisham’s deprivation is increasing. We have a high proportion of one person households (34%), and compared to London and England we have a higher proportion of single parent households.

Our population profile is characterised by the health inequalities we are striving to reduce. Life expectancy in Lewisham is below that of London and England, for both males and females. Within South East London, it is below those in Bexley, Bromley and Southwark, and not significantly different from those in Greenwich and Lambeth. The south east London context is very important to us and we work in partnership with those named boroughs, to develop a coherent health strategy for south east London.
We are pleased to report that life expectancy in Lewisham is increasing, for both males and females, as it is in England as a whole.

A major challenge for Lewisham is that by increasing numbers of our population live with two or more long term conditions, and the main causes of death in the borough are cancer, circulatory disease and respiratory diseases.

Cultural differences, social barriers, and poor communication inhibits some of our communities from engaging in some public health programmes which further contributes to poorer health outcomes for them. Examples include low up take by black women for breast screening, higher teenage pregnancy for black teenage girls compared to white teenage girls, and higher hospital admission for alcohol related problems for white men and white women.

Our published Commissioning Intentions explain what services we plan to commission from health providers to meet the health needs of our residents. Further information on our population can be found on our Joint Strategic Needs Assessment website.

We believe that the residents of Lewisham make vital contributions to our plans and priorities. We have committed resources, corporate attention and staffing structures to reflect this importance and have embedded ‘public engagement’ across the CCG through the authorisation and commenced implementation of our Public Engagement Strategy.

Vision for Engagement

The Lewisham Public Engagement Strategy is an ambitious two year plan to develop, design and deliver meaningful engagement in Lewisham – in multiple ways to include the views and aspirations of as many people as possible. We have made our commitment by stating:

‘We are committed to responsive, open and transparent engagement and putting the views of patients at the heart of everything we do. Through involving and engaging the public we will be better able to commission high quality services that meet the health needs of our local population. Effective engagement will not only help us improve health outcomes, it will also help us to make the best use of public money.

We know that effective engagement is not always easy; it can be challenging and not everyone will agree on difficult choices that need to be made. However, engaging well will ensure that service change options and financial implications are clearly communicated and community views are sought, acknowledged, valued and responded to in the decision making process’.

In this, we acknowledge the complexities and challenges facing engagement – , but also promote the opportunities for us to be innovative and transparent with our residents so that their views are taken into account as part of our decision making.
We have a strategic vision for ‘better health, best care and best value for Lewisham People’ that cuts across the whole organisation and is the anchor of our Public Engagement Strategy. This vision is followed through in our values:

we will:

- **Work in partnership** with other stakeholders and organisations.
- **Be responsive** so that the views of the public are reflected in key decisions.
- **Demonstrate integrity and honesty** by having open and transparent engagement.
- **Take responsibility** by providing leadership in the local health economy.

This approach will help us to deliver our strategic aims for Lewisham, to:

- Enable Lewisham residents to live healthy lives, support them to make healthy choices and reduce health inequalities.
- Support those with long term conditions to have greater choice in managing their conditions.
- Ensure the most frail and vulnerable in our communities get the care they need.

We have introduced multiple ways for local involvement as stated in our Public Engagement Charter within the Public Engagement Strategy.

The Charter is our promise to the public of what they can expect from involvement with us. The systems and structures are in place to ensure that we are actively delivering against the Charter, including on-going corporate monitoring of engagement through internal committees up to our Governing Body.

We also provide an explanation of our legal duties to consult and also to our equalities duties; which we feel the public should be aware of and better able to hold us to account for.

Our approach to Public Engagement has led to the collection of demonstrable evidence of engagement across the organisation; and has led to a significant improvement to engagement standards delivered in Lewisham in partnership with our key stakeholders.
Our Public engagement Charter

NHS Lewisham CCG will:

1. Listen to people and ensure in every way possible that public views are heard and acted upon.
2. Involve the public early in developing our strategic plans and how we plan to deliver improvements in local services.
3. Involve the public early in our decision making about how we commission new services, and redesign them.
4. Demonstrate what impact the public has had on the decisions we make.
5. Always feedback to people who have worked with us.
6. Use the information provided to ensure that we improve the quality of our services, support equality and identify inequalities in access to healthcare.
7. Be honest about when we are engaging, when we are consulting and when we are providing information.
8. Support the involvement of patients in decisions about their care.
9. Make sure that everyone who works with us will recognise and promote the value of involving the public.
10. Make sure that all the organisations that we commission services from have effective public engagement and systems in place to gather patient experience data.
11. Work closely with Healthwatch Lewisham, the independent organisation responsible for representing the views of local residents.
12. Meet all our legal and statutory duties in regard to effective engagement.
13. Ensure that all our feedback documents and responses collected from our work with the public complies with the Data Protection Act and our Information Governance policies.

Structure and Resources

Lewisham’s approach to engagement is to deliver an ‘in-house’ model that is staffed by 1.9 FTWE. A Head of Public engagement is employed to provide strategic lead, best practice advice and delivery of our Public Engagement Strategy 2 year delivery plan overseen by our Public Engagement Group.

To ensure that the CCG is in touch with local opinion, we have a .9 FTWE PPI Officer who engages with the public via community groups and patient participation groups directly, in addition to taking part in key engagement initiatives required throughout the commissioning cycle.

We have budgeted for our planned engagement activities identified in the delivery plan, so that appropriate engagement methods, tools and material are available to enhance engagement and increases participation.
As an organisation there is wide involvement in patient and public engagement activities by senior management and staff, such as participation in Healthwatch events and meetings of a various community groups.

The CCG Governing Body Lay Member with responsibility for Patient and Public Involvement also provides significant contribution to accelerate Public involvement and provides leadership and focus on engagement across the organisation.

SECTION TWO – Developing the Infrastructure for Engagement and Participation
(processors and networks)

Processes

For this year our approach to engagement has been to embed and raise the profile of an ongoing dialogue with our population and to improve the quality, visibility and access to direct involvement with the CCG.

We have delivered this by:

Communication

- Inserting dedicated CCG pages in the local authority publication ‘Lewisham Life’; a quarterly magazine delivered to every home in the borough
- Introducing an ‘engagement’ email address for inclusion on our published materials
- Contact with all GP Practice Participation Groups

Involvement in CCG decision making:

- We are working to widen participation in our Governing Body Meetings by holding an open session prior to the start of the formal meetings
- We have two patient representatives on a new Pilot Project Group for our Referral Support Service
- We designed our Annual General Meeting to include public Questions and Answers, as well as discussion tables facilitated by CCG leaders

Involvement in the voluntary and wider community infrastructure:

- Increased contact with the Community and Voluntary sector organisations by linking to their formal structures e.g. steering group membership of the Voluntary Sector Compact Steering Group, attendance at the Health and Social Care Forum, Membership of Community Connections Steering Group – all to gain better access to our population
- Through contact with local Councillors at the Healthier Communities Select Committee (OSC) we have engaged with 4 Local Assembly Ward Meetings –
providing information on the local health structure and invitation to participate in our initiatives **Outreach and involvement activities**

Throughout the year we have delivered a number of engagement initiatives to meet commissioning needs. We have:

- Held 11 Focus Groups with different specific community groups (reflecting our seldom heard and equalities protected characteristics groups) as part of our developing Commissioning Strategy
- Held face to face meetings as part of developing our Commissioning Intentions
- Provided on-line surveys for both Commissioning Intentions and Commissioning Strategy
- Held 4 focus groups to gather patient views and aspirations for our new Referral Support Service
- Provided presentations and Q and A at 3 Health and Social Care Forums
- Delivered 2 ‘Readers Panel’ sessions enabling the public to comment on content and redesign our summary Commissioning Intentions Document and our new ‘Annual Review Document that charts our first year progress. The Commissioning Intentions document has been well received by the public.
- A key achievement has been the delivery of a large scale public event ‘Quality in Health and Social Care: A People’s Summit’ attended by over 100 residents and opened by patient voice champion, Julie Bailey.

**Networks, Structures and Partnerships**

To date, the CCG has maintained its own ‘Public Engagement Group’ formally organised to be the source of assurance, advocacy and promotion of quality involvement and engagement initiatives delivered by and on behalf of the CCG. PEG is chaired by a lay member, Governing Body. This group is formally constituted as a group that reports into the CCG Strategy and Development Committee.

The group consists of engagement leads from all key partner organisations in Lewisham:

- Lewisham and Greenwich Hospital Trust
- South London and Maudsley NHS Trust
- London Borough of Lewisham, Public Health and Strategy and Performance
- Voluntary Action Lewisham
- Healthwatch

The group has a 2 year Workplan with clear actions to ensure the delivery of the Public Engagement Strategy. The group achieves success through valuable’ information exchange and supporting the development of engagement across the whole, complex health economy.
Examples of PEGs work include the Quality in Health and Social Care: A People’s Summit event, which involved over 100 local people. We have also undertaken interrogation of GP Patient Survey findings to explore the differences reported by BME and migrant communities through focus group discussions. We are now developing a Lewisham CCG Public Reference Panel to mirror the activities of this formal group, led by members of the public.

A recent introduction is the Joint Public Engagement Group, established to provide engagement advice and assurance to the London Borough of Lewisham’s Health and Well Being Board (HWBB). The group has already provided advice to the HWBB on:

- The need to deliver engagement within the emerging Adult Integrated Care Programme
- The engagement needs of the Public Health Programme

The group consists of the same partners involved in our Public Engagement Group and operates with its own Terms of Reference.

Within Lewisham, there are a number of local structures in place led by the voluntary sector that we contribute to and benefit from. We regularly attend:

- **Health and Social Care Forum** – brings together voluntary and community sector service providers and services. We have utilised the group to engage on our Commissioning Intentions and our Chair recently delivered a presentation and participated in a Q & A Panel.

- **Healthwatch Patient Reference Group Meetings**: Healthwatch hold bimonthly thematic public discussions. We support the development of the content and have actively participated in three key events this year; Mental Health, Care.data Transfer and the South East London Strategy conversations.

- **Voluntary Sector Compact Steering Group**: This group intends to provide the standard of frameworks that guide the Council and its partners to work well with the Voluntary and Community Sector. Our role has been to gain recognition that the ‘Compact agreement’ is outdated, and have influenced a programme of activity to refresh and refine the agreement – bringing it up to date and appropriate for the CCG to sign up to.

- **Community Connections Steering Group membership**: This new group, made up of key third sector organisations has been developed to progress core aims of the Adult Integrated Care Programme. Its role is to provide community development approaches to connect our residents to community and voluntary sector services to assist well being and reflect the changing service landscape resulting from the programme.

Our approach to engagement, fundamentally builds on existing community strength and infrastructures, resulting in our contact with many organisations in Lewisham. We maintain
contact with these groups through engagement and dialogue about our own initiatives, but also remain involved with their programmes.

particularly strong partnerships exist with:

- **Carers Lewisham**: We have delivered direct support to Carers through our ‘Medicines Management for Carers’ training; we delivered onsite training at the Carers Centre to 15 local carers. The Centre Director is also involved in a new initiative we are working on with the Royal College of General Practitioners to highlight the need for GPs to identify Carers at practice level to assist their connection to support services.

- **Lewisham Pensioners Forum**: This large active group, represent the voice of Pensioners in Lewisham. We have an ongoing dialogue with them, both face to face through attendance at their meetings and in writing, when they formally make enquiries. The CCG is also a regular participant in Lewisham Pensioners Day, an annual event that celebrates older people, where we provide information on local services and gather views on health provision.

- **St Laurence Church Mother’s Union**: This group of approximately 50 church members are very keen to share their experiences with the CCG; and more importantly, they actively promote us to the wider congregation. The group have created an information board of CCG literature, and regularly invite us to their meetings.

- **Speak Out**: This local support group for learning disabled residents are actively involved with us in a number of ways. Firstly, the group provides good participation in contributing their views e.g. Commissioning Intentions engagement. They also join our Readers Panels – where they read documents, then join in Workshops to feedback. Further involvement takes place as they review our Easy Read Versions of documents we have produced.

- **Lewisham Pensioners Action Group**: This group of mainly BME pensioners provide verbal and written feedback to us.

**section three- (meeting the collective duty) engagement & participation activity (what has been the outcome/impact?)

The Table below provides an overview of commissioning engagement activity undertaken this year. Much of the activity relates to engagement through the commissioning cycle, and some specific initiatives undertaken to reflect the needs of specific CCG Commissioning Project activity.

The feedback from all engagement activities has been mapped to identify where views are already being responded to and where there are opportunities to act on the views received.
The Key Findings from our Strategic Plan engagement provides full details of impact – highlights are reported below:

<table>
<thead>
<tr>
<th>Objective</th>
<th>Activity</th>
<th>Who</th>
<th>How</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>To gather views on the CCG Five Year Commissioning Strategy and CCG Commissioning Intentions</td>
<td>• Presentation to Health and Social Care Forum</td>
<td>Mixed group of community and voluntary sector providers</td>
<td>Existing Members of Forum</td>
<td>Provided additional channels for face to face engagement and wide distribution of materials. Public feedback has highlighted priority areas for further development included in our updated CCG Commissioning Strategy, such as access to primary care services, support for plans for self management, and integration of services</td>
</tr>
<tr>
<td></td>
<td>• Focus Group with Carers Lewisham</td>
<td>Mixed gender and ethnicity group of Carers</td>
<td>Recruited by support workers</td>
<td>Delivery of Proactive Primary Care programme responds to calls for more positive interactions with practice staff</td>
</tr>
<tr>
<td></td>
<td>• Attendance at St Mungo’s Supported Housing Scheme – completion of surveys</td>
<td>Vulnerable adults with specific social or substance needs</td>
<td>Recruited by support workers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Focus group with street homeless community (999 Club)</td>
<td>Homeless men</td>
<td>Direct recruitment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Lewisham Pensioners Day – completion of surveys</td>
<td>Mixed gender and ethnicity older adults</td>
<td>Face to face opportunities</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• BME Older People’s group</td>
<td>Mixed gender Black African and Caribbean</td>
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</tr>
</tbody>
</table>

Concerns raised on quality and variation contributed to the delivery of Quality Summit and the
### Focus group with Stroke Association
- Mixed gender white British residents
- Mixed gender mixed ethnicity

### Attendance at Lewisham Foodbank to complete surveys
- Mixed gender mixed ethnicity

### Attendance at GP Practices by Healthwatch to gather views
- Mixed gender mixed ethnicity

### Focus Group with LGBT adults

### Focus Group with LGBT young people

### Readers Panel to review Commissioning Intentions document
- Utilised members of our Involvement Register
- Mixed age, gender and ethnicity

### Centrally organised half day workshop
- Mixed gender white British

### Advertised through
- Specific interest in Primary Care,
<table>
<thead>
<tr>
<th>Activity</th>
<th>Description</th>
<th>Participants</th>
<th>Healthwatch staff</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>East London Strategy</td>
<td>delivered on borough boundary (Greenwich)</td>
<td>residents – Joint half day event with Healthwatch</td>
<td>60 Mixed gender, age and ethnicity residents</td>
<td></td>
</tr>
<tr>
<td>Review of engagement findings to inform Commissioning Strategy</td>
<td>Healthwatch activity to review our engagement intelligence against their recent findings from the public.</td>
<td>Healthwatch staff</td>
<td>N/A</td>
<td>The review validated the evidence we have collected and the gaps we plan to include in our refreshed strategy.</td>
</tr>
<tr>
<td>Readers Panel to Review CCG Annual Review publication</td>
<td>Virtual group of 8 newly recruited patients to our Involvement Register</td>
<td>Mixed gender and ethnicity group</td>
<td>Recent registrations received</td>
<td>Redesign in progress</td>
</tr>
<tr>
<td>NHSE Call to Action</td>
<td>A range of initiatives in response to the Call to Action have been reported to NHSE.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Improving the Asthma Care Pathway</td>
<td>A half day workshop for Asthma patients to influence improvements to the Asthma Care Pathway</td>
<td>Mixed Gender adult patient and carers</td>
<td>Promoted through existing support and community groups</td>
<td>Redesign of Pathway to include greater promotion of Annual Asthma Checks.</td>
</tr>
</tbody>
</table>

Creation of community Champions to include Asthma within COPD
Community Champions

Planning for End of Life Care

A Half day workshop to understand the priorities of end of life patients, carers and families

Mixed age, gender and ethnicity adults

Targeted recruitment

Priorities developed will be used to inform the workplan of the End of Life Care GP lead and nurse.

Additional Engagement

We have also delivered engagement work outside of the commissioning cycle:

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Participants</th>
<th>Activity</th>
<th>Internal/External</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality in Health and Social Care: A People’s Summit</td>
<td>Cross section of Lewisham residents (self selected) and key stakeholders including political leaders, but targeted recruitment ensured participation by a wide range of Lewisham communities</td>
<td>Video Footage can be seen here: <a href="https://www.mediafire.com/?23w538t2jj87thz">https://www.mediafire.com/?23w538t2jj87thz</a></td>
<td>CCG led event involving all key partner organisations. Organised internally with appointment of external facilitator to deliver event.</td>
<td>A joint action plan for all partner organisations Feeds into our Francis Action Group</td>
</tr>
<tr>
<td>Referral Support Service</td>
<td>3 Focus groups delivered to ensure patients are involved in this 2 year Pilot Project. Further focus group discussions will be held throughout the pilot project.</td>
<td>CCG initiative delivered internally</td>
<td>2 Lay representatives are members of the Project steering group</td>
<td>Improvements</td>
</tr>
<tr>
<td>Activity</td>
<td>Sample Size</td>
<td>Methodology</td>
<td>Source</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-------------</td>
<td>-------------------------------------------------</td>
<td>---------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Unplanned/Planned Care Review</td>
<td>Included targeted recruitment to include equalities groups</td>
<td>200 Surveys 5 focus groups 2 workshops</td>
<td>Externally commissioned</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Local intelligence gathered will inform further work to explore in more details with the known service user profile</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exploring the variation in findings of GP Patient Survey</td>
<td>focus groups: 1 Black African 1 Black Caribbean 1 New Migrant 1 White British</td>
<td>4 Focus groups to explore the variation in self reported measures for the GP Patient Survey</td>
<td>Internally designed and delivered</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>To be completed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Listening to the health needs of Parkinson Support Group</td>
<td>Mixed age and ethnicity adult patients</td>
<td>2 focus group discussions to explore health needs of this group</td>
<td>Internally delivered</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>CCG has submitted a funding application to Health Foundation to cover the costs of implementing UTI testing at Neighbourhood Hub practices – a direct response to suggestion made by this group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acupuncture services</td>
<td>Patient users of the service</td>
<td>Questionnaire for service users to understand satisfaction</td>
<td>Collated by service providers</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>This service will be decommissioned</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Review of Urgent Care Appointments</strong></td>
<td><strong>Patient users of the service</strong></td>
<td><strong>Questionnaire to understand the impact of extra urgent care slots in winter</strong></td>
<td><strong>Collated by service providers</strong></td>
<td><strong>The additional appoints enabled us to meet local need and will be repeated as part of 2013/14 Winter planning</strong></td>
</tr>
<tr>
<td><strong>Redesign of Desmond Structured education leaflet</strong></td>
<td><strong>Patients attending the Desmond structured education course</strong></td>
<td><strong>A workshop to make the leaflet more user friendly and appealing</strong></td>
<td><strong>CCG led and delivered</strong></td>
<td><strong>New leaflet received well by public</strong></td>
</tr>
<tr>
<td><strong>Recruitment of 15 Diabetes Community Champions</strong></td>
<td><strong>Male and female from BME and white British community</strong></td>
<td><strong>A community development approach to attract volunteers to provide signposting and risk profiling within communities with known high risk of diabetes</strong></td>
<td><strong>CCG in partnership with Diabetes UK; supported by funding from Health Education South London</strong></td>
<td><strong>These active volunteers have had over 1500 contact with potential diabetes patients</strong></td>
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<td><strong>Presentation and discussion at Ward meetings (Councillor led)</strong></td>
<td><strong>Mixed age groups and communities</strong></td>
<td><strong>Presentation and Q &amp; A Internally delivered</strong></td>
<td><strong>Awareness raising of CCG and its strategies</strong></td>
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In addition to our local engagement, we have actively participated South East London Strategy programme communications and engagement workstream, which is chaired by the Lewisham CCG Chief Officer. This work has led to Lewisham Patients being represented on a number of Committees and representation by our local Healthwatch. Further background to the strategy programme and engagement approach is contained in Appendix 1.
SECTION FOUR- (Meeting the Individual Participation Duty)

The CCG has a strong focus on Patient Experience, and are developing work to ensure that patient experience is a top priority across the organisation. We monitor and review our Francis Action Plan regularly, developed in response to the Francis Report. This work has led to a deeper understanding of patient experience and expectations with regard to dignity, respect and compassion. These insights will be used to further develop shared decision making, and we will look at how best to support our membership with patient decision aids. Our understanding of patients’ individual needs has also provided insight that has been used to develop a programme of self management initiatives to empower patients to take more control over their care.

To ensure our work and understanding of patient experience and quality is transparent and publically accessible, we are preparing to provide clear information on our website to direct the public to key quality monitoring and patient experience data published by our Providers and other sources such as CQC.

Since the introduction of the individual duty, the CCG has invested staff time to be involved in the Transforming Participation Programme through its role as member of the Advisory Group. We have been involved in developing the training and resources for Patients in Control and Public Patient Participation programme delivered by the CSU field force. Through this, we have been able to contribute our knowledge and experience of the Lewisham community to assist the development and design of workshops, voluntary and community sector case studies and governing body member leadership training. We have contributed to the development of these programmes and pilot testing of all elements of it:

The key elements of the programme are:

Leadership development sessions
Aimed at inspiring and equipping NHS leaders to deliver the objectives of ‘Transforming Participation in Health and Care’ – these sessions will provide leaders with the confidence and ability to develop their ‘vision’ of how they can get their organisation where is needs to be to put patients at the centre.

Patient and Public Participation workshops
These are:
• ‘Foundations in Engagement for Health and Care Services’
• ‘How to Measure the Impact on Engagement on the Ground’
• ‘Engagement through the Commissioning Cycle’
• ‘Empowering Patients to Participate’

Patients in Control – toolkits and resources
There are 3 main elements to the resources being offered for Patients in Control:
• Engaged Informed Individuals and Carers
A one stop shop of online resources to support clinicians, other health care providers, commissioners and patients to support patients to manage their own health.
• Incentives and measurement
A searchable menu of tools for measuring shared decision making and self-management
A searchable menu of incentives to enable commissioners and other interested parties to identify and use existing levers or mechanisms to encourage clinicians to adopt the Patient in Control agenda

- **Commissioning Differently**
A training toolkit and training workshops to increase commissioning capabilities and to support commissioners to consider the full breadth of services that can be commissioned to support individuals to better self-manage their conditions

**Specialist master classes**
Voluntary sector best practice case study examples of patient engagement – both collective and individual are being developed into specialist master classes.

Working titles to date are:
1. ‘The value of direct payments – empowering mental health users to take control’
2. ‘Reducing demand on over used health services – a collaborative approach to supporting people with complex needs’
3. ‘Asset Based Community Development’
4. ‘Improving access to services and information – engaging BME communities in self-management of care’
5. ‘Improving the health experience of marginalised groups by working with health buddies and maternity mates’.
6. ‘Strengthening the patient voice in the commissioning cycle through working with the VCS and Healthwatch’

In delivering the duty locally, we have local initiatives that demonstrate our approach to individual participation, and this is an area we will build on next year, explained in Section 5:

Currently, we have utilised key NHSE programmes to assist us to link our Providers and Members to the new Individual Participation Duty

1. **Collaborative Care planning** for our most vulnerable adults through our membership
2. **CQUIN arrangements with all our Providers**
3. **PROMS (Patient Reported Outcome Measures at Lewisham and Greenwich NHS Trust**

These initiatives reflect our approach to implementing the House of Care, the patient centred approach to achieving good health outcomes for all our patients.

**Collaborative Care Planning**

In line with NHSE Guidance, we have been supporting our GPs to meet the nationally required 2% list size of our most vulnerable patients, to develop collaborative care plans.

In preparation for this we:

- Delivered a Practice based marketing campaign to raise awareness with our patients
- Provided guidelines to support the completion of the basic NHSE Care Plan template
• Gained support from The Year of Care programme to introduce a proactive approach to Collaborative Care Planning
• We have made it EMIS friendly to enable it to be self populating, leaving GPs to spend more time with the patient
• Developed an Information Governance Framework to enable greater access for Multi Disciplinary Teams through our ‘Data Privacy Risk Review and Opportunities Development on Fairness, Openness and Transparency Aspects’
• Engaged with Diabetes Patients Group
• Attended membership Forums and Practice Nurse Forums to promote and answer questions
• Visited individual practices to support them

CQUINS

Below is an example from each of our Providers CQUIN arrangements:

Lewisham and Greenwich NHST Trust

Results of the 2013 Inpatient Survey showed that the Trust had deteriorated or maintained relatively low scores on a number of questions relating to aspects of nursing care. In order to support the Trust in achieving the aims of their Nursing Improvement Plan and to improve overall performance a CQUIN was developed with the aim of improving patient experience by ensuring a caring workforce

In order to achieve the CQUIN the Trust will need to:

• demonstrate improvements in staff showing care and compassion to patients through improved National inpatient survey results.
• Develop the nursing 6 ‘c’ s across the Trust – to be evidenced through improved scores in National questions relating to nursing care
• Improve care coordination in the last days of life delivered in accordance with patient’s personalised care plans, including rapid access to holistic support, equipment and administration of medication.

Our monitoring and involvement with the Trust allows us to be involved with other aspects of patient experience, shown in the example below.

Patient Involvement at Lewisham and Greenwich NHS Trust

Lewisham has an active Maternity Services Liaison Committee (MSLC). As a service user led group the MSLC work with the Trust and Commissioners to improve women’s experience of maternity services as well as informing commissioning intentions and direction.
In 2013/14 the MSLC identified key areas of improvement required in normalising birth and post natal discharge and support for vulnerable women.

The Trust agreed to work collaboratively with commissioners and the MSLC to improve women’s post natal experience by:

- Revising the post natal discharge pathway.
- Demonstrating the incorporation of women’s feedback in to service improvement
- Better support choice in place of delivery
- Show evidence of better joint vulnerability assessments impacting on outcomes

Kings College Hospital

A CQUIN was developed based on local Inpatient Survey results for Emergency admissions on MAU and ASU. The CQUIN incorporates questions where past data indicates significant room for improvement. As the National Outpatient survey only takes place every two years - additional evidence from local surveys provide a further picture of improvements on a more regular basis.

Achievement was measured on a composite score, calculated from 4/5 survey questions designed specifically for emergency patients. The elements were:

1. Did anyone explain why you needed to be admitted at short notice? Y/N
2. Do you feel you are kept up to date with what is happening? Y/N
3. Generally speaking, are staff kind to you? Y/N
4. Did you have any worries or fears? Y/N
5. If yes, did you find someone to talk to? Y/N
6. Did anyone explain what your operation was for? (ASU only)

The Trust was successful in achieving improvement targets in both areas and having a focused CQUIN in this area incentivised KCH to deliver a quality improvement to a large number of outpatient attendees.

Patient Involvement at Kings College Hospital

National Cancer Patient Experience Programme (NCPE).

The NCPE survey includes all adult patients (aged 16 and over) with a primary diagnosis of cancer who had been admitted to an NHS hospital as an inpatient or as a day case patient. A review of the 2013 results found that KCH was ranked 5\textsuperscript{th} from bottom based on a number of indicators in their performance was in the bottom 20% nationally.

Trust actions as a result included:

- A six month Trust wide action plan led by the Lead Cancer Nurse.
- Individual action plans for site specific tumours led by divisions.
**LONDON REGION TEMPLATE**

- Sessions where the Trust spoke to patients and staff
- 18 Clinicians attended an advanced communication course
- Two census exercises undertaken to understand where inpatients are cared for.
- Implementation of the Macmillan Values in Chemotherapy unit, Derek Mitchell Unit and recently Twinning
- A Kings Cancer Helpline for patients was launched in September 2013 which will be audited.

**Guys & St Thomas Hospital NHS Foundation Trust (GSTT)**

As part of the 2013-14 national CQUIN for Dementia in addition to ensuring high quality care Trusts have also been asked to ensure that carers of people with dementia feel supported. To help Trust understand the support needs of carers they have been asked to carry out regular surveys of carers of people with dementia

The following key themes emerged from GSTT surveys:

- Being able to visit their relative on the ward 24/7
- Importance of professionals communicating with each other so that carers did not have to repeat information
- Carers being present when information was shared with the person with dementia
- Importance of staff who were knowledgeable about dementia and trained to listen to carers
- Professionals who listened to carers and took their concerns seriously

**Areas for improvement:**

Although most carers were asked about their relatives dementia, living situation and care when the patient was admitted, very few were asked about the informal care their relative received. Only 1 carer was asked to complete a “This is me” document and this was visible by the patients bedside. Where discharge planning had begun, approximately half of respondents were involved as much as they wanted to be. Of those carers who wanted to, none were given the opportunity to discuss their own needs.

The Trust responded with the following corrective actions:

1. “This is me” documents can now be ordered directly from Procurement so that they are easier for ward staff to obtain. Ward staff have been given details of how to do this.

2. Although carers report not being asked about their support needs, OTs do offer information on sources of support as part of the care pathway. The timing of this and information provided will be reviewed.

**Near-time Patient Experience Feedback at GSTT**

GSTT reviewed its’ near time patient feedback and compared these to past National Inpatient Survey scores highlighting themes for improvement actions. The review showed
that some aspects of nursing care required improvement and as a result the Trust is ensuring that all new and existing nurses and nursing assistants undertake a training programme which covers the fundamental of care. Training programmes commenced in 2013

Some further example of how near-tome feedback was used to inform improvement actions are listed below:

1. **Inpatients:** A number of patients on elective surgical wards at Guy’s raised concerns about the levels of noise at night regarding building works in the local area and the disruption to sleep that this has caused. **Outcome:** Trust estates team have liaised with contractors to ensure that there is an out-of-hours contact number and escalation process in place so that any disturbances can be dealt with promptly.

2. **Within its’ Community Services directorate GSTT commissions an external company to carry out a telephone survey of patients who used its services during the year. Interviews were conducted over the telephone and face-to-face, from 27 service lines including adults with learning difficulties.** **Outcome:** Performance has statistically improved in relation to:
   - Reception staff being considered to be polite;
   - Explanation being offered as to how long patient would have to wait;
   - Information provided for patients being appropriate;
   - Questions being answered in a manner that the patient could understand;
   - Satisfaction with healthcare professionals’ attention to hygiene;
   - Adequate time being given to discuss the patient’s condition with a healthcare professional;
   - Patients receiving enough privacy when discussing their condition or treatment.

In addition to the CQUIN activities outlined above, we use our quality assurance, business intelligence and contract monitoring processes to identify individual concerns.

1. **Quality Assurance** through our monthly For Learning and Action Group (FLAG) that interrogates the data provided by all our Providers. Through this group we receive individual ‘quality alerts’ raised by GPs and other clinical staff, where they feel matters concerning individuals need closer attention. By monitoring individual issues we are able to see if there is a pattern or trend that requires escalation to our Governing Body. Conversely, we are also aware of the individual compliments that often come forward. Further monitoring takes place at our monthly quality review group meeting with Providers.

2. **Contract Monitoring:** through our contract monitoring we are able to review the development and delivery of Providers approach and activity to meet the individual duty.

3. **Business Intelligence** provides us with detailed Patient Experience data from our key Providers, GPs and other sources including Friends and Family Test. Data is
provided to a number of CCG Committees, including our Public Engagement Group. One example of action based on the evidence from the GP Patient Survey dataset is that we have undertaken focus groups discussions with specific communities due to the variation in responses received regarding perceived support for people with long term conditions.

4. **Community Champions**: The introduction of Diabetes Community Champions is also our contribution to supporting individual participation through the community. We already have 15 Champions in place, and will extend this to COPD Champions to deliver greater skills and capacity among our patients.

5. **Shared Decision Making**: We know that many of our member practices are delivering Shared Decision Making with patients daily. We intend to provide additional support through visual resources to help our patients take more control over their care. This will take place through improved care plans that are tailored to meet the needs of our patients and encourage active participation in the care planning process.

**SECTION FIVE- Forward Plans for 2014-15**

We have ambitious plans to build on the successful engagement delivered this year. Our workplan defines the key initiatives we will develop by way of improving our infrastructure, and we will also take forward opportunities to improve areas that we feel need strengthening.

To date, we have utilised our partnerships to reach members of the 9 protected characteristics Groups, and understand the profile of participation through systematic equalities monitoring at all our engagement activities. However, this monitoring has shown us that there are some groups that we need to do more to reach.

Our approach to including the Equalities groups will continue – building on existing partnerships within the voluntary and community sector and we will continue to monitor the equalities profile of all our engagement events. To ensure that our understanding of the demographic profile remains up-to-date, we will continue to liaise with Public Health in the development of the Joint Strategic Needs Assessment, so that our knowledge of new and emerging communities is accurate.

**In 2014/15 we intend to:**

- Improve our engagement with young people aged under 25 years, by introducing smart phone application
- Increase our engagement with young people by strengthening our relationships with youth organisations, youth workers and voluntary organisations
Secure better participation from the South Asian Community, who are underrepresented in our engagement work

Secure better participation from LGBT residents by actively going to their groups and networks in response to their preferred way of engaging with us.

Continue to build relationships with faith groups

As part of Commissioning, we have identified key programmes of engagement that will be tailored to suit our community and gather local insights to assist commissioning programmes:

1. Continue involvement in our Referral Support Service Pilot Project – further focus groups will take place in November 2014
2. Engage on our emerging Primary Care Strategy
3. Deliver additional engagement as part of our Review of Planned and Unplanned Care Services
4. Hold a further ‘large scale’ public event – the content will be developed in the new year, and will reflect a key corporate objective
5. We will further develop our Boroughwide Patient Reference Group; ensuring that it operates alongside our Public Engagement Group
6. Deliver a programme of initiatives within our Self Management offer – that attracts patients to participate in managing their care in meaningful ways
7. Provide meaningful engagement in the Adult Integrated Care Programme
8. Explore opportunities to support the delivery of Shared Decision Making with our members
9. Work with the public to improve and develop service monitoring of patient experience

SECTION SIX - Healthwatch Statement

Healthwatch Lewisham Response to NHS Lewisham Clinical Commissioning Group’s Statutory Participation Obligations Report 2013-2014

Healthwatch Lewisham is pleased to comment on NHS Lewisham Clinical Commissioning Group’s (CCG) Annual Statutory Obligation (Participation Duties) Report for the year 2013-2014.

We acknowledge the CCG’s commitment to improving the quality and safety of the services they commission and their desire to engage patients, carers, members of the public and Healthwatch Lewisham in this.

This report refers to the first full year of operation for the NHS Lewisham CCG and we feel that public participation has begun to be embedded in the planning of services. We look
forward to seeing the impact that continued participation will have on the commissioning, procurement, monitoring and improvement of services and we expect to see that described in next year’s report. We expect the CCG to be as responsive as its Engagement Strategy declares.

During 2013-14 NHS Lewisham CCG has used different approaches to participation, which we have fully supported and encouraged. We have welcomed the CCG participating in Healthwatch engagement events and we are pleased that Healthwatch has contributed to CCG engagement activities.

Healthwatch Lewisham has a close working partnership with the NHS Lewisham CCG and welcomes their continued commitment to engage with us. We would like this partnership to develop, acknowledging that there will be times when either partner may need to take the lead.

Healthwatch Lewisham looks forward to building and strengthening our relationship with the NHS Lewisham CCG and working with them, through a joint commitment, to improving the quality and safety of NHS commissioned services for our residents.

Miriam Long
Manager
Healthwatch Lewisham
28 September 2014

Submission date

Please send your completed template to s.frater@nhs.net by the 30th September
Appendix 1 – South east London Commissioning Strategy

South-east London CCGs have joined together to develop a five-year Commissioning Strategy that will enable them collectively to improve the health of people in south east London, reduce health inequalities, improve quality standards and to deliver a health care system which is clinically and financially sustainable. This will build on each CCG’s local needs and plans and will focus on areas where CCGs can work more effectively together to tackle issues of common concern. The programme’s approach has a strong focus on engagement, aiming to co-design with partners, including patients and local people. Initial thinking is being developed and amended through the engagement process. The process of engagement supported thinking on the development of the seven key areas of focus for the Strategy:

➢ Primary and community care
➢ Long-term conditions - physical and mental health
➢ Planned care
➢ Urgent and emergency care
➢ Maternity
➢ Children and young people
➢ Cancer

Engagement to date includes:

• Understanding feedback from the ‘Call to Action’ engagement activities across all six CCGs from 2013 and using this to inform the emerging draft case for change for south-east London

• Understanding feedback on local strategies during 2013 and 2014 and using this to inform the developing draft strategy

• Testing early thinking on the emerging draft case for change with the independently-chaired South East London CCG Stakeholder Reference Group (SRG) in December 2013. Using feedback to inform development of engagement plans and resources for engagement on the full draft case for change and the emerging strategic opportunities across south east London from January/February 2014.

• Sharing the full draft the case for change, the emerging strategic opportunities across south east London and the draft vision and ambition through south east London’s CCGs’, NHS providers’ and local authorities via Partnership Group, SRG
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Membership, Healthwatches and clinicians via Clinical Executive Group from February 2014

- Publishing plain English and technical summary versions of the draft case for change and emerging strategic opportunities for on-line engagement with local people and clinicians via “get involved” webpages on all six CCGs’ websites from March 2014.

- Regular updates on the strategy development at local public meetings of CCGs’ Governing Bodies and Health and Well-Being Boards.

- Updating CCGs’ GP memberships via CCGs on clinical developments and progress with the strategy.

- Recruiting patient and public voices and Healthwatch for direct involvement in the development and shaping of the strategy by working as members of the seven clinical leadership groups and three overarching governance groups. A public recruitment process for more patient and public voices is underway and a package of support for their continued engagement has been put in place. This includes establishment of a Patient and Public Advisory Group as the collective forum for the strategy’s patient and public voices and Healthwatch representatives.

Engagement approaches and methods

Engagement is being undertaken through a number of complementary activities, including the following:

- Using existing borough-level channels and planned activities, supplemented by engagement on a wider basis where this is helpful. Initial engagement included developing the emerging and draft case for change, testing emerging strategic opportunities across south east London and the scope and vision and the ambition of the programme. The focus of engagement is moving onto priorities and proposed models of care as the programme develops and will cover, amongst other issues, prevention (in the broadest sense) and making best use of community assets and resources.

- Healthwatch representatives and local patient and public voices have been recruited and are members of each of the seven clinical leadership groups, working with clinicians and social care leads from organisations across south east London on clinical design activities for service improvements and proposed models of care.

- Healthwatch representatives and local patient and public voices are members of the strategy programme’s over-arching strategic groups, including the Partnership Group, Clinical Executive Group and the Clinical Commissioning Board, working on shaping the overall strategy.
An early Equalities Impact Assessment has been carried out to ensure that the strategy has considered, from the outset, the potential impact on those groups of people protected under the Equality Act 2010 and the additional south east London groups who are considered to have specific engagement needs (carers and people living on low income/ in relative poverty); to ensure that plans for further engagement – locally and more widely – are targeted appropriately to reach local people and communities whose voices are seldom heard.

Two wider engagement events were held prior to the 20 June 2014 submission of the early strategy document. More than 100 people from voluntary and community stakeholder organisations across south east London attended the events. There was broad support for the direction of travel.

More wider engagement events are planned between July and December 2014 in addition to increased local engagement activity within CCGs and with partner organisations.

Participating in events organised by south east London-based voluntary organisations and other stakeholders where the aim or content is relevant to the development of the strategy.

Market research: an independently-run telephone survey with representative samples of local populations to gain deeper insight into local people’s views on priority areas for the strategy’s seven Clinical Leadership Groups is being carried out in July and August 2014. This is being supplemented with more in-depth face-to-face surveys with groups of people with those protected characteristics for which it would not be realistic to obtain a statistically valid sample through the telephone survey route. These individuals will be contacted via local community groups and surveyed in July and August 2014 via in-depth interviews by an independent research company.

**Further engagement April-July 2014**

Wider testing of the work of the clinical leadership groups and the overall shaping of the strategy was carried out during June 2014 via two south east London-wide engagement events involving more than 100 invited representatives of voluntary and public stakeholder groups and led by clinicians, social care professionals and commissioning leads. Rich feedback was provided by these events. Participants welcomed the overall direction of the strategy. Detailed feedback was gathered and is being used directly to inform further strategy development and engagement.

Key messages include:
Participants agreed with most of what they had seen of the draft strategy. A need for more detail on some of the aims was expressed, with helpful suggestions for additional focus areas.

Participants broadly agreed the case for change reflected their experiences.

Participants broadly agreed with the strategy’s clinical themes which they explored. A need for further detail, focus on certain elements and helpful additional suggestions were made.

Ideas for development include:

- Involving the voluntary sector more directly in service delivery and design
- Provision of effective signposting and information sharing to support improved access
- Important elements of building community resilience would include: supporting self-management, supporting carers, and recognising the influence of socio-economic factors on health outcomes
- Bringing mental health into more explicit focus
- The importance of education in prevention and in supporting wellbeing
- Public engagement via CCGs resumed post local elections with the draft strategy document published and discussed in public at Governing Body meetings from early June 2014. Direct re-engagement of key local stakeholders began in early June 2014 via written briefings from CCGs’ Chief Officers. A number of CCG-led stakeholder events and involvement in local community events are taking place during June and July 2014. Additionally, political re-engagement post-elections is beginning with written briefings for local politicians and Scrutiny members.

Arrangements to secure patient and public participation in the programme’s future work

The following arrangements have been put in place to enable active participation of patients and local people in the clinical design and shaping of the overall strategy and will be developed as the strategy moves into a further phase of significant engagement and starts looking at the impact of proposed interventions on individual organisations and institutions:

Clinical Leadership Groups – A Healthwatch representative plus three additional patient/public voices on each of the seven Clinical Leadership Groups participate in the work for planning service improvements and proposed models of care.
Clinical Executive Group, Partnership Group and Clinical Commissioning Board – A Healthwatch representative plus two patient and public voices participate in each of these over-arching strategic groups in shaping the overall strategy for south east London.

Patient and Public Advisory Group (PPAG) – this group has been established as a collective forum bringing together the strategy’s patient and public voices, Healthwatch representatives and potentially in the future, other local stakeholders with an interest in the strategy, to share messages from different groups and to provide peer support. PPAG has established a Reading Panel to advise the strategy on accessibility of public-facing communications and wider engagement resources.

PPAG reports to the strategy’s Clinical Executive Group. Its work is complementary to the independent advisory role to the strategy of the South East London CCG Stakeholder Reference Group.

The programme team is providing a full package of support for patient and public voices to support their active involvement in the strategy development and their role in bringing a wide range of voices from their constituent groups. This includes:

- Provision of a high level role description outlining how participants may contribute to groups, clarifying the level of commitment expected by participants and the support available to them in their role

- Ensuring participants are adequately briefed for meetings and workshops via a named “programme link” – including overview of programme in advance of first meeting, collecting and disseminating their feedback more widely within the programme as appropriate and supporting them, as required, to feedback to their constituent groups and communities.

- Establishing additional support arrangements for participants tailored to their identified needs.

Supporting the work of the Patient and Public Advisory Group in communicating the role and work of patient and public voices more widely. A public recruitment programme to bring more patient and public voices into the strategy development work is currently underway. This process is being informed by the recommendations of the early Equalities Impact Assessment.
NHS Lewisham Clinical Commissioning Group

Primary Care Development Strategy

2014-2016

Version 0.6 – FINAL
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Primary Care Development Strategy

1. Introduction

Lewisham Clinical Commissioning Group (CCG) has already published a commissioning strategy - A local Health Plan for Lewisham 2013 -18 in October 2013. The strategy has provided a clear case for change in the delivery of health services and a commitment to local people to improve their health outcomes. The Commissioning Intentions 2014/15 for Lewisham have stated that the CCG will:

- Support GP practice members to ensure high quality of care for all by levelling up standards and reducing variations between practices;
- Work with local providers to ensure optimisation of planned care services by commissioning effectively.

This Primary Care Development Strategy provides further detail about how the CCG intends meet its statutory responsibility in supporting and driving the improvement in services in primary care and also identifies new commissioning opportunities that will enable our strategic goals to be met.

1.1 The case for change

Primary care delivery tends to be centred on general practice because 90% of activity takes place in that setting. It is widely recognised in London that general practice is under significant and growing pressure due to population growth, widening health inequalities and patients with increasingly complex needs. In addition, the projected financial assumptions suggest that continuing to deliver health care in its current form, across all settings, is unaffordable. Therefore, there is a need for change across the whole system.

In 2014, the population is estimated to be 288,004. Lewisham has a young population; 25% of the population of Lewisham is under the age of 20 compared to 10.5% of the population being aged 65 years and over.

Over the next five years 2014 -2019 it is estimated that the total population will rise by 4.8%, to a total of 301,768 people. There has been a sustained rise in the birth rate in Lewisham for several years, reflecting a similar rise in London and the country as a whole. Much of the rise in births has been in births to mothers who were not born in the UK, the Commonwealth or the EU. Over 50% of all births in Lewisham now occur to women from minority groups. 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. In Lewisham, the number of residents aged over 65 years has been stable or even falling slightly over the last decade, despite an overall growth in the total population between 2001 and 2011 of about 11%. However, population projections suggest that from about 2015 the number of Lewisham residents over 65 years old will begin to rise.

Lewisham is a very ethnically diverse borough, 49.3% of the population are from Black and Minority Groups (BAME) compared to 40.2% London and 12.5% in
England. The two largest BAME groups are Black African (12%) and Black Caribbean (11%). In the school population the proportion from BAME rises to 77% and over 170 different languages are spoken.

Deprivation has increased in Lewisham. The 2010 Index of multiple deprivation (IMD) ranked Lewisham 31st out of the 354 local authorities in England compared to a rank of 39 in 2007, and 57th in 2004. Relative to the rest of the country Lewisham is becoming more deprived. Evelyn ward in the North of Lewisham is the most deprived ward followed by Bellingham, Downham and Whitefoot in the South of the borough.

Variation can also be seen in the services that are offered to the population. Lewisham CCG is aware of the differing quality of some primary care services. National benchmarks show that some practices are achieving excellent clinical outcomes and patient satisfaction but there is significant variation in performance, quality and access to services. For instance, in the north of the borough there is lower coverage of Bowel, Breast and Cervical screening compared to the rest of Lewisham. In the centre of Lewisham more than half the practices have a higher screening rate than Lewisham as a whole.

The CCG is also aware of the variability in outcomes across the borough. This is demonstrated in the south east of the borough there was a higher percentage of smoking quitters compared to Lewisham and a lower percentage of 4 week smoking quitters in the south west of the borough. For more information refer to the Neighbourhood profiles at Appendix A.

The reasons for the variability are not always clear, but it is the intention of the CCG to gain a better understanding and support practices to address these differences, so that Primary Care is best able to respond to the needs of local people but also be in a position to participate effectively in integrated health and social care services.

In order to respond to this increasing key role, primary care will need to have capacity and capability. Access in primary care will need to be improved and new models of care will need to be adopted to ensure the system is sustainable. This will require a cultural change that focusses on population outcomes and a whole system approach.

Lewisham CCG wishes to develop strong primary care. Primary care will need to work differently, utilising resources more efficiently, working at scale with improved partnerships between practices and with the wider health and social care community. This will result in better integration of services, better outcomes and improved patient satisfaction.

1.2 So what is primary care?

Primary care provides universal and comprehensive access for all. It provides a holistic approach to an individual’s health care, diagnoses and manages disease, prevents illness and protects health by promoting healthy behaviours, having a
whole population focus. It is the first element of the continuing healthcare process and supports patients to navigate across multiple care providers and settings.  

Primary care includes services offered by general practitioners (GPs), community pharmacists, general dental practitioners and optometrists. However, good primary care can be regarded as the hub of a wider system of care with important interfaces and interdependencies across the whole health and social care system, including but not limited to, planned and unplanned use of secondary care, prevention and health promotion, community health and mental health care, social care and end of life care.

2. Primary Care in Lewisham

In Lewisham we have a number of primary care providers who are contracted to deliver services by NHS England.

| GP Practices (Partnerships) | 41 |
| Community Pharmacies | 57 |
| General Dental Practices | 32 |
| Optometrists | 20 fixed site with 6 offering domiciliary |
| | 20 domiciliary in total |

Other key providers in the wider community are

- **Acute and Community Services**: Lewisham and Greenwich NHS Trust, Kings Health Partnerships
- **Acute Services**: Guys and St Tomas’ Foundation Trust
- **Mental Health Services**: South London and Maudsley NHS Mental Health Trust
- **Social Services, Health Visiting*, School Nursing and Public Health**: Lewisham Borough Council
- **A range of community health, social care, advocacy, information and support services**: Voluntary and community sector organisations

*Responsibility for commissioning will move from NHS England in 2015 to the Local Authority*

Our GPs work out of 44 surgeries (sites) across the borough and are arranged in four neighbourhood groups. This simple geographical grouping has been in place for more than four years and has seen the development of relationships between practices resulting in agreeing collective goals, e.g. effective use of medicines and improvement in MMR1 uptake. It is intended that this grouping will provide the platform on which other working arrangements can be based. It has more recently become aligned with local authority services, notably social care. A map showing the distribution and grouping of practices can be found below.
As at 1 April 2014 our registered population was 298,649.
Table 1 population split by neighbourhood

| Neighbourhood (1) North Lewisham | 60967 |
| Neighbourhood (2) Central Lewisham | 111679 |
| Neighbourhood (3) South East Lewisham | 60232 |
| Neighbourhood (4) South West Lewisham | 65801 |

GPs have a range of staff working in each practice to support the delivery of care. This includes Salaried GPs, Nurses, Health Care Assistances, Allied Health Professionals (therapists) Counsellors and an administrative team. The team varies in size and composition between practices. Each neighbourhood has a team of community nurses delivering district nursing services.

In Lewisham there is a Neighbourhood Network, a multidisciplinary team that links with practices within each Neighbourhood. The network consists of representation from community health services – usually District Nurses and Community Matrons, Social Care and Occupational Health. The meetings are designed to be monthly and provide a practice based case load discussion. It is anticipated that the meetings provide the basis for better integration and delivery of person centred care.

The practices offer core services but some are also commissioned to offer a range of additional or enhanced services.

Some further Neighbourhood facts and figures can be found at Appendix B

The role of GPs has historically been that of gate keeper, enabling people to access other health services. However, there is a growing role for GPs to act as navigators, supporting patients to choose what, where and how they access services. They are also increasingly acting as co-ordinators of care for people in the community, who need to access and be in receipt of care from a wider range of health and social care professionals.

Lewisham CCG has made significant progress in supporting improve quality in primary care with a number of projects and schemes. The CCG is well placed to build on this work ensuring that learning and good practice is rolled out across all practices. These achievements to date can be found in Appendix C

The tradition method of funding additional services in primary care, over and above the core contract, has been through voluntary enhanced services and incentive schemes. Invariably these were separate unsophisticated agreements incentivising the delivery of targets and were drawn up annually. Where the delivery was dependent on additional staffing, many practices chose not to deliver the scheme, as there was no guarantee that the scheme would continue beyond a year. This affected the ability to recruit and retain skilled staff. Some of the schemes also required a disproportionate amount of work compared with the funding that would be received which acted as a further disincentive. This has all added to the variation exhibited across the CCG.

A review of existing schemes is underway with a view to commissioning current and additional services across populations rather than on a practice by practice basis.
3. Health Needs

Each locality now has a detailed health needs profile, produced by Public Health. These can be found at Appendix A

4. Commissioning Partners

The commissioning landscape now enables a number of partners to commission services from primary care. These include NHS England who commissions the core services from the primary care providers, the Local Authority who commission and contract a range of enhanced services from primary care providers, as well as Lewisham CCG who commission other enhanced services from primary care providers. It is therefore essential that the commissioners work in partnership to ensure a comprehensive range of joined up services are developed and delivered to meet the needs of local people.

Co – commissioning of primary care presents a further opportunity. In a recent announcement the Chief Executive of NHS England, invited expressions of interest from CCGs wishing to expand their role and be more involved in the commissioning of primary care services. The potential to work more closely with NHS England is being explored by Lewisham CCG with the five CCGs in SEL. We believe that co commissioning primary care services would allow us to drive up the quality of care, addressing health inequalities, and help us to establish a sustainable health service.

At a local level, all GP practices in Lewisham are members of the CCG. GP member practices work closely in local neighbourhood groupings to have clinically led discussions relating to common problems that are arising and to explore how local services can be improved and co-ordinated better driving the commissioning agenda of the CCG as a whole.

The CCG already has a close working relationship with NHS England and will work with this commissioner in determining where additional services, established and funded through improvement initiatives can reasonably be contractualised when the primary medical services contracts are reviewed. This will allow for simplifying contractual agreements with individual practices.

This additional dimension of the GPs work needs to be taken into account when describing how future services are to be developed, ensuring periods of protected time for clinicians to actively contribute to the commissioning and developmental agenda.

Lewisham CCG will also work with NHS England to determine the growing opportunities in delivering services through Community Pharmacy. This will be through contractual arrangements and encouraging closer partnership working with general practice in facilitating the development of comprehensive primary care based services.

Whilst this two year strategy focusses mainly on general practice, Lewisham CCG is planning to widen this scope and engage with colleagues delivering local dental and
optometry services. Maps showing the distribution of General Dental Practices, Community Optometrists and Community Pharmacy can be found in Appendix A.

There are plans to align local authority and CCG commissioning to ensure that the uses of resources are optimised and services are delivered in an integrated way. This increased scope will ensure that the CCG is in a better position to commission services for the whole population which is outcomes based. This builds on the existing partnership arrangements with Lewisham Borough Council in the development of joint strategies, namely The Children and Young Peoples Plan 2012-2015 and the Health and Well Being Strategy Dec 2013. The links to copies of these strategies can be found in the reference section.

5. Lewisham’s Vision for Primary Care

The systematic development of primary and community care, to produce a network of advice, support, education, physical/mental health and social care hubs embedded in activated communities which all work together to maximise health and well-being of the population, with access to specialist and diagnostic services when needed.

In line with the South East London Strategy, Lewisham CCG will deliver this vision through four high impact changes and work to establish a local version of an emerging model of care which will drive local transformation.

The model developing across South East London, looks to deliver better outcomes for local people by encouraging local practices to work together. This will expand to include other providers, health, social care and voluntary organisations collaborating in the delivery of high quality care. A parallel workstream is underway in Lewisham developing integrated care.

Diagram 1
The diagrammatic representation above aims to show how care will be delivered in Lewisham. It will be population based and geographically coherent as the basis for primary and community services. Local Integrated care teams will be wrapped around the registered list of the general practice. The care team will include general practice, community services, social care, mental health, and pharmacy and specialist care. A wider enhanced range of care will be delivered outside of hospital providing equitable and consistent quality of care. The services will be sufficiently flexible to address the needs of the individual as well as to the wider population. There will be a focus on prevention, early detection and self-management across all areas of care. The system will be built to last beyond 5 years, be characterised by the delivery of proactive, accessible and well co-ordinated services that deliver holistic continuous care.

This strategy aims to ready colleagues working in primary care so that they have the capacity and capability to work in integrated delivery teams.

6. High Impact Changes

6.1 Proactive Care

Neighbourhood networks in Lewisham will work to ensure that every contact counts, seeing each contact with a patient as an opportunity to address preventative health needs, to provide brief interventions or to signpost the person to other services within the network. The information will be recorded on a virtual patient record.

Lewisham CCG will support primary care to empower people to take responsibility for their own health, to remain healthy and to stay connected with their communities by being able to identify the kind of services that would be most beneficial to them.

Primary Care providers will ensure that their patients have a personal health plan to help them lead a healthier lifestyle. This will be developed with patients and signposting to appropriate supporting services.

Local people will be engaged with and informed about services available to them so that they are able to access support to improve and maintain their health and wellbeing.

Primary care will seek to identify people who have difficulty accessing services and work with other organisations to ensure people access the care that they need.

Practices will be supported and encouraged to work together to improve public health outcomes, such as increasing the coverage of screening and immunisation across the population as a key preventative activity.

6.2 Accessible care

Primary care will support people to access care appropriately by working to simplify access points so that people can navigate the system. Access will be based upon a
minimum offer of care with tiered enhancements where necessary. This will include the growing role of Community Pharmacy in the delivery of services and the commissioning of the voluntary sector.

Lewisham CCG will work with practices to develop systems so that people can access appropriate care in a timely way, e.g. accessing same day care for urgent conditions.

Practices will ensure that specific needs of their local populations are responded to when planning and implementing improvement plans. E.g. language, religion, culture and mobility.

The population will be able to access appointments for general practice (Mondays – Saturdays) and can access primary care 8am-8pm every day in their neighbourhood for immediate, urgent and unscheduled care. This will not be at every site but will be a collaborative approach across neighbourhoods.

Practices will use technology to improve access and support different types of interactions that are appropriate to the needs of their patients.

Primary Care will regularly engage with patients to ensure that access to services is underpinned by an understanding of the key factors that affect patient experience.

6.3 Co-ordinated care

Practices will systematically identify people that will benefit from co-ordination of care and a care plan. People with long term conditions, mental health problems are examples of those who will benefit from this approach.

Patients will have care plans that
- Will be co-designed with them
- Set out agreed goals and improve self management
- Can act as a patient passport with health services
- Promotes a proactive, integrated, co-ordinated and holistic approach to patient care.
- Managed by a co-ordinator when necessary.
- Reviewed regularly or when needs change.

Practices will utilise appropriate technology to share the care plan across organisations to allow for care to be delivered in a co-ordinated way. This will be supported by agreed policies and processes to safeguard patients information.

6.4 Continuity of Care

Practices will identify people who would benefit from continuity of care. They will work with the patient and their carer to co design a care plan with the patient, and with their carer if appropriate.
Practices will ensure good care by having a named skilled professional accountable for a person's care. The patient will be made aware of the role of this person and how to contact them.

A co-ordinator will work with the named accountable professional to co-ordinate the co-designed care plan and support the patient by navigating them through the system.

7. Supporting Strategies

7.1 Workforce

The development of the primary care workforce is crucial to delivery of this strategy. It is expected that a separate strategy is drawn up that contains the following key areas of focus.

- Training and development of the primary care workforce to deliver the level of capability to deliver quality primary care - the skills for the job.
- Support new ways of working to deliver capacity across the system which looks at skill mix supporting the developing roles of different disciplines and adoption of different methods of patient interaction. E.g. telehealth, telephone consultations.
- Commissioning of education and training.
- Progressing improved professional development to support different staff groups to continually grow.
- Recruitment, retention and succession planning.

The importance of developing the role and functions of nurses working within the community is considered key in ensuring that people are able to access high quality responsive care. Lewisham CCG is already undertaking a review to strengthen this segment of the community-based workforce.

An element of this work concentrates on the role of Practice Nursing. This project is to identify General Practice Nursing (GPN)/Nurse Practitioners (NP) needs and supply additional resources in clinical training in practice, support revalidation of Nursing and Midwifery Council (NMC) registration by 2017 and identify additional practice placements for more student nurses in primary care.

The Project has a number of facets:
- Skills Review
- Development of a competency framework which will better support GPN/NP to deliver consistency in standards of care and against which appraisals can be measured.
- Identifying & commissioning training according to local need
- Purchase and implementation of software to support GPN/NP in professional development and aid revalidation requirements for the NMC and Personal Development Plans (PDP).
- Develop a mentor programme to support existing practice nurses and provide additional mentors for student nurses.
The project has also purchased a web-based toolkit, called HeART, which will support GPN/NP to:

- provide evidence for NMC revalidation;
- track their personal objectives for PDP;
- Act as a Skills Passport record of Continual Professional Development, linking documentation to the six Cs, Compassion in Practice - vision and strategy for nursing, midwifery and care staff published by NHS England in December 2012.

### 7.2 Information Technology

This work stream supports each of the high impact areas.

- A well-defined programme for the delivery of a virtual patient record is underway. This will need to be supported with appropriate mechanisms for the safe sharing of patient information.
- A focus on fit for purpose remote working to support improved and timely access to patient level information to deliver well co-ordinated care that meets the patient's needs.
- Access to up to date information to help people navigate through the system to access appropriate care at the right time.

### 7.3 Estates

Community based access to services will be a key facet for the delivery of new models of care. NHS England is planning an in-depth utilisation review that will inform the local approach to developing premises.

In Lewisham, the Borough Council wishes to engage effectively with Primary Care as they undertake a local utilisation review of premises for Health and Social Care. The CCG will work in partnership with the Local Authority to maximise the benefits of the review.

### 7.4 Commissioning

Lewisham CCG is looking to commission services that are outcomes focussed and deliver for the whole population in the community. This will be achieved by:

- A focus on the delivery of commissioning initiatives which move services into the community where services are provided by integrated delivery teams, with the associated shift in financial resources.
- Utilisation of contractual levers to support “every contact counts” and shared care records.
- Lewisham CCG will work with colleagues across SEL and NHS England to develop proposals to co commission primary care services. A single approach across SEL would allow for better efficiency and productivity gains for the operational management of commissioning and contracting.
- Lewisham CCG will work with local authority on commissioning joint plans and services.
- Aligning this primary care development strategy with other Lewisham Commissioning strategies e.g. Urgent care Strategy, End of Life Care Strategy.
7.5 Finance
Lewisham CCG is responsible for improving the quality of primary care delivery. However, NHS England is the core commissioner of primary care providers. This means that a small proportion of the funding currently invested in primary care sits within the CCGs budgets; the vast majority of the budgets are held by NHS England.

The CCG does have some non-recurrent development budgets. These are partly utilised to fund local primary care improvement schemes. The CCG has committed 1% of its budget each and every year until 2016/17 for investment in community based alternatives to hospital care, including new and expanded services provided by and also provided in support of GP practices and other primary care providers. This spend will be targeted towards sustainable shifts of activity from hospital settings that in turn will release recurring funds available to sustain new service alternatives in primary and community care settings.

The CCG, together with the other five CCG’s in south east London, is looking to develop the existing partnership with NHS England to establish co-commissioning of primary care with a potential towards delegation of commissioning responsibility. This will provide an opportunity for the CCG to understand more fully the entirety of current and future budgets and expenditure for primary care and to ensure that the CCG’s Primary Care Development strategy is aligned with the future commissioning intentions for general practice, other primary care providers and the wider integration agenda.

7.6 Patient Public Engagement
The CCG is committed to engaging effectively with local people to ensure that this strategy is implemented. In the production of the South East London Strategy, Lewisham has been well represented by a number of patients who have actively engaged in the many focussed development workshops. Their views have been instrumental in the shaping of this important strategy.

The CCG has subsequently engaged with Healthwatch Patient Reference Group in Lewisham. This group provided some helpful insights and comments on the Primary Care Development Strategy and has allowed the CCG to appraise the implementation programme during the next 18 months. The areas highlighted at the event on 26 September 2014 are listed below.

Proactive Care
- Health promotion – targeting school age children to have the maximum impact.
- Identification of people who rarely attend practices to ensure they are well and offering patient education.

Accessible Care
- Access to appointments at surgeries
- Appropriate use of other primary care professionals, out of hours, community pharmacy.

Co-ordinated Care
- The importance of care planning and how patients are identified who would benefit from a care plan.
• The importance of improving communication between services to deliver care plans
• The involvement of carers in the planning and delivery of the care plan.
• Patient education

**Continuity of care**
• Reiteration of the importance of good communication between service providers.

**Other issues**
• The use of audit to improve the quality of care
• Developing case studies to showcase good practice.

The CCG will continue to engage with local people to identify priorities for the future and to evaluate the progress towards achieving the necessary improvement in outcomes of commissioning plans.

### 8. Equalities Statement

This document demonstrates the organisation’s commitment to create a positive culture of respect for all individuals, including staff, patients, their families and carers as well as community partners. The intention is, as required by the Equality Act 2010, to identify, remove or minimise discriminatory practice in the nine named protected characteristics of age, disability, sex, gender reassignment, pregnancy and maternity, race, sexual orientation, religion or belief, and marriage and civil partnership. It is also intended to use the Human Rights Act 1998 and to promote positive practice and value the diversity of all individuals and communities.

The equalities analysis can be found at Appendix E

### 9. Next Steps

#### 9.1 Alignment with South East London Strategy

Lewisham CCG will continue to ensure that our local plans are aligned to the strategic planning being undertaken across South East London. The development of the strategic direction for South East London is still being finalised.

#### 9.2. Development of detailed implementation plans.

The implementation plan for 2014/16 has been attached at Appendix D. As the strategy is reviewed it is intended that the plans are updated to reflect the initiatives that are planned for successful implementation.
References

SEL Strategy – Draft 28/02/14

Lewisham Commissioning Strategy link

JSNA Link
http://www.lewishamjsna.org.uk/reports

Lewisham Health and Wellbeing Strategy Dec 2013

Children and Young Peoples Plan 2012-2015

Earlier Detection of Cancer produced by the Cancer Commissioning Team West and South London in May 2014

Compassion in Practice - vision and strategy for nursing, midwifery and care staff published by NHS England in December 2012.
http://www.england.nhs.uk/nursingvision/
Appendix A - Neighbourhood Profiles and Maps
## Appendix B - Neighbourhood Fact and Figures

Some Additional Neighbourhood facts and figures

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Appendix C - Achievements to date

**COPD Pathway**
This programme has been one of the truly 'integrated' successes for both Lewisham CGG and Lewisham and Greenwich NHS Trust – encompassing primary, secondary and community care. A number of initiatives were introduced including: the introduction of key workers in all GP practices for patients with COPD, a consistent and well developed education programme (competency framework) to support key workers, investments to enable early supported discharge from hospital and triaging of all referrals.

In 2012/13 emergency admissions related to COPD reduced by 22% in comparison to 2011/12. Early review of the data suggests that this reduction has been for patients over 65 years. In addition, there is an indication that the COPD programme has also positively impacted on reducing emergency admissions for other respiratory conditions across all providers. For patients this has meant a single point of access, a bespoke package of care for their condition and being treated in the most appropriate care setting.

**Diabetes**
A multi-disciplinary taskforce from the local health economy was established which developed the strategy for improving care for people with diabetes in Lewisham. There are a number of work streams and implementation plans have been developed with many being realised in 2013/14. However, the programme got off to an excellent start in 2012 with its first phase of ‘getting basic right’, which centred on improving care in primary care to enable patients to feel better supported in managing their own condition. The vision and strategy were developed in consultation with wider health economy, patients and the public. A further outcome of the work was the establishment of a public/patient reference group and plans are in place to establish ‘community champions’ in partnership with Diabetes UK to support local people to manage their condition.

**Heart Failure Pathway**
A new pathway for Heart Failure was developed by a joint steering group with Lewisham Healthcare NHS Trust (now L&GNHST) and Lewisham CCG. The pathway was supported by investments made by Lewisham CCG for a dedicated multidisciplinary team and was a direct response to the increase in the number of emergency admissions and readmissions for patients with this condition.

**MSK (Musculo-skeletal) Pathway**
A single point of access was developed in partnership with clinicians from Lewisham Healthcare NHS Trust and Lewisham CCG for all MSK referrals and the revised pathway went live in April 2012. Referrals are triaged to the most appropriate service.
Telehealth Pilot
The Lewisham CCG in partnership with Lewisham Healthcare NHS Trust completed a 12 month pilot funded by the CCG. This innovative technology enabled 100 patients with COPD and Heart Failure to better self-manage their conditions by providing them with monitoring devices in their own home. The pilot involved community matrons and GPs working together to support patients. An evaluation of the pilot was conducted by Public Health Lewisham. This confirmed that it was well received by patients, community matrons and GPs. The outcomes of the evaluation will inform future commissioning intentions.

Proactive Primary Care
Lewisham CCG completed a Proactive Primary Care feasibility study in 2012 with a local GP practice. Proactive Primary Care is essentially the use of routine telephone call follow-up with patients using motivational interviewing techniques. The idea is to support patients to self-manage through regular telephone contact initiated by the local GP practice. Lewisham CCG’s feasibility study focussed on 70 patients aged between 45 and 65 years and was evaluated with the support of the London School of Economics.

Urgent Care
Work continued on refining services provided at the Urgent Care Centre, which is delivered in partnership with Lewisham Healthcare NHS Trust by local GPs located in the centre. In July 2012 our evaluation of the centre, which included user and staff feedback showed that patients were confident in the service, were seen by the most appropriate person and that many were aware of the Choose Well Campaign. A further review of the ‘Effectiveness of Primary Care within the UCC’ was undertaken before Christmas and the summary will be shared in the New Year.

Mental Health
Improvements in mental health included:

- The reconfiguration of Mental Health of Older Adults (MHOA) Continuing Healthcare with the closure of Granville Park. Over £800k was reinvested back into MHOA services.
- Continuation of the Lewisham forensic triage model for those requiring a hospital admission from prison. This has saved over £1.3m from commissioning budgets and diverted over 75% of people away from medium secure services. This therefore ensures that people are in the right place from both a clinical and risk perspective.
- Reduction in Adult Mental Health complex residential placements to ensure that people are in the right place at the right time via regular clinical review.

Medicines Management
Last year the Lewisham CCG and Lewisham Healthcare NHS Trust medicines management and prescribing teams were successful in their collaborative approach in delivering a number of QIPP schemes, which focussed on reducing expenditure in prescribing by utilising the clinical specialist knowledge of primary and secondary care and the procurement advantages and formulary controls of secondary care. A medicines waste campaign was launched to encourage the public to use their medicines wisely.
**End of Life Care**

End of Life CQUINs (Commissioning for Quality and Innovation) were agreed with Lewisham Healthcare around three specific areas: Identification and registration of end of life care patients.

Processes and protocols to guide Community Nurses on the inclusion of patients on the End of Life Register have been developed and targets have been met for the number of nurses attending training on the Gold Standard Framework.

In February 2013, data from the current End of Life Care Electronic Register has been migrated to a new system called “Coordinate My Care” (CMC). This system can share information with all care providers including the NHS 111, London Ambulance Service and out of hours services.

**Care Planning**

The PEACE (Proactive Elderly Care Planning) document has been piloted on elderly care wards at UHL for patients being discharged to nursing homes who are likely to die within the next 12 months. Following the success of the pilot with two Residential homes in 2010/11, St Christopher’s Hospice has been engaged to facilitate a programme aimed at improving Palliative care in care homes. All nine Residential Care Homes (RCHs) in Lewisham have passed the “Steps to Success” RCH programme for end of life care, and the number of residents enabled to die in the home (as opposed to hospital) has significantly increased.

**Minor Eye Conditions Scheme**

This optometrist based service provides access for people suffering from common eye conditions. The scheme was designed to reduce attendances at an acute hospital and to enable local quick access to care. It has successfully reduced the demand on the Eye Casualty based at St Thomas’ Hospital, utilising the expertise of primary care contractors across Lewisham and Lambeth.
This implementation should be read with the Lewisham Corporate Objectives 2014/15 and the Quality Indicators, specifically corporate objective 4. Reporting of progress is via the Delivery Committee, a committee of Lewisham CCG Governing Body.

**Strong Primary Care focused on population based commissioning and developing improved outcomes**

<table>
<thead>
<tr>
<th>Output/timescales</th>
<th>Rationale</th>
<th>Outcome 31 March 2015</th>
<th>High Impact Change Delivery</th>
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| Improving quality in primary care by reducing variation; Implement a Referral Support Service to improve the quality of GP referrals, provide choice to patients and manage the demand of outpatient attendances. Supporting the delivery of the QIPP by reducing inappropriate GP 1st outpatient attendances and outpatient follow-ups. (All practices using RSS: Nov 2014) | - Reported increases in out-patient activity and local people appear to have to wait longer for appointments compared with neighbouring CCGs. Unexplained differences between referral rates and referral processes between practices.  
- Suggestion that some people could have been effectively treated in different services. | - Improve the quality of out patient referrals form primary care.  
- Patients report that they have been offered choice. | Accessible Care |
| Design Public Health Improvement Programme for GP Practices focusing on Cancer and Health checks delivered and facilitated by the Commissioning Facilitators (CF). (Oct 2014) | - Uptake of screening for cancers is variable across Lewisham, namely cervical screening uptake, only two practices achieving the 80% target. Similarly, no practice is achieving the 75% target coverage.  
- Observed prevalence of some long term conditions is much lower than the expected prevalence for the local population. See attached Neighbourhood profiles and refer to the Annual Health report. | - Increase the uptake of cervical screening by x%  
- Increase the number of people taking up the offer of a healthcheck | Proactive care |
| Improve early detection for Cancer, appropriate referral and treatment (with | - Incidence of some cancers is statistically higher than those for England,  
- Appointed GP Cancer Lead | Proactive care, accessible care |
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<tr>
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<tr>
<td>agreed baseline/plan for improvement). Develop a support package for practices to include; McMillan GP Cancer Lead to work with practices to improve education and quality including CF Support Programme. (Oct 2014)</td>
<td>e.g. Prostate Cancer.</td>
<td>• Established Neighbourhood review meetings</td>
<td>Proactive care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Differences between practices, specifically who GPs refer via the rapid two week wait referral route and the number of cancers diagnosed. Mortality rates vary across the population; specifically in lung cancer - higher than the England rate.</td>
<td>boxes 24</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• See Earlier Detection of Cancer – report produced by the Cancer Commissioning Team West and South London in May 2014</td>
<td>Proactive care</td>
</tr>
<tr>
<td>Quality Indicator Cancer % of 2 week referrals diagnosed with cancer No. diagnosed with cancer - other routes</td>
<td></td>
<td>• Practices demonstrate improvements in measurable outcomes and are no longer outliers.</td>
<td>boxes 24</td>
</tr>
<tr>
<td>Reduce the number of practices not meeting the NHS England Outcomes for General Practices. Develop improvement plans in partnership with NHS England for outlier practices as part of medium term plans to reduce unwarranted variation and improve quality. (TBC 2014/15 with agreed baseline/plan for improvement)</td>
<td>• The CCGs role is to support and develop primary care.</td>
<td>• Improved health outcome measures.</td>
<td>Proactive care</td>
</tr>
<tr>
<td></td>
<td>• Some practices are not meeting the NHS England outcomes framework and the CCG will work with these practices to develop and implement action plans to improve the quality of primary care.</td>
<td>• Practices agree how they are working together and preparations are underway to establish formal provider organisations.</td>
<td>Proactive care</td>
</tr>
<tr>
<td>Delivering ‘collaborative working’ through population based commissioning: (a) Supporting practices to work together by developing and implementing Lewisham Neighbourhood Primary Care Improvement Scheme (LNPCIS) to reduce unwarranted variation. (Launch Sept 2014) (b) Implement Engagement in Clinical Commissioning Local Improvement</td>
<td>• Current pressure on primary care to deliver improved population outcomes.</td>
<td>• Improved health outcome measures.</td>
<td>Proactive care</td>
</tr>
<tr>
<td></td>
<td>• Capacity and capability of current workforce to deliver improved outcomes.</td>
<td>• Practices agree how they are working together and preparations are underway to establish formal provider organisations.</td>
<td>Proactive care</td>
</tr>
<tr>
<td></td>
<td>• Reducing variation and sharing good practice.</td>
<td></td>
<td>Proactive care</td>
</tr>
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<td></td>
<td></td>
<td>boxes 24</td>
</tr>
<tr>
<td>Output/timescales</td>
<td>Rationale</td>
<td>Outcome 31 March 2015</td>
<td>High Impact Change Delivery</td>
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| Scheme (ECCLIS): encouraging practices to work together on delivering outcomes for each neighbourhood by developing ‘neighbourhood plans’ for reducing inappropriate A&E attendances in the line with QIPP (Nov 2014) | • Patient reported difficulty in accessing primary care.  
• Outcome of Primary Care Foundation recommendations made to individual practices and to CCG | • Patients report improved access to primary care.  
• Pilot study 7/7 8-8 working developed. | Accessible care |
| Improve access to GPs against agreed baseline/s and develop plans for improvement by;  
(a) Develop Pilot for 7/7 8-8 working for GP practices (Nov 2014)  
Develop packages to support improved access by demand and capacity management of appointment/booking systems (Nov 2014) | • Patient reported difficulty in accessing primary care.  
• Outcome of Primary Care Foundation recommendations made to individual practices and to CCG | • Patients report improved access to primary care.  
• Pilot study 7/7 8-8 working developed. | Accessible care |
| Redesign urgent care services (simpler to navigate) and improve access to primary care services to support reducing the number of inappropriate A&E attendances (QIPP);  
(a) Ensure that 111 services enables a local flow (E.g. DOS reflects any collaborative working)  
(b) Unplanned care review and implement recommendations (Sept 2014)  
(c) Pilot ‘Navigator Role’ in ED (Oct/Nov 2014)  
Design GP Urgent Care Slots to support ED Navigator (Oct/Nov 2014) | • Regular monitoring of acute service activity has identified that a significant and growing number of people are attending A&E who could be seen in primary care. | • Procurement of element of urgent care centre completed. | Accessible care |
<table>
<thead>
<tr>
<th>Output/timescales</th>
<th>Rationale</th>
<th>Outcome 31 March 2015</th>
<th>High Impact Change Delivery</th>
</tr>
</thead>
</table>
| **Quality Indicator** | Improving access and continuity of care - GP Survey  
Convenience of appointments Easy to speak to someone on phone. Being listened to  
Overall experience with out of hours |  
- Local people have stated that they wish for more involvement in managing their care.  
- In 2014 NHS England has determined an Unplanned Admissions National Enhanced Service that describes the risk stratification of people “at risk” of an emergency admission. |  
- People with a long term condition report that they feel supported.  
- Reduction in emergency admissions for people deemed at risk. | Co-ordinated care  
Continuity of care |
| **Quality Indicator** | People feeling supported with their long term condition (GP survey question)  
Long Term Condition  
Diabetes  
COPD/Respiratory  
Heart Failure |  
- Public Health reports show that there are significant differences between practices and the uptake of Immunisation and Vaccination programmes across Lewisham.  
- No herd immunity across the children who are fully protected on school entry  
- An increase in unplanned care for people aged over 65 and those “at risk”.  
- Acknowledge some practices exceed the expected coverage and can share good practice regarding systems and processes and share resources across a geographical area. |  
- 95% of children aged 5 have had their MMR2 and pre school booster.  
- Increased uptake in seasonal flu and pneumococcal vaccine. | Proactive care |
| **Improve take-up rate for all immunisations** | The CCG will encourage practices to work together to plan and implement services that will improve access to immunisation and vaccination programmes. |  

Public Health reports show that there are significant differences between practices and the uptake of Immunisation and Vaccination programmes across Lewisham.  
No herd immunity across the children who are fully protected on school entry  
An increase in unplanned care for people aged over 65 and those “at risk”.  
Acknowledge some practices exceed the expected coverage and can share good practice regarding systems and processes and share resources across a geographical area. |  

95% of children aged 5 have had their MMR2 and pre school booster.  
Increased uptake in seasonal flu and pneumococcal vaccine | Proactive care |
Appendix E - Equalities Analysis

Equality Analysis Checklist
An Equality Analysis is a review of a policy, function or service which establishes whether there is a negative effect or impact on particular social groups. In turn this enables the organisation to demonstrate it does not discriminate and, where possible, it promotes equality.

This check list is a way to help staff think carefully about the likely impact of their work on equality groups and take action to improve services and projects for local people where it has a positive or negative impact.

<table>
<thead>
<tr>
<th>Name of the policy / function / service development being assessed</th>
<th>Primary Care Development Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Briefly describe its aims and objectives:</td>
<td>The strategy aims to describe the support that the CCG will provide to practices to improve primary care services and identify new commissioning opportunities. It is designed to benefit all patients and deliver positive outcomes and reflects the internal response to local patient views. The objectives focus on four high impact changes: Proactive care, accessible care, co-ordinated care and continuity of care.</td>
</tr>
<tr>
<td>Directorate lead</td>
<td>Diana Braithwaite, Commissioning Director</td>
</tr>
<tr>
<td>Is the Equality statement situated in the first three sections of the document? If No you may wish to use the Equality statement below</td>
<td>Please refer to the statement below.</td>
</tr>
</tbody>
</table>

Equality Statement:
“This document demonstrates the organisation’s commitment to create a positive culture of respect for all individuals, including staff, patients, their families and carers as well as community partners. The intention is, as required by the Equality Act 2010, to identify, remove or minimise discriminatory practice in the nine named protected characteristics of age, disability, sex, gender reassignment, pregnancy and maternity, race, sexual orientation, religion or belief, and marriage and civil partnership. It is also intended to use the Human Rights Act 1998 and to promote positive practice and value the diversity of all individuals and communities“.
**Equality Analysis Checklist**

Go through each protected characteristic below and consider whether the policy / function / service could have any impact on groups from the identified protected characteristic, involve service users where possible and get their opinion, use demographic / census data (available from public health and other sources), surveys (past or maybe carry one out), talk to staff in PALS and Complaints.

Please ensure any remedial actions are Specific, Measureable, Achievable, Realistic, and Timely (SMART)

<table>
<thead>
<tr>
<th>1. Equality Group</th>
<th>2. What evidence has been used for this analysis?</th>
<th>3. What engagement and consultation has been used</th>
<th>4. Identify positive and negative impacts</th>
<th>5. How are you going to address issues identified?</th>
<th>6. Lead and Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td>The JSNA 2013/14 and individual neighbourhood profiles 2014/15</td>
<td>Information has been taken from the Quality Summit and the wider consultation on the South East London Strategy 2014, on which the local strategy is based.</td>
<td>All ages of people registered and non registered will benefit. E.G. 1) All people aged over 75 years will have a named GP which and will provide enhanced access to clinical cover. 2) An enhanced suite of self management products will be provided to people with long term conditions, irrespective of their age. 3) The expert patient programme a, and other condition specific patient education programmes will continue to be</td>
<td>Where older people have poor sight, literature can be provided in large print.</td>
<td>NHS England A’Oshaughnessy 31 March 2016 L Hughes</td>
</tr>
</tbody>
</table>
Disability
Think outside the box, you may not be able to see the disability. It could be physical (hearing, seeing) or a learning disability (Autism).
- Accessibility – venue, location, signage, furniture, getting around
- Disability awareness training for staff
- Actively involve the service user and talk it through with them

The JSNA and individual neighbourhood profiles

Information has been taken from the quality Summit and the wider consultation on the South East London Strategy 2014, on which the local strategy is based.

It explicitly states that practices will ensure that specific needs of their population are responded to when planning and implementing change. The information is provided within the Neighbourhood Profiles which are extracts from the JSNA.

The CCG is committed to developing strong accessible primary care which will benefit people with disabilities.

The CCG will continue to work with providers ensuring that they have access to local training and development programmes. E.g. All practice staff have accessed the programme for dementia carers.

No issues anticipated.
<table>
<thead>
<tr>
<th><strong>Gender Reassignment</strong></th>
<th>The CCG will have an ongoing dialogue with practices to monitor for any impact.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Think about creating an environment within the service / policy or function that is user friendly and non judgemental. If the policy / function / service are specifically targeting this protected characteristic, think carefully about training, confidentiality and communication skills.</td>
<td>The JSNA and individual neighbourhood profiles</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th><strong>Marriage and Civil Partnership</strong></th>
<th>The CCG has a Public Engagement Strategy in place which adheres to the Equalities Act 2010 and the Primary Care Development Strategy falls within this commitment. No anticipated benefits or disbenefits for this group.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Think about access and confidentiality, the partner may not be aware of involvement or access to the service. Staff training.</td>
<td>The JSNA and individual neighbourhood profiles</td>
</tr>
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<tr>
<th><strong>Pregnancy and maternity</strong></th>
<th>It explicitly states that practices will ensure that specific needs of their population are responded to when planning and</th>
<th></th>
<th>No anticipated benefits or disbenefits for this group.</th>
</tr>
</thead>
<tbody>
<tr>
<td>The policy / function / service must be accessible for all for example opening hours.</td>
<td>The JSNA and individual neighbourhood profiles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are the chairs appropriate for breast feeding is there a private area? Are there baby changing facilities and is there space for buggies?</td>
<td>implementing change. The health needs for each neighbourhood are contained within the Neighbourhood profiles. Whilst there is no specific reference to this group of people, the Commissioning strategy provides specific intentions regarding the improvement of services.</td>
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| Race  
You need to think carefully about the local demographics of the population who will be accessing the policy / function / service. Talk to public health.  
Think about:  
- Cultural issues (gender, clothing etc)  
- Languages  
- Support to access  
- Staff training on cultural awareness,  
JSNA | All practices will continue to have access to telephone translation services.  
The CCG has produced a new leaflet translated into the top 10 languages spoken in the Borough. This is available to all practices via a local electronic system – GP Interactive. |
<p>| Benefits are expected for the BME community suffering from long term conditions who report less satisfaction with practices. |</p>
<table>
<thead>
<tr>
<th><strong>Religion or Belief</strong></th>
<th><strong>Sex</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>As above think about local population and what religion or belief they may have.</td>
<td>This is simply the impact on males / females.</td>
</tr>
<tr>
<td>Think about:</td>
<td>For example same sex accommodation, are their areas for privacy?</td>
</tr>
<tr>
<td>• Staff training on respecting differences, religious beliefs</td>
<td>Is it accessible for both taking into account working service users / is it accessible would it be a venue they would go to?</td>
</tr>
<tr>
<td>• Are you trying to implement during a time of religious holidays e.g. Ramadan</td>
<td>Review of all of the initiatives against JSNA</td>
</tr>
<tr>
<td>• Is there an area for prayer times?</td>
<td>Women and men will benefit from this strategy as improvements in the quality of primary care will address improvements in the management of long term conditions and mental illness.</td>
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</table>

Specifically, extending access to services will take into account working

The CCG will work with practice staff to enable services to be delivered sensitively and appropriately to all people to have a positive impact by taking into account religious and other beliefs.

No anticipated benefits or disbenefits.
### Sexual Orientation

Don’t make assumptions and this protected characteristic may not be visibly obvious.

Providing an environment that is welcoming for example visual aids, posters, leaflets.

Using language that respects LGB&T people.

Staff training on how to ask LGB&T people to disclose their sexual orientation without fear or prejudice.

There are no anticipated benefits or disbenefits to this group as the CCG will work with staff in primary care to deliver services sensitively and appropriately. This will be through ongoing programmes of training and development.

### Carers

Does your policy / function / service impact on carers? Ask them.

Do you need to think about venue, timing?

What support will you be offering?

The accelerated identification of carers through the delivery of care planning will offer them greater control over their care. This will include better co-ordination and continuity of services.

Some carers may also benefit from having a named GP.

---

For all negative impacts, please provide a SMART action plan to identify how you will address these.
Please send to the Equality/Governance Lead for publication on website (this is a legal requirement).

Responsible Officer: ___________________________ Date: ___________________________

Team/Organisation: ___________________________

Equality Analysis approved by: ___________________________ Date: ___________________________

Team / Organisation: ___________________________

Date submitted to Equality Lead: ___________________________

For Croydon CCG, Lewisham CCG and SLCSU
Valerie Richards, Equality and Diversity Lead
Tel: 020 3049 4167
Email: valerierichards@nhs.net

For Merton CCG, Sutton CCG and SLCSU
Wasia Shahain, Equality and Diversity Lead
Tel: 020 8251 0510
Email: Wasia.Shahain@swlondon.nhs.uk
<table>
<thead>
<tr>
<th>Screening completed by (please include everyone’s name)</th>
<th>Organisation</th>
<th>Date</th>
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Delivery Committee

Thursday 28th August 2014

Present
Ray Warburton (RW) (Chair) Lay Member, LCCG
Tony Read (TR) Chief Financial Officer

Attending
David Abraham (DA) Senior Clinical Director, LCCG
Karen Bates (KB) Assistant Director Nursing, LCCG
Tom Bunting (TB) Urgent Care Network Manager, BLG CCGs
Bobbie Fasham (BF) Corporate Services Officer, LCCG (Minutes)
Chris Gadney (CG) Assistant Director Commissioning, LCCG
Mike Hellier (MH) Head of System Intelligence, LCCG
Susanna Masters (SM) Corporate Director, LCCG
Ashley O’Shaughnessy (AO) Associate Director Commissioning, LCCG
Neil Stevenson (NS) Assistant Director (acute), SLCSU

Observing
Debbie Brown (DBn) Practice Nurse Advisor, LCCG

Apologies
Dee Carlin (DC) Head of Joint Commissioning
Martin Wilkinson (MW) Chief Officer, LCCG (Chair)
Diana Braithwaite (DB) Commissioning Director, LCCG
Alison Browne (AB) Nurse Director, LCCG
Dr Hilary Entwistle (HE) Clinical Director, LCCG
Dr Faruk Majid (FM) Senior Clinical Director, LCCG
Dr Jacky McLeod (JM) Clinical Director, LCCG

1. Welcome and Introductions

RW welcomed all to the meeting. It was noted that the meeting was not quorate. It was agreed that the meeting would continue given the important nature of the agenda items. Minutes of the meeting would be circulated on 29.08.2014 requesting comments on the discussions and to ratify recommended decisions.

Action: TR to review learning on availability of members for committee meetings in August.

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 24 July were agreed with the following amendments:

- P1: Fleur Nieboer, Internal Audit KPMG, attended the last meeting as an observer not as an attendee.
- P8: The acute activity position for KCH was (£0.58m) not (£0.58).

4(b). Action Log

The following items were discussed and updated:

**July 5:** LGT confirmed the action to review bowel cancer screening pathways is now complete and will be green for the next review in September 2014. Action closed.

**July 6:** The IGSG work plan and terms of reference are included on the agenda for 28.08.2014, Item 6. Action closed.

**July 6.1:** A report on the responses received from LGT on its IG toolkit results is included on the agenda for 28.08.2014, Item 6, enclosure 2. The SIRO has approached Southwark CCG which has in turn approached Kings. No response has been received. Action closed on LGT.

**July 6.2:** AB received confirmation that IT problems related to email only. Further clarification was requested on whether problems related to email would have affected clinical care.

**July 6.3:** The CCGs responses to the Quality Account were circulated via email on 07.08.2014. Email will be resent and action closed.

**July 8:** Action outstanding. The District Nurse Management Team were introduced at the PLT on 19 August 2014, however contact details have not been circulated to all GPs.

**July 8.1:** TR confirmed that clarification on funding for GPs to attend safeguarding case conferences was the responsibility of NHS England. TR to work with FM to disseminate this information.

**July 8.2:** An update on the outstanding actions from the SEL national stroke audit is due in September from LGT at the CQRG.

**July 8.3:** The CCG is aware that LGT has not been able to routinely meet the 48 hour target for reporting serious incidents via the Strategic Executive Information Service. The CCG is working with the Trust to improve performance in this area. Delays are sometimes incurred because it is not clear that an “event” constitutes a “serious incident” until after preliminary investigations have been undertaken. Action closed.

**July 8.4:** Clarification was requested on what communication is given by the provider to patients on the 18 week RTT pathway. Clarification on what information the CCG provides to the public, i.e. should the CCG publish provider waiting times for local providers on the internet.

**July 8.5:** QIPP outpatient recovery plan included on the agenda for 28.08.2014 – Item 7. Action closed.

**July 8.6:** M3 2014/15 contract performance review included on the agenda for 28.08.2014 – Item 7. Action closed.
July 11: The SMT has agreed the process for the CCG to bring forward proposals to redefine support services. Business cases have been produced for services that the CCG intends to terminate on 30.09.2014. In response to SM’s question TR responded that the business cases must be approved by the CCG’s appropriate committee, no delegated authority to approve business cases has been given to joint meetings. Members were asked to contact TR if they wished to see copies of any of the business cases. Action closed.

June 4: Delivery Committee reporting from SLA monitoring is included in the August integrated performance report. The CSU has provided a dashboard for GP referrals from the acute Trusts, which is in the process of being tested by the System Intelligence Team. Actions closed.

June 7.1: LGT have confirmed that the lead clinician discusses with the patient that they are on the treatment 62 day pathway and that the patients throughout their pathway are supported by a clinical nurse specialist who acts as a conduit to the MDT and on-going support through the pathway. Action closed.

June 8: Patient experience measures are monitored by FLAG. Action closed.

May 12: The procurement policy has been drafted and being reviewed by TR.

Apr 6: Lessons learnt for the CCG on District Nursing has been included on the agenda for 28.08.2014, item 8. Action closed.

5. Matters Arising

Emergency Planning Resilience and Response (EPRR)
The paper on EPRR has been deferred to September to ensure the learning from the incident on 11.08.2014 has been incorporated.

A&E Over-Performance
In response to RW’s question TR responded that the main risks to the financial position referred to in the M3 finance report relate to budgetary risks rather than expenditure risks. The main expenditure risk is the overperformance against acute contracts, which includes A&E, outpatients, critical care and drugs and devices.

Update on SLA with CSU and Process for Support Services Business Case Approval
TR gave a verbal update. The contract with the SLCSU ends on 30.09.2014. Lewisham CCG is working with the other five CCGs in London on a new contract. Lewisham CCG has confirmed with the SLCSU the services that will be terminated by the CCG, the potential for new non-core services and those services requiring improvement. Service specifications and KPIs have been reviewed and a new pricing framework agreed. Heads of Agreement have been signed. It is anticipated the contract will be signed in September.

New Governance arrangements will be implemented including a high level board and service development board. The CCG has notified the SLCSU that the service quality and responsiveness of a number of commissioning support services require improvement.

SM is re-scoping some of the governance arrangements and DB the community contract management service. Formal notice to terminate the Financial Planning and Management and Clinical Procurement services with effect from 1st October has been given.
SM highlighted that transitional plans to ensure effective provision is in place for those services which are being brought in-house are being worked on.

**Update on the Corporate Objectives**

SM gave a verbal update. The July Delivery Committee requested further work was done to ensure objectives are SMART. Work on this has commenced and a report will come to the September Delivery Committee.

In response to RW’s question SM responded that there was a fundamental change to the objectives when the Governing Body recognised that they need to do less and focus on a few objectives. The objectives had been finalised previously so staff have been working towards these objectives in the first five months of the year and the SMT all have monitoring meetings with MW on their specific objectives.

RW asked for the constitutional requirements, particularly work on A&E and RTTs, to be featured more clearly in the corporate objectives.

**6. Report from sub-groups**

**Information Governance Steering Group (IGSG)**

TR gave the report from the IGSG and highlighted the following:

- The IGSG has reviewed its Terms of Reference. Changes were made to membership, to include additional managers from within the CCG and specialist advisors from the CSU, and to quoracy. The Delivery Committee were asked to approve the revised terms of reference.

- The high level rolling workplan is included in the IGSG Terms of Reference. A more detailed work plan focusing on improving the CCGs IG toolkit submission sits behind the workplan.

- A letter was sent to John Hennessey, Director of Finance at LGT on 29 July 2014 requesting additional information following the Trust’s failure to achieve the minimum level 2 score required for some of the IG toolkit standards. TR stated that the Trust’s response gives assurance that the Trust understands the shortcomings and that appropriate actions are being undertaken to address this.

- An email was sent to the SIRO at Southwark regarding Kings’ IG toolkit scores. The Southwark CCG SIRO has written to Kings however a response has not yet been received.

RW stated that he would give comments on the IGSG terms of reference to TR outside the meeting and commended the administration requirements set out in the terms of reference.

In response to RW’s question TR responded that the application of learning from the first IG toolkit assessment is included in the detailed workplan. RW said it would be helpful if it surfaced in the summary workplan.

RW highlighted the previous conversations around the difficulty caused by the restrictions on PID and asked whether this was being addressed. DA highlighted that the restraint that the current system imposes on commissioning has meant that the CCG has been unable to take some things forward. TR responded that much depends on whether the CCG elects to seek Accredited Safe Haven (ASH) status. [Tony – might this aspect somehow surface in the workplan.]

In response to SM’s question NS responded that there is a requirement in the information governance toolkit that an audit of clinical coding is undertaken. The audit that used to be performed nationally is no longer undertaken. Lewisham, Greenwich and Bexley CCGs have agreed a local PBR audit for LGT; the report is expected in November 2014.

**Action:** TR to circulate the detailed IGSG workplan to RW (and to others on demand).
The Committee noted the report from the IGSG and APPROVED (subject to ratification) the IGSG terms of reference

For Learning and Action Group (FLAG)

MH and KB gave the report of the FLAG meeting held on 10.07.2014 and highlighted the following:

- FLAG received the process map detailing how a patient gets admitted to a CAMHS bed. However no information was received on how long the process takes and whether a local bed is secured. Further information and assurance on how the pathway works and how the service is coping with limited beds and the impact on patient experience has been requested.

- The Healthwatch annual report on patient feedback received positive feedback from FLAG.

- FLAG noted the decrease in quality alerts being submitted. FM will highlight this to the Membership Forum and Neighbourhood Leads. AO highlighted that the drop in the numbers of quality alerts could be linked to the end of the incentive that was being given to practices up until March 2014.

- FLAG noted the increase in suicides for SLaM and that there has been a rise across London. It was agreed that further explanation and details of individual cases was required to identify trends.

DBn stated that the person reviewing the quality alerts has requested that those submitting serious incidents through this route include the patient’s NHS number however some GPs have been told not to put PID on quality alerts. It was noted that FLAG was reviewing the quality alerts system and that serious incidents should not be reported as quality alerts.

RW noted that some Members are uncomfortable with the notion of GPs being incentivised to provide quality alerts.

Action: FLAG to communicate to practices whether NHS number can be included on quality alerts.

The Committee noted the report from FLAG

Prescribing and Medicines Management Group (PMMG)

There had been no meeting of the PMMG since the Delivery Committee last met on 24.07.2014.

7. Integrated Performance Exception Report

TR introduced the Integrated Performance Exception Report highlighting that further work is required to link issues within the separate reports; this will be achieved using the cover sheet from September onwards. RW welcomed this ambition.

Quality

KB gave the report on Quality and highlighted the following:

- The LGT action plan in response to the CQC report is being monitored through the CQRG.
- Signet Health Care received an unannounced CQC visit and has been given a positive report.
- The CCG is awaiting the outcome of an unannounced CQC visit to the Blackheath Neuro disabilities unit.
- Monitor’s report into the governance arrangements at SLaM is expected mid-September.
- The outstanding MAR report has been reviewed by the Safeguarding Adults Board. Outstanding actions for the CCG are being addressed.

The following comments were made:
- With the exception of two new quality issues the quality report is identical to the report submitted
to the July Delivery Committee. The report does not give an update on the actions that took
place in July and August. A number of comments were made at the July Delivery Committee
have not been addressed including the severity of the quality issue around the unidentified
CIPs.
- The wording in the quality report on the increase in suicides does not reflect the severity of the
wording in the report from the Chair of FLAG. It is not clear how concerned the Committee
should be.
- The RAG rating for the issue regarding ‘Four Seasons’ Healthcare has changed from red to
amber. However there is no indication on what has happened to achieve this.
- The information on quality alerts and serious incidents is good. However an accompanying
narrative expounding on the types of issues being raised would be helpful.
- Clarity was requested on whether the outstanding CQC report is late or missing.
- Reports in previous months included symbols to show positive or negative assurance – this was
useful but has dropped off the reports.

KB responded that one of her objectives as part of her new role as Assistant Director Nursing was to
ensure the quality report was updated.

DA suggested that a quality alerts system allowing providers to give feedback to primary care should be
established.

Performance

MH gave the report and highlighted the following:
- The next formal review of cancer waiting times for GP referral time to treatment within 62 days is
due mid-September.
- LAS performance on the 8 minute standard for reaching patients with life threatening conditions
is currently red rated against the 75% standard. There has been a recovery plan agreed by
London commissioners and LAS but there has not yet been any indication of improvement.
- An exception report on the CDifficile infections will be provided for the September Governing
Body.
- Lewisham’s dementia register is improving however the improvement level is unlikely to be
sufficient to achieve the 2014/15 requirement.

TR highlighted that this week there had been delays of up to 5 hours transferring patients from LAS to
A&E at QE. MH confirmed that over 50% of the over 60 minute waits in London are for QE. This is due
partly to the shortcomings on the QE site identified by the CQC and also shortcomings in the LAS
conveyancing system. DA highlighted that LAS crews spend too long transferring patients with minor
conditions to A&E and there is a need to work with colleagues in Greenwich to find local solutions in
addition to contributing to the issue at a SEL and London level.

In response to SM’s and RW’s question on the rating for Governance Arrangements MH responded
that it has been rated red as this is the direction of travel. SM suggested the use of arrows to show
direction of travel. RW agreed and added that greater transparency of how the rating was arrived at
was needed.

Finance and QIPP

TR gave the finance report. At month four the CCG is reporting an overall underspend of £1.41m, this
represents a £0.14m favourable variance against plan. The CCG is forecasting to deliver its £3.81m
planned surplus in full. The following was highlighted:
- The acute expenditure year end projections forecast a £4.13m overspend. All three main providers, LGT, KCH and GSTT are over performing. In order to deliver the forecasted year end position the CCG will need to use reserves of £3.23m.
- Letters have been received confirming the allocation of system resilience and winter monies; however these the funds have not yet been received and are therefore not reflected in the budget or expenditure forecasts.
- The CCG has not yet received the return of the 2013/14 surplus of £3.7m.
- At month 4 the CCG QIPP is £0.15m below its planned position. The slippage is mainly caused by outpatient referrals. The position is being held by forecasted savings of £1.7m in ‘other emergency admissions.’ It was noted that the total reduction in emergency activity was not necessarily the result of QIPP plans.

In response to DA’s question SM responded that DB was drawing up QIPP schemes for 2015/16 which will incorporate learning from 2014/15. DA suggested there was learning to be gained from the readmissions audit.

In response to DA’s question on direct access NS responded that the level of overperformance was reducing. A successful exercise two years ago managing direct access for pathology is being replicated. The over-performance for direct access at GSTT is new and further information will be brought back.

In response to RW’s question regarding the acute overperformance TR responded that payments by results has created a systematic issue weighted in favour of the provider. There is financial strain within the system, KCH is forecasting an overspend for 2014/15 and SLaM overspent in 2013/14 and LGT have a significant savings plan. It is important that the SEL transformational work results in providers having the confidence to vary capacity and take cost out of the system.

The financial planning forecasts reported to the Governing Body have been based on NHS England’s planning assumptions. There is a risk that these will be overoptimistic ahead of the general election and the CFO will model additional scenarios through the Strategy & Development Committee.

**Action:** A report on the different financial scenarios to go to the Strategy and Development Committee.

NS recommended that the CCG include in its commissioning intentions the intention to move away from a PBR model.

**QIPP Outpatients Recovery Plan**

AO gave the exception report and recovery plan for outpatients. The implementation of the Referral Support Service (RSS) is integral to the delivery of savings. The RSS has gone live, as of 18.08.2014 23 practices have signed up to partake in the pilot. Work has commenced on recruitment to the next phase of the pilot and practices will be encouraged to sign up.

NS highlighted that the forecast position does included the estimated impact of the RSS.

In response to SM’s question on the action plan for outpatient follow-ups, AO responded that a link between the number of outpatient appointments and follow up appointments has been assumed, in addition the full implementation of the anti-coagulation pathway to manage patients through the community pharmacy service will reduce follow up appointments.

RW suggested that the recovery plan actions are prioritised based on impact.

**Lewisham CCG M3 2014/15 Contract Performance Review**
NS gave the report outlining key contractual and activity issues for Lewisham CCG at LGT, GSTT and KCG. The following was highlighted:
- The KCH position is maintaining the level of overperformance. The Trust is the most challenged with 18 week waiters however there is a plan to reduce this and resource has been allocated.
- Regarding GSTT position, £100k of activity has been identified that has been charged to the CCG but should be charged to NHS England.
- LGT overperformance has increased in M3. A&E attendances are increasing, outpatients and electives are over performing.
- Emergencies continue to underperform at LGT and Kings.

The Committee NOTED the Integrated Performance Report

8. Lessons Learnt for the CCG on District Nursing

TR gave the report highlighting the key reflections and lessons learnt from the issues raised by the membership on local district nursing service, from the perspective of the CCG as a commissioner. The following lessons were highlighted:
- Contract management arrangements were not sufficient. A separate community contract group under the Contract Management Board arrangements has been set up to ensure appropriate contract management focus on community services.
- There was an absence of data. Community data and metrics to underpin commissioning with more clinically based, outcome orientated rather than process measures is being developed.
- FLAG to develop reporting into Delivery Committee and Governing Body to aid clarity of assurance.
- Improve the quality alert and feedback loop. Improvements have been made including introducing a clinical triage of all quality alerts.
- Greater use of clinical audit programmes and staff feedback and views as a source of investigation and assurance.
- Work with LGT to ensure appropriate leadership and culture of community based services.

The following comments were made
- The CCG knew there was an issue from quality alerts however LGT was not receiving a high number of official complaints about the service. There is an issue regarding how vulnerable people are supported to put in a complaint. The Trust needs to find new ways to record patient experience without relying solely on complaints.
- For the review the patient’s voice was sought belatedly and only six people were interviewed. We need to build in patient experience from the outset and to secure a good spread of individuals patients.
- The presentation given at the PLT on 19.08.2014 should be circulated.
- Contracts do not define clinical quality; more sophisticated outcome based measures are required.
- It was recognised that a report of the issue and action taken needs to be available to the public and go to part 1 of the Governing Body. However it is important not to taint the whole service as this could have a negative impact on the recruitment and retention of good community nurses.
- The dashboards being developed by FLAG include metrics to measure staff engagement including vacancy rates.
- Patients have commented how nice it is to see district nurses in uniform with kit bags.

Action: Report on district nursing and action being taken to go to part 1 of the Governing Body. Delivery Committee to receive regular updates on progress against DN action plan
The Delivery Committee NOTED the headline lessons learnt for the CCG from the issues raised by membership on local District Nursing Services.


TB gave the report giving an update on the development of the system resilience plans. The following points were highlighted:

- System Resilience Guidance published by NHS England in June proposed that the remit of Urgent Care Working Groups evolve so that as well as overseeing the ability of local systems to deliver against the A&E target, they will also oversee against the Referral to Treatment (RTT) (18 weeks) target. The initial meeting of the Bexley, Greenwich and Lewisham System Resilience Group took place on 6 August 2014 and the draft terms of reference were agreed.

- The initial draft of the System Resilience plan for Lewisham, Greenwich and Bexley was submitted to the regional tripartite panel by commissioners on 30 July 2014. The key initiatives contained within the unscheduled care section of the plan includes maximising capacity, further enhancement of 7 day working, improving the emergency care pathway and minimising delayed discharge. The plan is on track to be authorised by the tripartite by 23 September 2014.

- Referral to Treatment Time performance has been falling across London since December. Monies have been allocated by local area teams; all providers are eligible for funding regardless of whether they are currently meeting targets in order to support the national position. It is envisaged that the majority of the 847 cases will take place between July and October. As a result performance on RTT thresholds will dip in July and August and be back on track by September.

- The combined allocation across the three CCGs for winter funding was £5.18m. The total value of bids received was £12.9m. Each CCG has agreed to an allocation principle of 60:40 weighted more heavily to the acute schemes. This ratio does represent a move toward greater parity of allocations for winter schemes compared with previous years. The September and October SRG meeting will review implementation/readiness of the winter plans and if there has been any slippage money can be reallocated.

The following comments were made:

- Some of the winter bids focus on short term arrangements in hospital to increase capacity. This is resourcing the symptoms not fixing the causes. The SRG needs to think about long term solutions linking with the SEL Commissioning Strategy and Better Care Fund.

- The sorting of bids leaves the CCG open to providers potentially claiming that they cannot meet the performance targets as not all their bids were funded.

- The SRG needs to link better with CFOs to ensure alignment with the bidding process and use of funds.

- This is not commissioning on an outcome basis but commissioning people, capacity and process. Funding should be linked to performance. It was suggested that if there was slippage to hold money back which providers will receive if they deliver on performance.

- In past years there have been examples where commissioners have paid twice for some activity. TB was instructed that such double counting must be avoided.

- The allocation to support additional staffing in the emergency department for paediatrics is huge compared to the SELDOC scheme. Given that many of the cases should be dealt with by primary care this is not a good use of funds.

- There are additional out of hospital schemes being funded by the CCG

Action: TB to review schemes and confirm safeguards to avoid potential duplicate payment.

The Delivery Committee NOTED the report and AGREED that Lewisham CCG would not sign off the winter bids if they incur double costs.
10. **Key Items to be Report to the Governing Body**

The key items to be reported to the Governing Body include:
- The August Delivery meeting was not quorate and the process to ratify decisions
- Availability of members and the holding of Committee Meetings in August to be reviewed
- The IGSG terms of reference were approved
- Positive assurance was received from the IGSG on LGT’s IG toolkit standards and the IGSG will continue to monitor progress
- Clarification required on a number of points in the Quality report i.e. increased number of suicides
- Over performance on acute
- Additional financial planning modelling to be undertaken to reflect possible different scenarios (referred to Strategy and Development Committee)
- The financial position is being managed using reserves
- A public report on the district nursing issue to go to the Governing Body
- Winter bids will not be signed off if they incur double costs.

11. **Items for Information**

**Minutes from sub-groups**

**FLAG**
The approved minutes of the FLAG meeting held on 10.07.2014 were taken for information.

**Urgent Care Working Group**
The approved minutes of the Urgent Care Working Group held on 02.07.2014 were taken for information.

**Lewisham IFR Requests Trend Analysis**
The report on the first quarter of 2014/15 for IFR requests was noted.

**Safeguarding Inspections**
The briefing on the consultation for integrated inspections of services for children in need of help and protection, children looked after and care leavers and joint inspections of the LSCB was noted.

14. **Any Other Business**

There was no other business taken at this meeting.

16. **Date of Next Meeting**
The next meeting would be held on Thursday 25 September 2014
<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>Aug 1</td>
<td>TR to review learning on availability of members and the practicality of committee meetings in August.</td>
<td>TR</td>
<td>Sept</td>
<td>19.09.2014: Clinical Director annual leave will be notified to CCG in advance to support forward planning. CCG Directors to be clear about deputising arrangements.</td>
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<tr>
<td>Aug 6</td>
<td>TR to send the detailed IGSG workplan to RW</td>
<td>TR</td>
<td>Sept</td>
<td>19.09.2014: To be sent prior to September meeting.</td>
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<td>Aug 6.1</td>
<td>FLAG to communicate to practices whether NHS number can be included on quality alerts</td>
<td>FLAG</td>
<td>Sept</td>
<td>19.09.2014: Quality alerts cannot include patients’ NHS numbers as GP Alerts are seen by the CCG and the CCG is not allowed to have access to PID. Communication via GPI.</td>
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<tr>
<td>Aug 7</td>
<td>A report on the different financial scenarios to go to the Strategy and Development Committee.</td>
<td>TR</td>
<td>Dec</td>
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<tr>
<td>Aug 9</td>
<td>TB to confirm that the CCG will not pay twice for activity through the winter monies.</td>
<td>TB</td>
<td>Sept</td>
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<tr>
<td>July 6.2</td>
<td>AB to find out if SLaM’s recent IT problems affected clinical care</td>
<td>AB</td>
<td>Aug</td>
<td>12.09.2014: IT problems related to internal email only which did not affect clinical care. 28.08.2014: Further clarification was requested on whether problems related to email would have affected clinical care. 07.08.2014: confirmation received that IT problems related to email only.</td>
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<td>July 8</td>
<td>Contact details for the district nursing interims to be circulated to GPs</td>
<td>AB</td>
<td>Aug</td>
<td>12.09.2014: Complete 28.08.2014: Action outstanding. The District Nurse Management Team were introduced at the PLT on 19 August 2014 however contact details have not been circulated to all GPs.</td>
</tr>
<tr>
<td>July 8.1</td>
<td>TR to seek clarification on funding for GPs to attend safeguarding case conferences</td>
<td>TR</td>
<td>Aug</td>
<td>28.08.2014: TR confirmed that clarification on funding for GPs to attend safeguarding case conferences was the responsibility of NHS England. TR to work with FM to disseminate this information.</td>
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<tr>
<td>Date</td>
<td>Description</td>
<td>Responsible</td>
<td>Due Date</td>
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| July 8.2| The following to be clarified in the quality report:                        | AB  
|         | - When the outstanding actions from the SEL national stroke audit will be  |             | Aug       | 12.09.2014: In progress, included on the exception report                                                                             |
|         |    complete.                                                                 |             | 07.08.2014| 07.08.2014: Update due in September from LGT at CQRG                                                                              |
|         |                                                                            |             |           |                                                                                                                                        |
|         |                                                                            |             |           |                                                                                                                                        |
| July 8.4| Communication to patients on 18 weeks RTT commitment to be reviewed          | TR          | Sept      | 19.09.2014: Provider performance, including 18 week RTT information to be made available to the public initially through Governing Body papers. Developing an approach around transparency of local provider data. |
|         |                                                                            |             |           | 28.08.2014: Clarification was requested on what communication is given by the provider to patients on the 18 week RTT pathway. Clarification on what information the CCG provides to the public, i.e. should the CCG publish provider waiting times for local providers on the internet. |
|         |                                                                            |             |           |                                                                                                                                        |
|         |                                                                            |             |           |                                                                                                                                        |
| May 8.6 | Business case for alternative services to IAPT                               | DV          | October   | 14.08.14: Included on the forward planner for October.                                                                                 |
|         |                                                                            |             |           | 24.07.14: Recommendation accepted to allow the commissioning team to complete IAPT consolidation work before embarking on a review of talking therapies provision locally. Timeline to be agreed with Darren Vella and Dee Carlin. |
|         |                                                                            |             |           | 18.06.14: Darren Vella taking forward.                                                                                                  |
|         |                                                                            |             |           |                                                                                                                                        |
| May 12  | DB and TR to produce the procurement framework including a robust            | DB/TR       | Aug       | 16.07.14: Procurement Policy has been drafted – review being undertaken by CFO.                                                          |
|         |    procurement policy and procedure. A procurement plan for 2014/15 to be    |             |           |                                                                                                                                        |
|         |    developed including timelines for specific schemes.                       |             |           |                                                                                                                                        |
Delivery Committee

Thursday 25th September 2014

Present
Martin Wilkinson (MW)  Chief Officer, LCCG (Chair)
Diana Braithwaite (DB)  Commissioning Director, LCCG
Dr Hilary Entwistle (HE)  Clinical Director, LCCG
Dr Faruk Majid (FM)  Senior Clinical Director, LCCG
Dr Jacky McLeod (JM)  Clinical Director, LCCG
Tony Read (TR)  Chief Financial Officer
Ray Warburton (RW)  Lay Member, LCCG

Attending
David Abraham (DA)  Senior Clinical Director, LCCG
Bobbie Fasham (BF)  Corporate Services Officer, LCCG (Minutes)
Mike Hellier (MH)  Head of System Intelligence, LCCG
Susanna Masters (SM)  Corporate Director, LCCG
Angelika Razzaque (AR)  Clinical Director, LCCG
Neil Stevenson (NS)  Assistant Director (acute), SLCSU

Apologies
Dee Carlin (DC)  Head of Joint Commissioning, LCCG & LBL
Alison Browne (AB)  Nurse Director, LCCG

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 28 August were agreed.

4(b). Action Log

The following items were discussed and updated:

Aug 1: Clinical Director annual leave will be notified to the CCG in advance to support forward planning. CCG Directors to be clear about deputising arrangements. Action closed.

Aug 6: IGSG workplan has been sent to RW. Action closed.
Aug 6.1: Quality alerts cannot include patients’ NHS numbers as GP Alerts are seen by the CCG and the CCG is not allowed to have access to PID. Communicated to GPs via GPI. Action closed.


Aug 9: Action is in hand, conversations with the Trust are taking place.

July 6.2: It was confirmed that IT problems related to internal email only which did not affect clinical care. Action closed.

July 8: Contact details for the district nursing interims circulated to GPs via GPI. Action closed.

July 8.1: TR confirmed that payment for GPs to attend safeguarding case conferences should be paid through primary care support services. TR to ask Richard Pooley to send an email to GPs confirming arrangements.

July 8.4: Provider performance, including 18 week RTT information to be made available to the public initially through Governing Body papers. Developing an approach around transparency of local provider data.


5. Matters Arising

Capacity in the quality directorate
In response to RW’s question about the arrangements to support the quality agenda following the comments made by the Nursing Director at the September Governing Body meeting SM stated that a meeting has been arranged to discuss administration support and the CCG is looking at how best it can use its administration capacity. TR highlighted that the CCG is operating at the running cost level the CCG is required to achieve in April 2015 if more is spent in the interim it will have to be cut by April 2015.

6. Report from sub-groups

Information Governance Steering Group (IGSG)
TR gave the report from the IGSG and highlighted the following:
- The IGSG has adopted the refreshed terms of reference approved by the Delivery Committee in August.
- The IGSG has reviewed the response from LGT and is assured that the Trust has a good understanding of the IG challenges identified in the 13/14 IG toolkit submission and that an appropriate action plan is in place. No response has been received from Kings to date and the SIRO will follow up with Southwark CCG.
- There are some planned changes to the IG team structure. It is not anticipated that these changes will affect the workplan.
- The IGSG has received the Root Cause Analysis report into the Information Incident involving the CCG’s server. The report failed to cover all of the causes and effects of the incident and was rejected by the IGSG. A fuller report is expected for the next meeting.
- The IG risk register was reviewed and the IGSG agreed to monitor 2 new risks concerning the identification of CCG data and the use of mobile devices.
In response to MW’s question regarding the highest rated risks TR stated that most risks are low and well managed, no risks are red rated. The highest risk in April 2014 was the risk concerning compliance with principle 8 of the Data Protect Act within the CCG’s contracts; the risk was closed when 2014/15 contracts were signed as the 2014/15 contract wording was compliant.

The Committee noted the report from the IGSG

For Learning and Action Group (FLAG)

FM gave the report of the FLAG meeting held on 09.09.2014 and highlighted the following:

- Further information has been provided in the report following the comments made by the Delivery Committee in previous months. Further feedback is welcome.
- Significant progress is being made in the area of Adult Safeguarding. The safeguarding adults audit shows that we are compliant in all standards but two, these are PREVENT training and a review of the Mental Capacity Act policy which needs updating in light of recent changes in the law. The CCG has placed a bid for funds from HESL to implement PREVENT training.
- FLAG received a progress report on District Nursing Services.
- FLAG received Quality Dashboards for both SLaM and Community Services.
- FLAG does not have sufficient assurance from SLaM in a number of areas including safeguarding and governance arrangements. Mental Health data presented at FLAG raised a number of concerns which will be explored in the forthcoming CQRG.
- Due to the dispute and delays with LGT over the discharge CQUIN practices are finding it hard to complete the audit resulting in reports from only 3 practices. FM agreed with Liz Aitkin to take a clinical view. This has been raised at the CQRG and may need escalating to the CMB.

MW stated that the CCG were prepared to go at risk and book the PREVENT training prior to funding being confirmed.

Action: PREVENT training to be organised.

It was agreed that SLaM Board would be invited to a Delivery Committee meeting or FLAG meeting with extended invite to other CCG board members to address concerns and as an opportunity to present how SLaM are moving forward.

HE highlighted that there are issues with the way SLaM quality alerts are dealt with. SLaM use datix which is not used in Lewisham and the system we use is very reliant on specific individuals rather a system. MW responded that there is an outstanding action requiring a quality alerts business case.

Action: SLaM to be invited to a CCG Delivery Committee or FLAG meeting with extended invite.

MR highlighted there may be funding available from Health Innovation Network for work on discharge summaries.

The Committee noted the report from FLAG

System Resilience Group: Stroke Unit

DB gave the report which described how the mismatch between demand and capacity in the emergency pathway at QE will be addressed by consolidating stroke services on the UHL site. The proposal releases beds for emergency inpatient care to support acute admissions at QE. By consolidating specialist services on one site, the Trust aims to reduce length of stay and support earlier discharge and improve repatriation waiting times. This is a temporary solution which will be subject to future consultation.
The paper has been approved by LGT’s Board, the CQRG and the Greenwich Overview and Scrutiny Committee. The paper was sent to the Lewisham CCG Membership on 22.09.2014 for comment.

FM expressed concern that the UHL site was already under pressure and winter has not yet arrived. DA highlighted that the acuity of patients is the reason for the current pressure. MW confirmed that the performance of the UHL has been a concern over the past two weeks; UHL has experienced an increase in admissions, attendances and has been slow to discharge patients. The Tripartite has assured LGT’s recovery plans but recognise they are high risk. A quality summit has been held and commissioners are assured that safety is not comprised but quality might be a times of increased pressure.

HE expressed concern that discharging patients from the Hyper Acute Stroke Unit (HASU) to their homes is a change in the pathway which has a lot of implications. MW responded that extra support in the community was being agreed supported by the resilience funding.

JM stated that the cost and knock on effects were unclear and asked how the service was going to be monitored. HE agreed that it is important for the CCG to be assured that the pathway is working. Monitoring needs to be in place or there is a risk that the CCG’s concerns will be realised as they were with the changes to the vascular pathway. MW responded that there is a lot of monitoring in the area of stroke with more professional advice and guidance than in many other areas. The service will be formally reviewed in quarter one 2015/16.

SM stated that the CCG needs to be clear what assurance they are looking for and what is to be monitored. It was agreed that DB would write a letter to LGT confirming the CCG’s support for the consolidation of the stroke services on the UHL site, requesting:
- positive assurance on the resilience of the community element of the pathway
- monitoring of the reduction in the length of stay
- that the review in Q1 2015/16 will be independent
- monitoring of the impact on wider medical wards
- how patient experience will be monitored and used

**Action:** DB to write a letter to LGT confirming support for the consolidation of the stroke services on the UHL site, requesting positive assurance on the areas highlighted above.

**The Committee noted the report detailing the transfer of the Acute Stroke Unit from QE to UHL.**

**VPR Programme Board**

TR presented the report that went to the VPR Programme Board on 04.09.2014 and highlighted the following:

- The VPR project is on target
- A lot of work is being undertaken around information governance. Legal services have been procured to advise on contractual requirements for information sharing.
- A launch event for Lewisham GPs was held on 10th September and a team is also going to the October Membership Forum and Neighbourhood meetings.

It was noted that there were a lot of acronyms in the report and it was requested that future reports are clearer.
In response to JM’s question regarding the go live date TR stated that implementation is phased. Phase 1 covers Lewisham GPs and LGT. It will be important to ensure that the implementation date is not pushed back as other partners join.

In response to HE’s question regarding the link to the GP system TR responded that the MIG is the gateway with EMIS. The VPR will not create a new record but only enable users to view connected records. The GP will not need to come out of EMIS to view the connected record. Controls will be in place at both a practice and individual level. Practices will decide what can be viewed and each individual user will have restrictions.

TR confirmed that the public engagement work will review how to manage and communicate consent.

In response to RW’s concern regarding the issue with pathology TR stated LGT has a different system on the QE site to the UHL site and it is not possible to bring these into a single view so it will result in a two line view until the source systems are merged.

The Committee noted the report from the VPR Programme Board.

7. Corporate Objectives

SM presented the progress report on the delivery of the CCG’s corporate objectives for 2014/15. Further work has been undertaken to ensure that the objectives’ outputs are SMART and to address comments made at the July Delivery Committee including clear statements on RTT, A&E and cancer waiting times.

The Delivery Committee has responsibility for overseeing the monitoring of the delivery of the Corporate Objectives and will receive bi-monthly progress reports which are RAG rated. An exception report will be produced for any objective that is assessed to be ‘red’ for the Delivery Committee to consider and onward reporting to the Governing Body. The Delivery Committee will also review the monthly ‘operational dashboard’ which monitors KPIs associated with the delivery of the Corporate Objectives.

SM highlighted that the RAG rating assesses the current position, green is on target, amber is not on target but there is action in place to bring back to target, red is not on target with no action in place to bring back to target. There is only one red rating ‘Reduce the number of practices not meeting the NHS England Outcomes for General Practices. Develop improvement plans in partnership with NHS England for outlier practices as part of medium term plans to reduce unwarranted variation and improve quality.’ DB stated that this is red as there is no action in place to achieve this output. It has been raised at the SEL Primary and Community Care Clinical Leadership Group however it may be that Lewisham CCG will have to identify its own metrics. It was agreed that MR should be the clinical lead associated with this output.

Action: DB to bring back an exception report on output 4.1(d) to the October Delivery Committee.

In response to MR’s question on whether 4.1(b) should involve public health DB stated that public health was referenced in the status box.

HE stated that high quality care should relate to other providers including SLaM, KCH and GSTT and needs a managerial lead.
JM highlighted that two outputs under ‘Establish Neighbourhood care networks as part of Adult Integrated Care’ were not RAG rated. It was agreed that it would be assumed that these were red and an update required for the next meeting in October.

**Action:** Update on the following outputs to be provided at the October Delivery Committee:
- ‘Agree and implement a neighbourhood network model in partnership with LBL, and SLaM. Service specification to be implemented by 15/16’
- ‘Strong communities and networks are developed to support people to live well and stay healthy and be self-directing working in partnership with the Communities’

RW stated that for some outcomes, i.e. financial planning, processes and outcomes are included in the status box which gives more assurance, whereas for other outcomes only include the processes that are in place i.e. patients are involved in decisions about their care. SM responded that the report needs to be read alongside the operational dashboard. TR stated that the Corporate Objectives report should draw on different sources and cross reference and make connections to other documents for example the risk register and BAF. Further work also needs to be done to ensure all the outcomes are measurable. The following suggestions were made:
  - An additional column showing a RAG rating which indicates whether or not the outcome is on target to deliver.
  - An additional column showing the date by which the outcome can be seen.

**Action:** Further work on the corporate objectives report to cross reference other sources of information including the dashboard and risk register.

The Delivery Committee noted the progress made on the delivery of the agreed Corporate Objectives.

**8. Integrated Performance Exception Report**

TR introduced the Integrated Performance Exception Report.

**Quality**

FM gave the report on Quality and highlighted the following:
- LGT has not, for a fifth successive month, met the 70% target for all complaints to have been addressed within 25 days. This has been RAG rated red and the CCG is no longer able to accept legacy issues as a reason for not meeting the target and demanded immediate action.
- LGT is on trajectory to achieve the cancer 2 week waits and treatment within 62 days targets by April 2015 however there remains concerns particularly with those waiting over 100 days on the impact for these patients. The CQRG is going to monitor the exception reports on a monthly basis for all patient breaches.
- There has been an increase in formal complaints at GSTT in relation to staff behaviour.
- KCH’s A&E performance is struggling and there has been a growth in patient acuity, however strong quality and governance processes are in place.
- There is currently no mechanism for reviewing quality of care for patients using private providers and the CCG will be asking private providers to report.
- Neighbourhood leads have been asked to encourage GPs to submit quality alerts.

RW made the following comments
- The breakdown of quality alerts is useful which highlights an issue in radiology which is helpfully expanded on in the report.
- The August quality exception report highlighted outstanding CIPs and Infection control as quality issues for GSTT which do not appear on the September report. The report does not explain why they have been removed. The hospital death review is highlighted as a new issue for GSTT and it is not clear why this has been included. Greater clarity is needed throughout the report to track through issues to resolution and explain the basis for a change in RAG rating if there is one. Dates should be included so the Committee knows when they can expect an update.

**Action:** Ensure quality report tracks issues from previous months.

In response to DA’s question regarding a GP liaison for radiology MW responded that it has been agreed that diagnostics is not a priority area however this could be considered in relation to work on outpatients.

**Action:** Ashley O’Shaughnessy to consider the need for a Clinical Lead to support diagnostics.

**Performance**

MH gave the report and highlighted the following:

**Everyone Counts**
- In August 2014 an IAPT recovery rate of 46% was delivered against the recovery rate plan of 40%. The IAPT service has implemented a telephone triage and therefore the number of people entering treatment has gone down. A key question is who is not being accepted for treatment and what other services are needed. A progress report, update on the recovery plan and a report on alternative services is expected at the October Delivery Committee.
- The dementia register as a percentage of prevalence has increased to 53% against a target of 58% at the end of March 2015. An exception report will be presented to the Delivery Committee.

HE highlighted that there was no plan in place to enable the CCG to achieve the dementia target. It is important to diagnose dementia early, Lewisham has an excellent pathway but it is underutilised. A funded coding exercise undertaken by GPs may be a solution.

**Action:** Joint SMT/Clinical Directors to discuss options to improve the dementia register target

**Constitutional Standards**
- Extra funding for LGT of £1.5m has been agreed to achieve the 18 weeks RTT standard. Data at the end of August showed a shortfall against the plan (388 were treated out of 468 planned for July and August). The key specialities behind plan were Vascular and Orthopaedics.
- There has been a suspension of incomplete waiting times, non-admitted and diagnostic waiting times for patients at the QE site in July following implementation of the new patient administration system. LGT aim to resume reporting within 3 months.
- The Lewisham site has struggled to achieve the A&E 95% standard over the last 2 weeks.
- A letter from LAS regarding current pressures and the impact on patients was included in the papers.

MR highlighted that the indicator ‘older people over 75 emergency admissions’ needs to be update.

**Action:** MH to update the performance indicator ‘older people over 75 emergency admissions.’

In response to RW’s question regarding the performance graph for ‘cancer first treatment 62 days’ MH stated that there is an action plan to improve performance by the beginning of Q3 2014/15.
RW stated that LAS give no assurance that performance will improve and consideration should be given as to whether these indicators should be red. MH highlighted that the graphs show a rolling year. MW suggested that in some areas the CCG are being measured on performance from April 2014 and therefore the RAG rating should be based on the performance since April 2014. SM suggested a further column outlining the frequency of data.

**Action:** Review whether performance report should include frequency of data and what the RAG rating represents.

RW requested that the exception report on Cdifficile with progress against actions is brought back to the Committee.

**Action:** Exception report on Cdifficile for the November meeting.

FM stated that patients want to be seen quickly and the health service is not and cannot meet that demand consistently. Patients are treated individually and privacy is respected but this demands staff and resource. The public need to be engaged on different models of delivery to meet the rising demand for services i.e. group therapy for MSK. MW suggested this was a discussion for a Governing Body workshop.

**Finance**

TR gave the finance report. At month five the CCG is reporting an overall underspend of £1.7m, this represents a £0.11m favourable variance against plan. The CCG is forecasting to deliver its £3.81m planned surplus in full. The following was highlighted:

- The acute budget year to date is £2.41m over-spent and the forecast year end position is a £4.63m overspend. This is being offset by small underspends in other budgets and by the release of £3.9m of reserves. Whilst the current overspend is affordable the CCG is using its investment funds to manage in-year risk. The reserves will need to be replenished which will mean increasing the QIPP in 2015/16.
- The CCG has received £1.54m non-recurrent funding for RTT. A further £2m funding is expected for the winter schemes.
- 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. All staff will be reminded to authorise invoices on time or place on an appropriate hold.

**QIPP: Exception Report – A&E Attendances**

DB gave the report. At month 4 A&E attendances continue to over perform in comparison to activity in 2012/13 for all providers. Consequently delivery of the 2014/15 QIPP target of £300k continues to look unachievable, with a projected under-delivery of £150k. The Urgent Care Review went to the Joint Clinical Directors/SMT meeting on 18.09.2014. The recovery plan included updates against the following actions:

- Consolidate project management
- Develop a practice engagement programme to raise the profile of the A&E QIPP position
- Maximise contract levers
- Develop a navigator post
- Implement a ‘Hello Nurse’ role
- Commission urgent care slots from GP practices
- Neighbourhood plans as part of the engagement LIS
- Work with SELDOC and the CSU on an out of hours publicity campaign
- Lewisham CCG has signed up to the SEL ‘A&E won’t kiss it better’ campaign and has commissioned addition activity.

**Lewisham CCG M4 2014/15 Contract Performance Review**

NS gave the report outlining key contractual and activity issues for Lewisham CCG at LGT, GSTT and KCG. The following was highlighted:

- Discussions are taking place over the elective overperformance at LGT
- A remedial process has agreed for July – September to tackle reporting issues on RTT. The impact on Greenwich and Bexley is much greater than Lewisham.

HE highlighted the PLT on emergency admissions on 09.10.2014 which provides a good opportunity to engage with the Membership and receive feedback.

**Action:** Support to be provided to HE on the emergency admissions PLT.

JM highlighted that 1 in 5 referrals are ophthalmology related and asked whether the Minor Eye Conditions Service was working. MW suggested that this is picked up through the RSS evaluation.

**Action:** To consider how work coming out of the RSS, i.e. ophthalmology is going to be resourced.

In response to RW’s question regarding the timeframe for the financial scenarios TR stated that the planning guidance is released in December and it is on the forward planner for the February 2015 Strategy and Development Committee.

RW stated it would be good to achieve the aim agreed at the August meeting of linking issues within the separate reports using the cover sheet.

**The Committee NOTED the Integrated Performance Report**

9. **CSU Contract Update**

TR gave a verbal update. The current contract expires on 30.09.2014. Three significant issues remain:

- Intellectual property rights
- Signing off the service specifications and KPIs
- Service credits

It is predicted that an agreement will be reached by 30.09.2014 however it is unlikely the documentation will be ready for signature.

10. **Nursing Update**

In the absence of the Nursing Director the Committee were asked whether they had any comments or questions on the report circulated with the papers which will be followed up after the meeting.

RW stated that the involvement of the public in the review was done at a late stage and asked who the patient representative on the stakeholder group were and how are they going to be involved going forward.

HE asked for an update on the recruitment for the senior leadership post and also for an update on the vacancy rates.

A written update was requested on the practice nurse audit.
Action: Responses to the questions raised on the nursing update and a written update on the practice nurse audit to be provided.

11. Contracting Round 2015/16 Process

DB gave a verbal update. Draft letters to the main acute providers setting out the CCG’s commissioning intentions have been reviewed by SMT and will be sent on 30.09.2014. MW highlighted that the letters translate what the CCG’s commissioning intentions mean for providers.

12. Emergency Planning Resilience and Response (EPRR)

BF gave the report and asked the committee to note the progress made on the CCG’s EPRR action plan, the amendments to the Business Continuity Plan (BCP) and the arrangements for the national EPRR assurance process.

The key areas for the CCG to address in its EPRR action plan were highlighted:
- To ensure Lewisham Care Homes have adequate Business Continuity Plans
- To ensure the CSU has adequate Business Continuity Plans

The Committee was also requested to confirm that the recommendations from the Hillsborough Independent Panel Report are being complied with. The CCG’s EPRR action plan provides assurance that the CCG is compliant with the recommendations.

In response to MW’s question regarding the lessons learnt from the June and August incidents BF stated that these have been included in the BCP and include:
- The need to be able to communicate to staff quickly out of hours and options to facilitate this are being reviewed
- The need to review the security contract
- That the designated lead for an incident may need to be the most senior manager present if no Director is available.

RW asked that the need for a solution to enable communication with staff quickly out of hours is included in the CCG’s EPRR action plan.

In response to JM’s question regarding public engagement in Lewisham’s business continuity plan MW stated that this was not applicable as EPRR is undertaken on a command and control basis.

The Committee AGREED that positive assurance had been received, on behalf of the Governing Body, that the CCG is aware of and prepared for its EPRR responsibilities and has a BCP that is fit for purpose, approved and tested. The Committee AGREED that the AEO could confirm that the recommendations from the Hillsborough Independent Panel Report are being complied with.

13. Key Items to be Report to the Governing Body

The key items to be reported to the Governing Body include:
- National performance issues
- The transfer of the Acute Stroke Unit from QE to UHL

14. Minutes from sub-groups

FLAG
The approved minutes of the FLAG meeting held on 14.08.2014 were taken for information.

System Resilience Group
The draft minutes of the System Resilience Group held on 03.09.2014 were taken for information.

Information Governance Steering Group (IGSG)
The approved minutes of the IGSG held on 02.07.2014 were taken for information

14. Any Other Business

There was no other business taken at this meeting.

16. Date of Next Meeting

The next meeting would be held on Thursday 23 October 2014
<table>
<thead>
<tr>
<th>REF</th>
<th>ACTIONS</th>
<th>BY WHOM</th>
<th>TIMESCALE</th>
<th>STATUS/COMMENT</th>
</tr>
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<tbody>
<tr>
<td>Sept 6</td>
<td>PREVENT training to be organised</td>
<td>AB</td>
<td>Nov</td>
<td>15.10.14: Prevent training dates organised for the 01.12.2014 and 08.12.2014</td>
</tr>
<tr>
<td>Sept 6.1</td>
<td>SLaM to be invited to a CCG Delivery Committee or FLAG meeting with extended invite.</td>
<td>AB/DC</td>
<td>Nov</td>
<td>10.10.14: A letter has been drafted to reflect LCCGs concerns but also to incorporate SEL CCGs and fulfil LCCGs role as ‘host’ commissioner for LGT.</td>
</tr>
<tr>
<td>Sept 6.2</td>
<td>DB to write a letter to LGT confirming support for the consolidation of the stroke services on the UHL site, requesting positive assurance on the areas recorded in the September minutes.</td>
<td>DB</td>
<td>Oct</td>
<td>16.10.14: Included on the agenda for 23.10.14 (item 5 enclosure 2)</td>
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<td></td>
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<td></td>
<td>10.10.14: The SEL PCC work stream meeting takes place on 29.10.14. It has been agreed that there will be an SEL approach to outlier GP practices.</td>
</tr>
<tr>
<td>Sept 7</td>
<td>DB to bring back an exception report on output 4.1(d) to the October Delivery Committee.</td>
<td>DB</td>
<td>Nov</td>
<td>16.10.14: Included on the agenda for 23.10.14 (item 5 enclosure 2)</td>
</tr>
</tbody>
</table>
| Sept 7.1 | Updates on the two Corporate Objectives outputs:  
- ‘Agree and implement a neighbourhood network model in partnership with LBL, and SLaM. Service specification to be implemented by 15/16’  
- ‘Strong communities and networks are developed to support people to live well and stay healthy and be self-directing working in partnership with the Communities’                                         | AB/DC  | Oct       | 16.10.14: Included on the agenda for 23.10.14 (item 5 enclosure 2)                                                                                                                                        |
<p>| Sept 7.2 | Further work on the corporate objectives report to cross reference other sources of information including the dashboard and risk register.                                                                   | SM     | Oct       | 16.10.14: The quality exception report records current quality exceptions. When FLAG considers an issue is no longer an exception it is removed from the report.                                   |
| Sept 8 | Ensure quality report tracks issues from previous months                                                                                                                                                                                                            | AB     | Oct       | 16.10.14: The quality exception report records current quality exceptions. When FLAG considers an issue is no longer an exception it is removed from the report.                                   |
| Sept 8.1 | Ashley O’Shaughnessy to consider the need for a Clinical Lead to support diagnostics.                                                                                                                                                                           | AO     | Nov       |                                                                                                                                                |</p>
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<tr>
<th>Date</th>
<th>Action</th>
<th>Responsible Party</th>
<th>Due Date</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sept 8</td>
<td>Joint SMT/Clinical Directors to discuss options to improve the dementia register target</td>
<td>HE</td>
<td>Oct</td>
<td><strong>16.10.14:</strong> Business case discussed and approved in principle at the Joint SMT/Clinical Directors meeting on 16.10.14.</td>
</tr>
<tr>
<td>Sept 8</td>
<td>MH to update the performance indicator 'older people over 75 emergency admissions.'</td>
<td>MH</td>
<td>Oct</td>
<td><strong>16.10.14:</strong> Completed. Included in the dashboard for the meeting on 16.10.14.</td>
</tr>
<tr>
<td>Sept 8</td>
<td>Exception report on Cdifficile for the November meeting</td>
<td>MH/Public Health</td>
<td>Nov</td>
<td><strong>16.10.14:</strong> An update on the previous Exception Report will be brought to the Delivery Committee meeting on 28.11.14.</td>
</tr>
<tr>
<td>Sept 8</td>
<td>Support to be provided to HE on the emergency admissions PLT</td>
<td>All</td>
<td>Oct</td>
<td><strong>16.10.14:</strong> Completed.</td>
</tr>
<tr>
<td>Sept 8</td>
<td>To consider how work coming out of the RSS, i.e. ophthalmology is going to be resourced.</td>
<td>DB/OO</td>
<td>Dec</td>
<td><strong>10.10.14:</strong> 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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<tr>
<td>Sept 10</td>
<td>Responses to the questions raised on the nursing update and a written update on the practice nurse audit to be provided.</td>
<td>AB</td>
<td>Oct</td>
<td><strong>16.10.14:</strong> Included on the agenda for 23.10.14 (item 5 enclosure 3a and b)</td>
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<tr>
<td>Aug 7</td>
<td>A report on the different financial scenarios to go to the Strategy and Development Committee on 05.02.2014</td>
<td>TR</td>
<td>Feb 2015</td>
<td><strong>25.09.14:</strong> On the forward planner for the Strategy and Development Committee on 05.02.2015.</td>
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<tr>
<td>Aug 9</td>
<td>TB to confirm that the CCG will not pay twice for activity through the winter monies.</td>
<td>TR/DB</td>
<td>Sept</td>
<td><strong>10.10.14:</strong> This has been considered as part of the System Resilience process. <strong>25.09.14:</strong> Action is in hand, conversations with the Trust are taking place.</td>
</tr>
<tr>
<td>July 8</td>
<td>TR to seek clarification on funding for GPs to attend safeguarding case conferences</td>
<td>TR</td>
<td>Aug</td>
<td><strong>16.10.14:</strong> TR has requested communication to be sent by SLPCSS. <strong>25.09.14:</strong> TR to ask Richard Pooley to send an email to GPs confirming arrangements. <strong>28.08.14:</strong> TR confirmed that clarification on funding for GPs to attend safeguarding case conferences was the responsibility of NHS England. TR to work with FM to disseminate this information.</td>
</tr>
<tr>
<td>July 8</td>
<td>Communication to patients on 18 weeks RTT commitment to be reviewed</td>
<td>TR</td>
<td>Sept</td>
<td><strong>16.10.14:</strong> Provider performance now included in the dashboard to be part of the Governing Body papers. Transparency of Outcomes.</td>
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<tr>
<td>Date</td>
<td>Task Description</td>
<td>Responsible Party</td>
<td>Completion Date</td>
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<tr>
<td>May 8.6</td>
<td>Business case for alternative services to IAPT</td>
<td>DV</td>
<td>October</td>
<td></td>
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<tr>
<td>May 12</td>
<td>DB and TR to produce the procurement framework including a robust procurement policy and procedure. A procurement plan for 2014/15 to be developed including timelines for specific schemes.</td>
<td>DB/TR</td>
<td>Nov</td>
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</table>

**19.09.14:** Provider performance, including 18 week RTT information to be made available to the public initially through Governing Body papers. Developing an approach around transparency of local provider data.

**28.08.14:** Clarification was requested on what communication is given by the provider to patients on the 18 week RTT pathway. Clarification on what information the CCG provides to the public, i.e. should the CCG publish provider waiting times for local providers on the internet.

**16.10.14:** Paper on IAPT recovery rates and service development options included on the agenda for 23.10.14 (item 9).

**14.08.14:** Included on the forward planner for October.

**24.07.14:** Recommendation accepted to allow the commissioning team to complete IAPT consolidation work before embarking on a review of talking therapies provision locally. Timeline to be agreed with Darren Vella and Dee Carlin.

**18.06.14:** Darren Vella taking forward.

**10.10.14:** Procurement Policy will be reviewed by the November Finance and Investment Panel.

**25.09.14:** Procurement Policy reviewed by SMT on 14.09.2014.

**16.07.14:** Procurement Policy has been drafted – review being undertaken by CFO.
AUDIT COMMITTEE

Minutes of the meeting held 16 July 2014
Room 1 Cantilever House

PRESENT

Ray Warburton Lay Deputy Chair (Chair), LCCG
Prof Ami David Registered Nurse Member, LCCG
Dr Faruk Majid Senior Clinical Director, LCCG
Diana Robbins Lay Member, LCCG
Tan VanDal Secondary Care Doctor, LCCG

IN ATTENDANCE

Lesley Aitken Board Secretary (minutes), LCCG
Paul Cuttle Internal Audit Manager, KPMG
Sue Exton Director, External Audit, Grant Thornton
Kam Johal Local Counter Fraud Specialist, LCFS
Fleur Nieboer Head of Internal Audit, KPMG
Tony Read Chief Financial Officer, LCCG
Lorraine Smedmor Governance Officer, LCCG (until item 78)
Martin Wilkinson Chief Officer, LCCG

APOLOGIES

None

AC14/72 Welcome

Mr Warburton welcomed all to the meeting and introductions were made.

AC14/73 Declarations of Interest

There were no interests declared which would knowingly affect the business of the meeting.

Mr Warburton commended all those involved in the production of the guidance for the management of conflicts of interest during a CCG meeting which is incorporated in every set of committee papers.

AC14/74 Minutes of the last meeting

The minutes of the meeting held on 3 June 2014 were agreed as a correct record.

AC14/75 Matters arising
59.4 Summary Annual Report – a communication plan to be developed – this would go to PEG for discussion. Ms Robbins reported that this was delayed as the item did not go to the last PEG meeting because of time restraints. Instead it may be discussed virtually.

- **Action Log**

The following was clarified:

14/61 – regarding the LAC report on Data Protection would come to the July Audit Committee for discussion – Mr Read reported that a draft report had been received from the London Audit Consortium (LAC). Mr Read has written to them pointing out inaccuracies.

The outcomes from the report will be brought to the October meeting.  
**ACTION:** Tony Read

Internal Audit has undertaken a follow up audit on Information Governance which is in the set of meeting papers.

The Information Governance Toolkit scores were promoted in the Annual Report.

14/63 – Internal Controls – Mr Read has responded to the six recommendations in the 2013/14 External Audit Report. As the pack of papers only showed four responses a full paper would be tabled at the appropriate time on the agenda.

Regarding access to the CCG systems; Mr Read reported that for logging onto the network security would be reviewed with the CSU. There has been a review of CSU staff and the process of reviewing CCG staff is to be undertaken with a view to authorise and de-authorise staff where necessary.

14/66 – the security leaflet to be distributed to all staff would also be sent to Governing Body members.  
**ACTION:** Kam Johal

14/50.1 – High level CCG running costs are available from the accounts, the details which sit below will be pulled together and circulated following the meeting.  
**ACTION:** Tony Read

Dr Majid asked how many people were doing similar functions across CCGs and how could best value be measured. Mr Read responded that this was difficult to ascertain and added that in-year performance appraisals can give assurance of the effectiveness of staff.

Ms Robbins said that this could be looked at in line with the underspend on RCA. Mr VanDal added that the CCG should show that it was keeping in line with its allocation, was delivering value for money and management of statutory functions.

All other actions were detailed on the action log.

- **Glossary of Terms**
The glossary has been revised in line with requirements, any comments on the content of the glossary to be sent to Ms Aitken.

- **2013/14 Year End debt still outstanding as at 30.6.2014**

Mr Read gave a report on the 2013/14 year end debt still outstanding at 30.06.14. The overdue debt reported in the accounts was £564k. By the end of June this had been reduced to £107,370 and related to two debtors – Lewisham and Greenwich Trust and St. Christopher’s Hospice. The full recovery of the debt was expected.

Mr Warburton noted that this and other items had been sent to Committee members without a cover report, which makes it difficult to prepare for the meeting and to understand what is being asked of the Committee. He asked for cover reports to be fully completed and included in all future agendas.

The Committee NOTED the report and confirmed the requirement for cover reports.

**AC14/76 Audit Committee Cycle of Business**

Mr Read presented the revised Audit Committee Cycle of Business which has been extended to June 2016. Some areas have been shaded to indicate either issues relevant to the start-up of the CCG that will not require the Audit Committee’s attention until 2017, or were one-off items. Ad hoc business has not been included. Items which fell outside of the 2014 – 2016 timeframe included:

- Re-procurement of the Internal Audit, Counter Fraud and Security Management services.
- Service Auditor arrangements for CSU which meant the removal of local internal audit arrangements for 2013/14 and reduced reporting to twice yearly.
- The Local Audit and Accountability Act 2014 will require the Audit Committee to appoint an External Auditor after 2017.

The body of evidence for the draft Annual Governance Statement (AGS) would be collected throughout the year with a progress report would come to the January Audit Committee. This would be added to the planner. Committee Chair’s reports to the Governing Body would be drafted in a way so that they can be used for the AGS.

**ACTION: Susanna Masters**

The draft Annual Report and AGS will be produced by end of March 2015. There is a need to know what the body of content will be for both reports. This will be discussed further.

**ACTION: Ray Warburton/Martin Wilkinson**

It was questioned whether the Audit Committee Annual Report was required and if so in what form. Ms Exton said that it was good practice to produce a report but that it needs only to be brief showing key areas of responsibility and how these have been discharged over the year. The report is from the Audit Committee to the Governing Body and should comply with the Code of Governance.
Mr Read added that the HFMA guidance also said it was good practice. An example of an Audit Committee Annual Report would be shared with Mr Warburton.

**ACTION: Tony Read**

The report can be produced using a self-assessment. A check list would be sent to Committee members for information, and this would include a role description and KPIs.

**ACTION: Internal and External Audit**

Mr VanDal added that all Governing Body Committees should produce an Annual Report to assess their effectiveness.

**ACTION: Martin Wilkinson and Tony Read to take forward**

The Committee AGREED that it would not produce an Annual Report for 2013/14, instead it would review its effectiveness as discussed. An Annual Report would be produced for 2014/15.

**AC14/77 Board Assurance Framework 2014/15**

Mr Wilkinson gave an update on Risk Management and the Board Assurance Framework. The new BAF went to the July Governing Body meeting which detailed the risks to the Core Corporate Objectives.

There were five objectives; three core:

1. Commission high quality care services today
2. Ensure robust governance arrangements are in place
3. Public engagement is intrinsic to all commissioning activities

And two developmental:

4. Strong Primary Care focused on population based commissioning and developing improved outcomes
5. Establish Neighbourhood care networks as part of Adult Integrated Care

The BAF would go to the next Risk Management Group for further development and to 7 August Governing Body workshop where risk appetite will be discussed.

Mr Warburton said that there had been a good discussion at the Governing Body meeting. At that meeting assurance had been given that risks were still being identified and managed while the new BAF and Risk Register are being finalised.

Mr Wilkinson added that there had been discussions around two areas; the new Corporate Objectives and associated risks and the map across of risks from last year such as LGT not focusing on community services because of the merger of the Trust with the Queen Elizabeth Hospital. Work is continuing with the neighbourhoods and a package of local incentive schemes are being developed to deliver outcomes. Discussions are being held with directors with regard to their new portfolios and there will be consultation with staff commencing 22 July and completing in September on restructure proposals.
Dr Majid said that the BAF and Risk Register (RR) had tiered risks and acknowledges that not everything can be shown. Mitigation of risks needs to occur through committees.

Ms Nieboer added that Internal Audit look at how the low level risks feed up and when they need to go onto the BAF, which is the escalation route. IA can look at how long it takes for a risk to be escalated from point of identification.

The Committee NOTED the progress made in developing the Risk Registers and BAF for 2014/15, NOTED that the risks to the two developmental Corporate Objectives were being defined and NOTED that a full review of the BAF had been arranged for the September Governing Body meeting.

AC14/78 **Internal Audit**

### 78.1 Progress Report against annual internal audit plan for 2014/15

Ms Nieboer gave the update report on the progress of the 2014/15 audit. She reported that the 2014/15 audit plan has been finalised, the Information Governance review completed and the Quality Management review commenced. IA had attended the FLAG and would attend the next Delivery Committee meeting. There was a scoping exercise underway for a Governing Body Governance review to pick up key issues including the revised structure.

The Information Governance review had achieved a Significant Assurance rating and four new low priority recommendations were made as a result of the review. Of the nine recommendations, carried forward from 2013-14, seven have now been cleared.

The Finance and Investment Committee was being held on Monday 21 July which meant that August may be too early for the Governance audit. Ms Nieboer said that the timing needs to work for a report to come back to the Audit Committee in October.

Dr Majid queried the QIPP review timing. Mr Wilkinson explained that they were looking at planning for next year and beyond and potential plans for slippage this year. IA would look at lessons learned from last year.

Regarding the Quality Management audit Mr Warburton asked if Francis recommendations were being looked at in the risk management review and whether quality assurance processes were being managed. Ms Robbins said that the Francis Working Group was being refreshed and would look at the recommendations which had been postponed this year. She stressed that this was an integral part of the quality process. The Risk Management review would provide an opportunity to pick up any issues relating to Francis that could not be covered in the Quality Management Audit. Regarding monitoring of outcomes Mr Read said that data confidence was not currently reported on. IA could share some examples with Mr Read.

**ACTION: Internal Audit**

The Committee warmly welcomed the Sector Update. Regarding the Sector update; Mr Wilkinson gave examples of work the CCG was doing around specific areas identified by Internal Audit, understanding the new NHS, Sign up to Safety Campaign, Analysis of Assuring Transformation.
data, NHS 111 and European cross border healthcare. Information on ethical procurement for GPs and CCGs would come back to a relevant Committee.

**ACTION:** Martin Wilkinson

It was agreed that a digest for the Governing Body giving a similar Sector Update would be useful. A monthly bulletin would be produced using the NHSE bulletin.

**ACTION:** Martin Wilkinson - Corporate Team/CSU

### 78.2 Information Governance Report

Mr Cuttle gave the report which reviewed the design and operation of key Information Governance (IG) controls, the review had achieved an overall assessment of significant assurance which was in line with expectations.

Six requirements had been agreed with the Information Governance Manager; three at level 3 and three at level 2.

Four areas of development have been identified, all of which have been agreed and have action plans.

IA routinely looks at IG across organisations and said that the CCG’s report was positive.

Prof David asked if it was still onerous for CCGs because of Personal Identifiable information (PID) issues. Mr Read said that the CCG does still hold PID in areas such as HR and Payroll and for Continuing Care, Mental Health and Learning Disabilities.

Mr Warburton said that it was an excellent report and was a credit to Ms Nieboer and Mr Cuttle. He said that lack of staff awareness needs to be addressed with further training sessions with the IG manager. Mr Read would write to staff to promote awareness with an invitation to training. There would be a rolling programme and review of policies.

**ACTION:** Tony Read

In response to the question of whether the Governing Body were sufficiently aware of IG issues Mr Wilkinson said that a report routinely goes to the Delivery Committee from the Information Governance Steering Group.

The Committee NOTED the content of the quarterly progress report and the Information Governance report.

### AC14/79 Service Auditor Arrangements including CSU

Mr Read tabled a letter from the SLCSU regarding Service Auditor reporting 2014/15. Deloitte as the service auditor for the SLCSU will undertake the review on the processes and controls operated in the CSU on the CCG’s behalf. Last year this was undertaken by KPMG. A response to the letter was expected by the end of June 2014 but Mr Read had informed NHSE that the matter would be discussed at the July Audit Committee therefore the response to them would be outside of their timescale.
It was proposed that there would be a mid-year and end of year report.

The areas given within their scope did not cover all business critical areas provided by the CSU, for example acute contract management was missing. The areas covered were all finance process-based:

- Financial Ledger
- Accounts Payable
- Accounts receivable
- Financial Reporting
- Treasury and Cash Management
- Payroll (HR processes)

The question was raised on whether the CCG could influence Deloittes on which services to cover. How would the CSU assure the CCG on areas provided over and above the list given such as IFR, HR, ICT and Business Continuity?

Mr VanDal said that as the CCG would not be assured on some of the services provided by the CSU, could we ask an organisation such as KPMG to undertake an audit?

Mr Read said that the question would be asked if IA (KPMG) could look at those areas not covered by Deloitte.

Mr Read would clarify if the statement in the letter which states customer’s internal and external auditors not being permitted access to the CSU relates just to the areas mentioned (in list above) and also to clarify who would pay for audits of the other services provided.

The Committee NOTED the letter

AC14/80   External Audit

80.1 Progress Report

Ms Exton gave a verbal update. External Audit’s review of the Annual Report and Accounts was completed on 5 June. The Annual Audit Letter 2013/14 would now be drafted and sent to Mr Read by the end of July. This would go to the September Governing Body meeting.

The External Audit Plan 2014/15 would commence in the autumn.

80.2 Response to 2013/14 External Audit Report recommendations

Mr Read tabled the covering report for the management response to recommendations made in ISA 260 report from External Audit concerning 2013/14 audit findings.

There were six recommendations for the CCG; two which related to ICT and ledger access controls and four that related to preparation of the accounts.
It was acknowledged that there had been problems with the Pension Agency this year with accessing information in particular with GP information.

Regarding prescribing accrual, this recommendation had not been fully agreed as Mr Read considered that the PPA forecasts to be the most reliable basis for accrual. This would be reviewed next year.

In conclusion, all recommendations had been accepted with a caveat regarding prescribing accrual.

The Committee NOTED the management responses

AC14/81 Counter Fraud Annual Report 2013/14

81.1 Review LCFS Annual Report for 2013/14

Ms Johal gave the report which detailed all the counter fraud work undertaken during the financial year 2013/14 in the key generic areas of the NHS Counter Fraud Strategy.

A copy of the Annual Report which included the signed declaration from the Chief Financial Officer was submitted to NHS Protect on 30 June 2014. Ms Johal highlighted some of the initiatives which had been undertaken in 2013/14:

- An Anti-Bribery Risk Assessment Tool (RAT) was developed for the CCG which demonstrated procedures in place and ensured that the CCG implements anti-bribery requirements. The review gave 12 recommended areas of action of which 11 have been completed and one is currently in progress.

- The Counter Fraud survey which comprised 16 questions was issued to all staff (68 staff were directly employed by the CCG) and in total 38 responses were received.

- A Counter Fraud leaflet was attached to the August payslip.

- Leaflets and posters were produced for the CCG.

- Awareness training has been given to staff

- Input into CCG policies

In response to a question on the staff response rate to the staff survey, Mr Read said that this was a better response than from other SEL CCGs; it was more than a 50% return. Ms Johal would look at other ways to engage staff and completing surveys, an e-learning package was being produced.

‘Fraud Watch’ the London Audit Consortium’s in-house counter fraud newsletter which had been shared with CCG employees would be sent to Governing Body members.

ACTION: Kam Johal
Ms Johal confirmed that third party assurance had been sought and received from Essentia (non-clinical procurement) that anti-bribery training had been completed by their hosts GSTT and Solent Supplies (clinical procurement).

A letter is to be sent out annually to current and future contractors which would enforce the CCG’s stance on bribery. This was good practice.

At the last Audit Committee it was agreed that the KPIs for Counter Fraud and Anti-Bribery would be prioritised, Mr Read explained that the KPIs had been included in the tender specification and Ms Johal had suggested the KPIs for services which had been adopted. The outcomes need prioritising; these would come back to the October meeting.

**ACTION: Kam Johal/Tony Read**

Ms Johal reported that the standards have been approved by NHSE but not yet released. Mr Wilkinson would write to them to request their release.

**ACTION: Martin Wilkinson**

The Committee NOTED the Annual Counter Fraud Report for 2013/14.

**AC14/82  Local Security Management Specialist (LSMS) Review**

**82.1 Security Management Annual Report for 2013/14**

Mr Read gave the report, produced by the Local Security Management Specialist Tony Brown, which provided details of all security management work undertaken at the CCG during 2013/14. Awareness sessions on security for the building and staff were held during the year. Two incidents regarding Cantilever House had been investigated and action plans are now in place.

Tony Brown would also provide security training to non CCG (NHSE) staff in Cantilever House. He would also look at a door entry policy in order to restrict tailgating.

This report would be signed by Mr Read and sent to NHS Protect by 31 July 2014.

The Committee NOTED the Annual Security Management Report 2013/14

**82.2 Progress Report**

Mr Read gave the report which detailed the progress made by LSMS since the last Committee meeting.

Policies had been discussed with the Head of Integrated Governance and changed to suit CCG format.

The Committee received the LSMS progress report for information only.

**AC14/81  Detailed Financial Policies – Detailed Budget Setting Guidance**

Mr Read tabled a report which related to Internal Audit’s review on budget preparation and control arrangements within the CCG and describes how movement in budgets is acted upon but not how
money is budgeted. It is a good practice procedure and has been brought to the Audit Committee for information. This will form part of a suite of comprehensive financial policies. This will be discussed further at the Finance and Investment Committee and go to the Governing Body for approval.

It was acknowledged that Internal Audit had concluded that budget holders were dealing with their specific budgets appropriately.

It was to be decided whether any major changes to budgets would be reported to either Finance and Investment Committee or Governing Body.

ACTION: Tony Read

The Committee received the report on detailed budget setting guidance for information.

AC14/82 **Review of losses and special payments**

Mr Read reported that there were no losses or special payments to report since the last meeting.

AC14/83 **Waiver of SFIs**

Professor David declared an interest in this item and left the meeting.

Mr Read tabled the waiver of tender in regards to a single source supplier for a review of District Nursing Services. The Business Case has been previously discussed in January 2014 at a Management Team meeting where the level of concern from CCGs had been acknowledged which highlighted the urgency in completing the review. A review had been undertaken for two other London CCGs recently and a team of professional reviewers was still in place and could be utilised for Lewisham’s review. The team is employed through AD Community Nursing Consultancy which is a subsidiary of Prasand International Limited which is owned by Professor David.

The waiver was requested as the team used was experienced and were able to undertake the review quickly; the review had a value of just over £10k. All the reviewers had academic links.

Mr VanDal said that it was irrelevant that the review had been successful, what matters for the Committee was whether the process was appropriate or not. Mr Wilkinson responded that the rationale for the single waiver had been met. The management team would look at lessons learned from the process. There was a retrospective opportunity for scrutiny.

Mr Read added that there was justification for the expediency of making the decision to enable the use of a proven supplier. He acknowledged that the proper process had not been followed at the time and the use of the company required a declaration from a Governing Body member.

Mr Warburton said that this should not have happened; there is a need to be transparent and appropriate. He noted that the conflict of interest would not have been discovered except for a passing remark made at a Governing Body meeting.
Internal Audit, through the governance review of financial systems this year, would look for assurance that this situation would not happen again.

It was noted that the Audit Committee has had the opportunity to discuss the issues and sought assurance that this would not happen again.

Mr Read said that he would raise awareness and budget and expenditure commitment training with CCG staff.

ACTION: Tony Read

Mr Warburton thanked Mr Wilkinson and Mr Read for their openness.

The Committee NOTED the waiver and acknowledged that further management learning was required.

Professor David re-joined the meeting.

AC14/84 Constitutional requirements of NHS Trusts’ and Clinical Commissioning Groups’ audit committees

Mr Read gave the report. In 2013 DH consulted on proposals for new constitutional requirements for audit committees in preparation for the Local Audit and Accountability Act 2014. In March 2014 the Audit Committee reviewed a self assessment against the proposals. Although the Committee is appropriately constituted the DH requirements include the following which would be considered:

The Audit Committee, to ensure appropriate levels of skill and experience, may also include members who are:

- Non-Executive members of the health service body’s governing board but do not meet the definition of independent
- Independent persons, who are not members of the governing board.

For clarification it was considered that Clinical Directors were akin to Executive Directors and the Lay Members, Secondary Care Doctor and Registered Nurse akin to Non-Executive Directors. Independent members, who are not Governing Body members, should meet the criteria which was laid out on page 105 of the Constitutional Requirements. There were two ways to appoint an independent member; by going through an appointment process or by buddying with neighbouring CCG Audit Committees and using their skills.

Currently, and atypically, the Committee does not include any members with a professional accountancy qualification and the question was raised whether this was a necessity. An option would be to hold ‘understanding’ sessions run by an external organisation for core members.

Ms Nieboer said that rather than having a professional accountancy qualification having a member with reasonable relevant financial experience would be sufficient, a self-assessment could be held to see what skill sets were required. Dr Majid added that the Audit Committee represents all work of the CCG, not just financial.
It was agreed that Audit Committee members would discuss this issue outside of the meeting. Their conclusions on how to proceed would come back to the next meeting.

**ACTION:** Ray Warburton

The Committee NOTED the Government’s response to the consultation and would consider the skills range required by Audit Committee members and the benefits of extending the Audit Committee membership to include additional independent members and the process for recruitment outside of the meeting.

**AC14/85 Progress Report on appointment of Local Counter Fraud Services and Local Security Management Services**

Ms Johal left the meeting for this item.

Mr Read gave a verbal report on the progress report on the appointment of LCFS and LSMS. The LCFS and LSMS services were provided by London Audit Consortium who were contracted to the CSU who in turn had a contract with the CCG. The contracts with LCFS and LSMS would expire on 30 September 2014.

The six SEL CCGs had gone through a competitive quotation process. Two quotations had met the required criteria. Mr Read said that the evaluation would be completed by 18 July. Once the preferred provider had been recommended Mr Read would inform the Committee.

**ACTION:** Mr Read

The Committee NOTED the verbal report

Ms Johal re-joined the meeting.

**AC14/86 Register of Gifts and Hospitality**

Mr Read gave the report. It was agreed that the Committee would only see the register in future with declined entries included. The item would go to the September Governing Body.

It was noted that entries to date relate to a few staff. It was queried whether all staff are aware of the need to declare.

Mr Read said that staff have been made aware of the policy and that he would follow this up at a staff briefing.

**The Committee NOTED the Register of Gifts and Hospitality Register to 8 July 2014.**

**AC14/87 Business of other committees and review inter-relationships**

Mr Warburton acknowledged that the Finance and Investment Committee would not duplicate the work of the Audit Committee. He was pleased to see that the Governing Body workshop on 7 August would focus on the BAF.

**AC14/89 Any other business**
There was no other business reported.

**AC 14/90  Date of next meeting**

Tuesday 28 October 2014; 2pm – 5pm at Cantilever House.
1. Welcome and Introductions

DA welcomed all to the meeting. It was agreed that Membership of the Committee would be reviewed as part of the review of Clinical Directors' portfolios.

Action: Review of Strategy and Development Committee Membership terms of reference regarding membership and quorum rules.

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 5th June 2014 were agreed as an accurate record.

4(b) Review of Action Log/Tracker

05.06.2014/5: Action deferred to October. As of 1st September 2014 the public engagement function was relocated to the Corporate Directorate. SM to meet with DR to review the PEG terms of reference.

05.06.2014/6a: Maternity Commissioning Steering Group Terms of reference included on the agenda for 04.09.2014 – item 6. Action closed
05.06.2014/7a: CCG 5 year Strategy included on the agenda for 04.09.2014 – item 7. Action closed.

05.06.2014/7b: Further discussion on membership engagement with the CCG Strategy required under item 7. Action closed.

05.06.2014/7c: Revised public health profile included in the draft strategy plan. Action closed.

05.06.2014/7d: The fall in emergency admissions per registered population relates to those that should have alternative care pathways and those that should not usually be admitted. First to follow up ratios is monitored by the Delivery Committee and there has been a rise. Further information was requested for the October meeting of the Strategy and Development Committee when the Monitoring Framework is reviewed.

05.06.2014/7e: The monitoring framework showing the key comparisons against our like CCGs or local Trusts has been provided. Action closed.

05.06.2014/7f: Communication on the stakeholder survey feedback was included in the stakeholder newsletter. Action closed.

05.06.2014/7g: A list of the Membership practices who did not respond to the stakeholder survey is not available. Action closed.

05.06.2014/8a-8e: Actions relating to the Communications Framework have been deferred to October.

05.06.2014/9: TR sent an email on 09.06.2014 to Andrew Bland, Southwark Chief Officer, regarding the KCH service move proposals. The Overview and Scrutiny Committee decided that the proposals did not amount to a substantial variation. Action closed.

03.04.2014/5: The Quality Summit feedback was presented at the July FLAG meeting and August Membership Forum. Action closed.

06.03.2014/7a: Communication to the Membership on the 2014/15 budget is outstanding. It was agreed that this action would be transferred to the Joint Clinical Directors and SMT meeting action log. The integrated performance report to be tailored for the Membership.

06.03.2014/7b: The Governing Body discussed risk management and risk appetite at their workshop on 07.08.2014. Action closed.

02.01.2014/10a: Action is outstanding. The SEL benchmarking group has not met – escalation required.

5. Report from PEG and JPEG

The Committee received the written report of the PEG and JPEG meetings on 01.05.2014.

The PEG report highlighted the extent to which engagement has become a reality in a number of areas of CCG business but raised concern that this may not be the case across organisations in Lewisham.

The JPEG report raised concern that there is no coordinated, systematic engagement plan in place to support the implementation of the HWBB’s priorities. DR has written to Danny Ruta regarding the engagement plan linked to the HWB Strategy and further discussions are taking place with Lewisham Council.
MR requested a briefing from Lorna Hughes and CM-S prior to his meeting with the new Healthwatch Chair on 26.09.2014.

**Action:** LH and CM-S to provide a public engagement briefing to MR prior to his meeting with Healthwatch on 26.09.2014.

Further discussion of the progress reports were deferred to the October Strategy and Development Committee.

**The Committee NOTED the reports.**

6. **Report from the Maternity Commissioning Steering Group**

JE presented the report and highlighted the following areas of focus:

- The development of midwifery led community based continuity of care that puts the mother and child at the centre of care.
- The implementation of the Perinatal Institute’s still birth FGR toolkit to identify women and babies at risk.
- Identification of space in children’s centres and other community premises for midwifery teams. Three premises have been found.
- Comment on the maternity CQUINS
- Monitor the LGT’s CQC maternity action plan
- Inform the SEL Maternity Clinical Leadership Group
- Implementation of a CLARHC funded research pre-term birth study at LGT for women meeting certain criteria in Lewisham

The Committee made the following comments:

- Communication on maternity services to be developed for the Membership
- SLaM could be approached regarding estates capacity
- The gap left by the resignation of Judy was noted. Until a new Clinical Lead is appointed, Alison Browne, Nurse Director, will Chair the Steering Group.
- Future progress reports to include evidence of engagement
- Future progress reports to reflect outcome measures and report on impact as well as process

In response to DA’s question regarding the quality of postnatal care JE responded that one of the drivers for the maternity model is to improve postnatal care in the community. The CQC report also highlighted poor postnatal inpatient care which is being addressed through the CQC action plan.

In response to MR’s question about links between LGT’s two sites JE responded that there is one team however not all protocols have been merged.

In response to FM’s question about low birth weight JE responded that this is not a greater problem in Lewisham compared to the rest of London. Whilst it is an issue a recent Public Health report shows there has been some improvement.

MW highlighted that it would be useful if a Clinical Director could attend the launch of the SEL Maternity Network on Monday 29th September, 12:00 – 14:00 in the Governor’s Hall, St Thomas’ Hospital.

7. **CCG 5 Year Strategy**

CM-S presented an updated version of the CCG’s strategy incorporating changes made following the discussion at the June Strategy and Development Committee meeting. The following changes to the CCG Strategy were highlighted:
- revised vision and ambition to show the expected shift in care settings,
- revised population health needs assessment,
- analysis of member and public engagement outcomes and how they inform strategic priorities,
- revised equalities analysis.

In response to CM-S's question on how to present and develop the CCG's ambition and ensure that it is clear and owned by the Membership and local population the Committee made the following comments:

- The vision needs to be more granular and demonstrate what it might mean for practices, the population and providers
- The wording and graph on page 14 do not reflect the same ambition. The wording describes a shift in resources to commission more services in community however the graph shows the same percentage of expenditure on community services in 2014/15 and in 2018/19. It was suggested that groups of expenditure are put together and expressed as a range.
- Concern was expressed about focusing on a shift in resources; the strategy should instead express confidence in the service plans, a consequence of which will be a shift in resources.
- The ‘Best Value’ section is short and focuses on money; this could be broadened to include efficiency and productivity.
- The public are interested in what services looks like, i.e. friendliness, timeliness, professionalism and where services are based. A compromise is needed between the clinical and social model of healthcare.
- Include how the SEL models work for Lewisham
- The potential impact on LGT cannot be hidden. There is a gap between what the CCG plans to spend with LGT and the Trust’s income plans.

**Actions**
- TR to update the financial case for change and expenditure model to reflect the ambition.
- A summary to be prepared for Members for engagement during September.

The Committee NOTED the changes made to the CCG 5 year Strategy and NOTED further work will be undertaken to develop the clarity of the vision and ambition at the October Governing Body Workshop.

8. **Primary Care Strategy 2014-216**

AO and PT presented the Primary Care Strategy which details the actions that Lewisham CCG will take to support primary care providers to improve local health outcomes and the quality of health care services. The strategy is aligned with the SEL strategy on primary care. The strategy has been developed in consultation with the Governing Body, the Primary Care and Planned Care Group, Public Health, LMC and the Membership.

The Committee made the following comments:
- The importance of the role that the supporting strategies and implementation plans will play in delivering the aims of the primary care strategy was highlighted
- The outcome measures need to be more clearly defined and aligned with the operating dashboard
- Ensure consistency in terminology – 44 GP practices (sites) 42 GP practices (partnerships).
- Include pharmacist and optician sites on the map
- It was recognised that the strategy focuses largely on GP practices however future development will broaden the focus of the strategy to other primary care provision
- Revise section 7.5 to refer to the SEL strategy rather than the CBC strategy.
- Refer to neighbourhoods as geographical populations rather than 1,2,3,4.
The Committee RECOMMENDED that the Governing Body APPROVE the Primary Care Development Strategy 2014-2016.

9. **Equalities and Diversity Update**

CM-S gave the report providing an update on progress made regarding the EDS2 assessment and proposing changes to the CCG’s equalities objectives.

Following the Equality and Diversity Summit in May 2014 the objectives have been revised as follows:

- **Objective 1:** Reduce the gap between BME patients’ experience and White British patients’ experience in relation to feeling supported with their long term condition.
- **Objective 2:** Assure the effectiveness of the Lewisham GP Patient pack that has been improved and rolled out to GP practices to support increased understanding of navigating the NHS.
- **Objective 3:** Ensure that Collaborative Care Plans are communicated well.
- **Objective 4:** Ensure that papers that come before Lewisham CCG’s major committees identify equality-related opportunities, risks and say how these risks are to be managed.

The Committee made the following comments:

- Of the inequalities already identified there is no coherent plan for rectifying them. Further information needs to be coming through to the Delivery Committee.
- Objective 4 is a process and part of everyday business rather than an objective. It was noted that it is an area that the CCG needs to develop and improve on. It was agreed to revise the objective to ensure that the Governing Body can evidence it has appropriately considered the public sector equality duty in its decision making.

Governing Body Members have been asked to provide examples of how they have demonstrated commitment to Equality and Diversity since April 2013. A template for responses has been circulated and should be returned to Valerie Richards, Equality and Diversity Lead, by 12.09.2014.

**Actions**

- CM-S to revise objective 4
- CM-S to resend email relating to evidence collection for the equality delivery system to Governing Body Members

The Committee APPROVED the changes to the Lewisham Equality Objectives subject to the revision of objective 4 and NOTED the progress made regarding the EDS2 assessment.

10. **Joint Commissioning Intentions for Integrated Care**

SM presented the report requesting that the Committee note the proposed scope and content of the Joint Commissioning Intentions for Integrated Care, endorse the proposed process and timeline to produce the Commissioning Intentions and note the guidance for the Better Care Fund.

Informed by the refreshed CCG Commissioning Strategy and the CCG’s Operating Plan, three priority areas for action have been identified to achieve system wide change: community wide engagement and development, strong primary care, and integrated community based care.

The Joint Commissioning Intentions will seek to align the collective resources available through the BCF, the Council’s (Adult Social Care and Public Health) budget and the CCG’s budget. SM gave a presentation on the local action plans demonstrating how these align to the Better Care Fund.

**Community wide engagement and development (BCF – Scheme 1)**

- Promoting healthy life styles
- Developing a Single Point of Access
- Supporting community networks
- Enhancing the support to all carers

**Primary Care (BCF – Scheme 2)**
- Focusing on prevention
- Increasing earlier identification
- Supporting patient education and self-management
- Reducing variation in care between practice
- Improving quality of urgent care

**Community Based Care – Neighbourhood community care (BCF – Scheme 3)**
- Neighbourhood Community Teams
- Disability Facilities Grant
- Adult Mental Health
- People with learning disabilities and / or physical disabilities

**Community Based Care – Enhances care and support (BCF – Scheme 4)**
- Establishing alternatives to hospital stay
- Ensuring effective, fast response and assessment

**Supporting Enablers (BCF – Scheme 5)**
- Public communication and engagement
- Workforce
- Information Technology
- Commissioning
- The Care Act
- Programme support for Adult Integrated Programme

SM outlined a common specification for all providers focusing on the continuous improvement in quality of care. Commissioners are to expect the provider to demonstrate evidence of how they have met their commitments.

The Committee made the following comments:
- Concern was expressed about the implication of costs for the CCG
- The diagram should show the three priority areas for action at the top with an arrow going down to deliver the strategic priorities.
- A lot of time is spent in GP practices attending to the ‘worried well’ this service is not commissioned for. This needs to feed into the discussion concerning access and patient experience in the Primary Care Stream.
- The common specification for all providers to also go to primary care
- Would like to see a commitment from the provider to match capacity to commissioner plans.

The Committee NOTED the proposed scope and content of the Joint Commissioning Intentions for Integrated Care with further work to be done through the AICP. The Committee ENDORSED the process and timeline to produce the Commissioning Intentions and NOTED the Guidance for Better Care Fund.

11. **SEL Strategy**

**NHS England Feedback**

CM-S gave the report. Areas highlighted for improvement or action by NHS England include:
- Further development of the strategy through a local health economy partnership group to ensure ownership of the Strategy
Further development through the clinical leadership groups to provide more detailed service models and their workforce implications.

A gap is identified between the strategy costs and providers projected income assumptions, specifically that Lewisham Hospital assumed £288m more income.

The Committee NOTED the feedback received from NHS England on the South East London Strategy and NOTED that further work was taking place prior to a further review meeting in October.

Clinical Feedback
MW requested that clinical feedback forms particularly highlighting any areas of concern were completed before the October Strategy and Development Committee.

Action: CM-S to circulate clinical feedback form.

12. Organisational Development Plan

CM-S gave the report and requested comments on the updates to the CCG’s organisational development plan particularly on the summary development needs.

13. Items for Information

SEL Commissioning Strategy Programme
The SEL Commissioning Strategy Programme July 2014 Briefing was taken for information.

Commissioned Child and Adolescent Mental Health Provision
The current arrangements for commissioning child and adolescent mental health provision in Lewisham were noted.

14. Minutes from sub-groups

Children’s Young People’s Joint Commissioning Group: The approved minutes of the meeting held on 30.03.2014 were taken for information.

Public Engagement Group: The approved minutes of the meeting held on 01.05.2014 were taken for information.

Joint Public Engagement Group: The approved minutes of the meeting held on 01.05.2014 were taken for information.

Adult Integrated Care Programme Board: The Chair’s report of the meeting held on 08.01.2014 was taken for information.

15. Any Other Business

There was no other business.

16. Date of Next Meeting

Thursday 2nd October 2014.
<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>04.09.2014/1</td>
<td><strong>Strategy &amp; Development Committee</strong>&lt;br&gt;Review of Strategy and Development Committee Membership terms of reference regarding membership and quorum rules</td>
<td>CDs</td>
<td>October 2014</td>
<td>23.09.2014: Included on the agenda for 02.10.2014, item 5</td>
</tr>
<tr>
<td>04.09.2014/5</td>
<td><strong>Public Engagement</strong>&lt;br&gt;LH and CM-S to provide a public engagement briefing to MR prior to his meeting with Healthwatch on 26.09.2014</td>
<td>LH, CM-S</td>
<td>September 2014</td>
<td>25.09.2014: Meeting postponed, to be re-arranged – date to be confirmed.</td>
</tr>
<tr>
<td>04.09.2014/7a</td>
<td><strong>CCG 5 Year Strategy</strong>&lt;br&gt;TR to update the financial case for change and expenditure model to reflect the ambition.</td>
<td>TR</td>
<td>January 2015</td>
<td>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>04.09.2014/7b</td>
<td><strong>CCG 5 Year Strategy</strong>&lt;br&gt;A summary to be prepared for Members for engagement during September</td>
<td>CM-S</td>
<td>October 2014</td>
<td>25.09.2014: CCG 5 year strategy – to be finalised with development of revised 5 year strategy</td>
</tr>
<tr>
<td>04.09.2014/11</td>
<td><strong>SEL Strategy</strong>&lt;br&gt;CM-S to circulate clinical feedback form.</td>
<td>CM-S</td>
<td>October 2014</td>
<td>25.09.2014: Revised form to be tabled at the meeting on 02.10.2014.</td>
</tr>
<tr>
<td>05.06.2014/5</td>
<td><strong>PEG</strong>&lt;br&gt;DR to review the focus of PEG with Faruk Majid, Diana Braithwaite and Lorna Hughes</td>
<td>DR</td>
<td>October 2014</td>
<td>04.09.2014: Action deferred to October. As of 1&quot; September 2014 the public engagement function was relocated to the Corporate Directorate. SM to meet with DR to review the PEG terms of reference.</td>
</tr>
<tr>
<td>05.06.2014/6a</td>
<td><strong>Primary Care Development Group ToR</strong>&lt;br&gt;Terms of Reference to be revised</td>
<td>AO</td>
<td>September 2014</td>
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</tbody>
</table>
### Strategic Outcomes Monitoring Framework

Further analysis on acute data on the fall in emergency admissions and first to follow up ratios to understand the reasons behind the falls

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
<th>Responsible</th>
<th>Due Date</th>
<th>Notes</th>
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<tbody>
<tr>
<td>04.09.2014</td>
<td>Further information was requested for the October meeting of the Strategy and Development Committee when the Monitoring Framework is reviewed.</td>
<td></td>
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</tr>
<tr>
<td>29.08.2014</td>
<td>Fall in emergency admissions per registered population relates to those that should have alternative care pathways and those that should not usually be admitted. First to follow up ratios is monitored by delivery committee and there has been a rise.</td>
<td></td>
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</table>

### Communications Framework

- **Revise the Communications Framework and action plan and bring back to the next meeting**
- **Review the methods of achieving accessibility of communications used by the CCG, balancing cost and accessibility, to determine the most appropriate methods for the CCG to use.**
- **Collate and review the evidence on how the preferred method of communication for CCG’s Stakeholders to inform the communication strategy**
- **Extend the stakeholders analysis**
- **To find out about the website pilot using different languages**

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<tbody>
<tr>
<td>23.09.2014</td>
<td>Included on the agenda for 02.10.2014, item 9.</td>
<td>PF</td>
<td>October 2014</td>
<td>29.08.2014: Action outstanding deferred to October</td>
</tr>
<tr>
<td>23.09.2014</td>
<td>Included on the agenda for 02.10.2014, item 9.</td>
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</tr>
<tr>
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<td>PF</td>
<td>October 2014</td>
<td>29.08.2014: Action outstanding deferred to October</td>
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### Commissioning for Value - Benchmarking

MH to follow up findings with analytical teams in South East London and with CBC.

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<tr>
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<th>Due Date</th>
<th>Notes</th>
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</thead>
<tbody>
<tr>
<td>29.08.2014</td>
<td>Action is outstanding. The SEL benchmarking group has not met – escalation required.</td>
<td>MH</td>
<td>Mar 2014</td>
<td>03.04.2014: Action is outstanding. The SEL benchmarking group has not met.</td>
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</tbody>
</table>
MINUTES OF THE HEALTH AND WELLBEING BOARD
Thursday, 3 July 2014 at 2.00 pm

PRESENT: Mayor Sir Steve Bullock (Chair), Cllr Chris Best (Cabinet Member for Community Services), Aileen Buckton (Executive Director for Community Services, LBL), Dr Danny Ruta (Director of Public Health, LBL), Frankie Sulke (Executive Director for Children and Young People, LBL), Elizabeth Butler (Chair, Lewisham and Greenwich Healthcare Trust), Jane Clegg (Delivery, NHS SE England – South London Area, London Region), Tony Nickson (Director, Voluntary Action Lewisham), Peter Ramrayka (Voluntary and Community Sector), Chris Freed (interim representative of Healthwatch Lewisham), Brendan Sarsfield (Family Mosaic).

IN ATTENDANCE: Jade Fairfax (Healthwatch Lewisham), Dr Roger Green (Goldsmith’s College, University of London), Laura Harper (Housing, Health and Social Care Integration Project Manager, LBL), Joseph Knappett (Service Manager, Performance, Community Services, LBL), Carmel Langstaff (Service Manager, Strategy and Policy, Community Services, LBL), Genevieve Macklin (Head of Strategic Housing, Customer Services, LBL), Corinne Moocarme (Joint Commissioning Lead, Community Support and Care, CCG/LBL), Nickie Roome (Campaign in Lewisham for Autism Spectrum Housing), Dr Donal O’Sullivan (Consultant in Public Health Medicine, LBL), Simone Riddle (Lewisham Healthwatch), Sarah Wainer (Head of Strategy, Improvement and Partnerships, Community Services, LBL), Martin Wilkinson (Chief Officer, Lewisham Clinical Commissioning Group, for Dr Marc Rowland, Lewisham CCG), Kalyan DasGupta (Clerk to the Board, LBL).

Apologies were received from Dr Marc Rowland (Chair, Lewisham Clinical Commissioning Group and Vice-Chair, Lewisham Health and Wellbeing Board) and Dr Simon Parton (Chair, Lewisham Local Medical Committee).

1. Minutes of the last meeting

1.1 The minutes of the previous meeting (25 March 2014) were agreed as an accurate record, with the following amendment (under Item 2, “Declarations of Interest”): Cllr John Muldoon’s credentials should read, “elected governor of South London and Maudsley (SLaM) NHS Foundation Trust, representing the public constituency of Lambeth, Southwark, Lewisham and Croydon.”

1.2 There were no matters arising.

2. Declaration of Interest

2.1 There were no declarations of interests.
3. **South East London Commissioning Strategy**

3.1 The draft strategy was presented by Martin Wilkinson (Chief Officer, Lewisham Clinical Commissioning Group).

3.2 A further version of the strategy, focusing on local implementation, will be submitted to the Board in September 2014.

3.3 The following points were raised or highlighted in the discussion:

- The key priorities are well aligned to Lewisham’s local ones, although there are differences between regional and local implementations of the strategy. Further iterations will ensure alignment with other key strategies. Martin Wilkinson will update the HWB as the local strategy develops.

- The key principles that underpin the HWB strategy, e.g. integration and prevention, are embedded in the SEL strategy.

- The ultimate responsibility for the strategy lies with the Governing Body of the CCG.

- Because there is no 6-borough cluster of local authorities in South-East London to match the CCG cluster, the strategy places particular responsibility on the HWB members across south east London to act collaboratively.

3.4 The Board noted the draft South East London Commissioning Strategy.

4. **Adult Integrated Care Programme update**

4.1 Sarah Wainer (Head of Strategy, Improvement and Partnerships, Community Services, LBL) presented the report, and highlighted the following points:

- The Care Act received Royal Assent on 14 May 2014. The Act represents a major reform of the law relating to the care and support of adults and their carers and sets out a number of new duties.

- New guidance on the Better Care Fund is awaited.

- A series of events with respect to the Adult Integrated Care Programme has taken place. The 26 June 2014 workshop to review and further develop the neighbourhood model was very well attended and provided a good platform to take the work forward.

4.2 The following points were raised or highlighted in the discussion:
• The language in which the various sectors communicate and use in their work is not always shared and fully understood by all.

• Brendan Sarsfield commented that leadership and culture were critical to the success of integration.

4.3 The Board:
1. Noted the updates provided in sections 4 and 5 which are relevant to the Integration Programme;

2. Noted the activity in relation to planning and setting of Commissioning Intentions;

3. Agreed that the Board’s work programme should include those priority areas for 2014/15 identified in paragraph 5.1.6 of the report; and

4. Agreed the proposals for enhancing communication and engagement activity (as set out in section 7 of the report).

5. Agreed that a report on Lewisham’s progress in relation to the implementation of the Care Act will be presented to the Health and Wellbeing Board at its next meeting.

5. Housing and Health in Lewisham

5.1 Genevieve Macklin (Head of Strategic Housing, Customer Services, LBL) presented the report, setting out the wider relationship between housing and health/wellbeing that goes beyond the previously discussed new models of housing for older residents.

5.2 The report highlighted the following points:

• Residents’ health and wellbeing are affected by housing issues chiefly in three ways:
  - The quality and condition of homes
  - The provision of new housing, and
  - The management of homelessness.

• Partner agencies should work together to:
  - Expand and further prioritise the current focus on targeted support and prevention;
  - Share intelligence for specialised and other housing;
  - Pilot the provision of a housing advice service in health settings, and
  - Support the Warm Homes Healthy People Project.

5.3 The following points were raised or highlighted in the discussion:

• Integrated working is key to improving health and wellbeing within the housing agenda.
• Anyone can access the Handyperson Scheme, but this may be more effective if targeted.

• The model required for housing provision in the Borough is one that factors in longer life expectancy.

• Loneliness and lack of accessible information can be addressed through the Information and Advice Workstream of the Adult Integrated Care Programme, as well as through the voluntary sector.

• Brendan Sarsfield suggested that the housing strategy should be driven by health rather than the impact of homelessness on health.

• Martin Wilkinson agreed to explore the case for investment further with Genevieve Macklin and suggested that the recommendations should be considered as part of the Adult Integrated Care Programme and the allocation of Winter Pressures resources.

The Away Day should consider some of the strategic aspects of the relationship between housing and health.

5.4 The Board:

1. Noted the three main areas in which housing impacts on residents’ health and wellbeing, and the work that is currently being carried out in each;

2. Agreed the recommendations made in the report which are intended to further support integrated working across housing, health and social care, namely:

   a. To further expand the current focus on prevention, in particular on interventions which have the greatest impact;

   b. For partner agencies to work more closely together to share intelligence;

   c. To pilot the provision of a housing advice service in health settings;

   d. To continue to support the Warm Homes Healthy People Project and where possible help to secure greater engagement and buy in from local healthcare providers.

6. Health and Wellbeing Board Performance Dashboard

6.1 Dr Danny Ruta (Director of Public Health, LBL) presented the draft Performance Dashboard, designed to assist the Board in monitoring the
progress against its agreed priorities within the Health and Wellbeing Strategy and the integration of health and care for adults.

6.2 The following points were raised or highlighted:

- The dashboard will include those indicators on which BCF activity is focussed.

- The dashboard includes a number of indicators (including those on birth weight, immunisation and excess weight) from the Be Healthy priority of the Children and Young People’s Partnership.

- The dashboard is based on 26 national metrics drawn from the Quality and Outcomes (Primary Care), Public Health, NHS and Adult Social Care Outcomes Frameworks.

- The indicators will be used to monitor the health outcomes and the integration of health and social care services on an annual and, where possible, quarterly basis.

6.3 The Board agreed the proposed health and care indicators as set out in the submitted draft dashboard.


7.1 Dr Danny Ruta (Director of Public Health, LBL) presented the report. Dr Ruta explained that the report is made up of three separate sections. He circulated a copy of the first issue of Well!, a magazine aimed at providing information and support to residents to help them improve their health and fitness and which forms the first part of the annual report. Lewisham’s Joint Strategic Needs Assessment website provides the second section of the report. The third section is the electronic publication of resources to support weight management by health professionals. These include the Weight Management Care Pathway for both children and adults and a range of other resources.

7.2 The Board:

1. Noted the report, which is targeted at mothers with young families, and has a particular focus on obesity.

2. Endorsed the use of the “Well!” logo to become a trademark for future Public Health reports.

8. Healthwatch Lewisham Annual Report

8.1 Jade Fairfax and Simone Riddle of Healthwatch Lewisham presented the report.
8.2 The following points were raised or highlighted in the discussion:

- The CCG welcomed the report and explained that many recommendations made had been implemented.

- In response to a query, Jade and Simone clarified that there were enough volunteers for the work being undertaken at the moment.

- Information about Healthwatch’s work with Kaleidoscope should be fed into the education and health sectors as well and disseminated more broadly beyond this Board.

8.3 The Board noted the Healthwatch Lewisham Annual Report.

9. Immunisation in Lewisham

9.1 Dr Donal O’Sullivan (Consultant in Public Health Medicine, LBL) presented the report, focusing on the universal childhood programme and highlighting the following points:

- Immunisation is the second most important method of preventing diseases and illnesses after ensuring clean water.

- Very few areas within Lewisham have witnessed parental resistance to immunisation.

- A Lewisham immunisation workplan has been developed for 2014/15, with the following actions as priorities:

  - The development of a new Lewisham Immunisation Strategy, based on an agreement as to the relative roles of NHS England, the Clinical Commissioning Group, Public Health England and the local Children’s Commissioning team. The existing Lewisham Immunisation Strategy Group, which has representation at a senior level of all of these stakeholders and which reports to the Lewisham Health and Wellbeing Board, would seem to be the best way of overseeing the development of this new strategy.

  - A review of the use of the health visiting services as an alternative to the GP practice immunising children.

  - Further development of immunisation care pathways.

  - Introduction of the new national immunisation programme to ensure that secondary school children and young adults are protected against disease caused by Group C Meningococcus.

  - The immunisation of pregnant women against influenza and pertussis by midwives.
9.2 The following points were raised or highlighted in the discussion:

- The Children’s Partnership Board has observed that the current NHS England system of paying GPs for immunising children at age 6 rather than at age 5 directly delays earlier immunisation. Jane Clegg noted the point and promised to pass it on to the relevant colleagues within the NHS. She added that work was also underway in the NHS to address the discrepancy between actual uptake and reported uptake.

- Collaborative commissioning is due to become operational and will become an important aid to progressing immunisation. The CCG is already commissioning on a more population-based approach than before.

- NHS England manages the contracts for immunisation and monitors performance. It was noted that the improvement in MMR1 was not achieved through performance management alone.

9.3 The Board:

1. Noted the content of the report on immunisation in Lewisham and

2. Endorsed the priorities and Immunisation Workplan for 2014/15.


10.1 Dr Danny Ruta (Director of Public Health, LBL) provided an update on the progress towards achieving the improvements and outcomes of the HWB Strategy’s priority area 1: achieving a healthy weight in children and adults. The focus of the report was on the objectives and actions identified in the delivery plan of the Health and Wellbeing Strategy, but it also covered the ongoing work of the various strategies and plans supporting this priority.

10.2 In the discussion, it was recommended that the Board seek to help residents achieve and maintain a healthy weight by sign-posting some of the ways in which this could be done—for instance by marking out safe cycling routes.

10.3 The Board noted the content of the report on Health and Wellbeing Strategy: Progress Update Healthy Weight / Obesity.

11. Food Poverty in Lewisham

11.1 Dr Danny Ruta (Director of Public Health, LBL) provided information on the causes, scale, consequences, and current interventions relating to food poverty in Lewisham.
11.2 The following points were highlighted:

- The Greater London Authority report *Child Hunger in London* stated that 21% of parents surveyed reported skipping meals so that their children could eat and 9% of children in London said they sometimes or often go to bed hungry. If these figures were applied to Lewisham it is estimated that 19,000 parents in Lewisham skip meals so their children can eat and 6,000 children in Lewisham sometimes or often go to bed hungry.

- Findings of the report should be used as the foundations for the future development of action plans for Lewisham, modelled on the Greater London Authority report on child hunger and the London Assembly report on food poverty. This will become part of the overall strategy for food and nutrition in the Borough.

11.3 The following points were raised or highlighted in the discussion:

- The cost of housing contributes to food poverty in London.

- The Whitefoot Nutrition Project was cited as an example of good practice locally.

11.4 The Board:

1. Noted the content of the report Food Poverty in Lewisham and
2. Endorsed the next steps outlined in the report.

12. **Voluntary and Community Sector Response to Poverty, with a Focus on Food Poverty**

12.1 Tony Nickson (Director, Voluntary Action Lewisham) and Dr Roger Green (Goldsmith’s College, University of London) presented the report about independent community responses to poverty in the Borough, with a focus on food poverty. The report included findings from Goldsmith’s College researchers on the use and operation of food banks in the Borough.

(Please click on this link for the report: *Putting Food On The Table--Understanding Food Poverty: Exploring Food Bank Use In Lewisham* )

12.2 The following points were raised or highlighted in the discussion:

- Food banks are short-term solutions to food poverty in the Borough.

- People are presenting at food banks with a multitude of issues and are being sign-posted to other services.
• It was suggested that a Lewisham food summit may help address food poverty in the borough.

12.3 The Board:

1. Acknowledged the issue of food poverty in the Borough, as indicated by the experiences of local voluntary and community organisations and initial research findings presented, and

2. Endorsed a discussion, to be initiated by VAL and partners, with all key stakeholders, including food bank users, to discuss approaches towards solutions to food poverty and to further investigate why people are increasingly accessing food banks and other food distribution points, with the aim of improving co-ordination and effective support for voluntary action locally in addressing food poverty in the Borough.


13.1 Corinne Moocarme (Joint Commissioning Lead, Community Support and Care, CCG/LBL) and Laura Harper (Housing, Health and Social Care Integration Project Manager, LBL) presented a six-monthly update on the local implementation of the National Autism Strategy, focusing on the main areas of the Self Assessment where Lewisham had rated itself amber.

13.2 In particular, there was an emphasis on the specific identification of adults with autism in the local housing strategy and more detail on how Lewisham Housing is working to identify a range of housing to support residents with particular needs.

13.3 The following points were raised or highlighted in the discussion:

• Lewisham is looking to establish a community that accepts and understands autism and which has an infrastructure that provides opportunities for adults with autism/Asperger's syndrome to live fulfilling and rewarding lives.

• The Self Assessment Framework (SAF—for 2013) provided an opportunity to recognise Lewisham’s achievements, take stock of the Borough’s current position, and understand where further work was required.

• There were 17 questions in the Self Assessment Framework (SAF). Lewisham rated itself green on 6 questions and amber on the remaining 11. There were no red ratings. Some of the main areas rated amber requiring further work to progress were:
- The inclusion of autism in the local Joint Strategic Needs Assessment
- Improving the data collected regarding numbers of adults with autism in the borough
- The level of information about local support in the area being accessible to people with autism
- Promotion of employment of people with autism.
- Specific identification of adults with Autism in the local housing strategy

• Presentation and discussion of the SAF in November 2013 provided an opportunity to ensure autism was on the Health and Wellbeing Board agenda, and the request to provide regular updates was welcomed.

• This update coincided with the publication of Think Autism and the launch of the Autism Innovation Fund. Further updates will be provided as work progresses in these areas.

• Autism has now been included in the local Joint Strategic Needs Assessment (JSNA) and data collected regarding numbers of adults in the Lewisham is being improved.

• The Housing and Autism Project Group has been reinstated and met twice in 2014. Meetings are planned for the remainder of the year at six-weekly intervals.

13.4 The following points were raised or highlighted in the discussion:

• Some of the amber-rated areas had been amalgamated within in the report.

• In response to a query from Nickie Roome (Campaign in Lewisham for Autism Spectrum Housing—CLASH) about the possible creation of an Autism Partnership Board in the Borough, the following observations were offered:

  - Corinne Moocarme currently corresponds informally with a pool of people who support the work on autism. A group could be convened to support this area of work.

  - There is a need for caution regarding the possible proliferation of partnership boards, appreciating that specific arrangements around particular tasks or agendas may not always require the oversight of a formal board.

13.5 The Board:
1. Noted the content of the Progress Report on Implementing the National Autism Strategy “Fulfilling and Rewarding Lives” in Lewisham;

2. Approved the local implementation work, and

3. Agreed for another update to be submitted in January 2015.

14. Health and Wellbeing Board Work Programme

14.1 Carmel Langstaff (Service Manager, Strategy and Policy, Community Services, LBL) presented the draft programme for discussion and approval, highlighting the following points:

- The following items were agreed during the course of the meeting and will be added to the draft Work Programme:
  - Lewisham’s progress in relation to the implementation of the Care Act
  - Joint Commissioning Intentions
  - CCG South East London Commissioning Strategy update
  - Update on Winter Pressures planning
  - Progress in relation to the Performance Dashboard
  - Update on the Autism Strategy in January 2015
  - Evaluation of the Community Connections Project
  - Update on the Food Strategy and work in relation to food poverty. (January 2015).

14.2 The Board:

1. Agreed the draft Work Programme and the additional items.

2. Agreed that items “For Noting” only should in future be circulated to HWB members for information and not presented at the HWB meeting.

3. Agreed that the report writing guidance will be amended so that the report pathway is clearly highlighted.

15. Information Item: NHS Lewisham CCG Annual Report 2013-14

15.1 The Board noted the contents of the NHS Lewisham CCG Annual Report 2013-14.

The meeting ended at 17:00 hrs.
Enclosure 21

Review of Audit Committee Terms of Reference

RESPONSIBLE LEAD: Ray Warburton, Audit Chair

AUTHOR: Tony Read, Chief Financial Officer

RECOMMENDATIONS:

The Committee is asked to note the revised terms of reference for the Audit Committee.

SUMMARY:

The Audit Committee regularly reviews its terms of reference to keep pace with the requirements of the CCG, statutory developments and good practice. The attached terms of reference show deletions in strikethrough and insertions in italics.

KEY ISSUES:

The changes to the terms of reference in place are:

1. Para 3.1.1 replace “the South London Commissioning Support Unit” with “commissioning support services.”
2. Para 3.2.1 reference to the NHS Internal Audit Standards is replaced by the Public Sector Internal Audit Standards.
3. Para 6.11 The Governing Body Chair is an ex officio member with full voting rights, of other committees. It was agreed that this did not apply to the Audit Committee. Note 6.11 is amended to remove the term ex officio. This has the effect of preserving the Governing Body Chair’s ability to attend Audit Committee meetings but without affecting quoracy and with no voting rights.
4. New Para 6.12 “The Audit Committee may recruit or co-opt additional members that are independent of the CCG Governing Body.”

Para 6.6.3a) of the CCG’s Constitution sets out the Audit Committee composition. The terms of reference membership wording has been amended to allow the appointment of additional independent members that are not Governing Body members, in line with the expectations of the Local Audit and Accountability Act 2014.
5. New 3.3.2 Additional wording to formalise that the Audit Committee will fulfil the role of an independent auditor panel from 2015/16, in line with the requirements of the Local...
Audit and Accountability Act 2014.

The Committee shall fulfil the role of an Independent Auditor Panel, as described in the Local Audit and Accountability Act 2014

6. New para 8.2 Whilst not specific in the terms of reference the Audit Committee currently reports to and makes its minutes available to the Governing Body in public. A new paragraph 8.2 is suggested for confidential or commercially confidential matters to be reported to a Part II meeting of the Governing Body; as follows

“Items that are confidential or commercially confidential and any associated minutes will be reported to the Governing Body not in public.”

CORPORATE AND STRATEGIC OBJECTIVES

Good governance

CONSULTATION HISTORY INCLUDING MEMBERSHIP ENGAGEMENT:

Audit Committee

PUBLIC ENGAGEMENT

To be presented to the Governing Body in public

HEALTH INEQUALITY DUTY

No impact

PUBLIC SECTOR EQUALITY DUTY

No impact

STAKEHOLDER INVOLVEMENT

None

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1. Introduction

1.1 The Audit Committee (the Committee) is established in accordance with the Lewisham Clinical Commissioning Group’s (CCG) Constitution, Standing Orders and Scheme of Delegation. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Committee and shall have effect as if incorporated into the CCG’s Constitution and Standing Orders.

2. Purpose

2.1 The Committee provides the CCG’s Governing Body with an independent and objective view of the CCG’s financial and control systems, financial and business information and compliance with laws, regulations and directions governing the CCG in so far as they relate to quality, finance, control systems and risk management. The Governing Body has approved and keeps under review the terms of reference for the Audit Committee.

2.2 The Committee shall critically review the clinical commissioning group’s quality and financial reporting and internal control systems and ensure an appropriate relationship with both internal and external auditors is maintained.

3. Areas of Focus

3.1 Integrated governance, risk management and internal control

3.1.1 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the CCG’s activities that support the achievement of the CCG’s objectives, including core business services provided to the CCG (for example the South London Commissioning Support Unit).

3.1.2 Its work will dovetail with that of any Committee(s), which the CCG has established to seek assurance that robust clinical quality is in place. In particular, the Committee will review the adequacy and effectiveness of:

- All risk and control related disclosure statements (in particular the Annual Governance Statement), together with any appropriate independent assurances, prior to endorsement by the CCG.

- The underlying assurance processes that indicate the degree of achievement of CCG objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.
• The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification.

• The arrangements for and effectiveness of Internal and External Audit.

• The policies and procedures for and effectiveness of all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud and Security Management Services.

• The arrangements for and effectiveness of services provided by Commissioning Support providers, including Internal Audit arrangements and alignment with CCG audit plans.

3.1.3 In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

3.1.4 This will be evidenced through the Committee’s use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

3.2 Internal audit

3.2.1 The Committee shall ensure that there is an effective internal audit function that meets mandatory NHS Public Sector Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Accountable Officer and CCG. This will be achieved by:

• Consideration of the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal.

• Review and approval of the internal audit strategic and operational plans and more detailed programmes of work, ensuring that this is consistent with the audit needs of the organisation, as identified in the assurance framework.

• Considering the major findings of internal audit work (and management’s response) and ensuring co-ordination between the internal and external auditors to optimise audit resources.

• Ensuring that the internal audit function is adequately resourced and has appropriate standing within the clinical commissioning group.

• An annual review of the effectiveness of internal audit.
3.3 **External audit**

3.3.1 The Committee shall review the work and findings of the external auditors and consider the implications and management’s responses to their work. This will be achieved by:

- Agreement of fees
- Consideration of the performance of the external auditors, as far as the rules governing the appointment permit.
- Discussion and agreement with the external auditors, before the audit commences, on the nature and scope of the audit as set out in the annual plan, and ensuring co-ordination, as appropriate, with other external auditors in the local health economy.
- Discussion with the external auditors of their local evaluation of audit risks and assessment of the clinical commissioning group and associated impact on the audit fee.
- Review of all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the CCG and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

3.3.2 *The Committee shall fulfil the role of an Independent Auditor Panel, as described in the Local Audit and Accountability Act 2014*

3.4 **Counter fraud**

3.4.1 The Committee shall satisfy itself that the CCG has adequate arrangements in place for countering fraud. This will be achieved by:

- Approving the counter fraud work plans and programme.
- Reviewing the progress against the counter fraud plan and outcomes of counter fraud work.
- Reviewing the effectiveness of the counter fraud service.
- Reviewing the CCG’s assessments against NHS Protect’s qualitative assessments.
- Receiving the counter fraud, anti-bribery and other relevant policies.
- Receiving the counter fraud annual report.
3.5 **Financial management and reporting**

3.5.1 The Audit Committee shall monitor the integrity of the financial statements of the clinical commissioning group and any formal announcements relating to the CCG’s financial performance.

3.5.2 The Committee shall ensure that the systems for financial reporting to the CCG, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the CCG. This will include:

- Reviewing proposed changes to the CCG’s prime financial policies
- Reviewing reported losses and special payments
- Authorising the write off of debts
- Reviewing all instances where requirements of prime financial policies have been formally waived.

3.5.3 The Audit Committee shall review the annual report and financial statements before submission to the Governing Body and the CCG, focusing particularly on:

- The wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee;
- Changes in, and compliance with, accounting policies, practices and estimation techniques;
- Unadjusted mis-statements in the financial statements;
- Significant judgements in preparing of the financial statements;
- Significant adjustments resulting from the audit;
- Letter of representation; and
- Qualitative aspects of financial reporting.

3.6 **Management**

3.6.1 The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

3.6.2 The Committee may also request specific reports from individual functions within the clinical commissioning group as they may be appropriate to the overall arrangements.

3.7 **Other assurance functions**
3.7.1 The Audit Committee shall review the findings of other significant assurance functions, both internal and external, including quality, and consider the implications for the governance of the CCG.

3.7.2 These will include, but will not be limited to, any reviews by Department of Health arm’s length bodies or regulators/inspectors (for example, the Care Quality Commission and NHS Litigation Authority) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges and accreditation bodies).

4. Meeting Schedule

4.1 The Committee will meet sufficiently to fulfil its work plan or no fewer than four times per year as a minimum. The Governing Body reserves the right to call a meeting at any time (with appropriate notice) if an urgent matter arises.

4.2 The external auditors or Head of Internal Audit may also request a meeting if they consider that one is necessary.

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

5. Accountability

5.1 The Committee will be accountable to the Governing Body through the distribution of its minutes and work plan in addition to the production of a report detailing its activities at least annually.

5.2 The Committee will have access to regular CCG performance and quality reports, strategies and plans.

6. Committee Membership

6.1 The Committee shall be appointed by the CCG as set out in the CCG’s constitution.

6.2 Members:
- Chair – the lay member 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 Governing Body member
- Registered Nurse Governing Body member

6.3 The provisions for appointment and tenure of the members of the Committee are defined in the Standing Orders relating to these posts in the CCG Constitution.
6.4 In the event of the Chair of the Audit Committee being unable to attend all or part of a meeting, he or she will nominate a replacement from within the membership to deputise for that meeting.

6.5 Individuals in regular attendance but who are not members of the Committee include the CCG’s Accountable Officer, Chief Financial Officer and representatives from internal and external audit services.

6.6 At least once a year the Committee will meet privately with the external and internal auditors without any director or senior officer present.

6.7 Representatives from Local Counter Fraud Services and NHS Protect may be invited to attend meetings and will normally attend at least one meeting each year.

6.8 Regardless of attendance, external audit, internal audit, local counter fraud and local security management providers will have full and unrestricted rights of access to the Audit Committee.

6.9 The Accountable Officer will be invited to attend and discuss, at least annually with the Committee, the process for assurance that supports the Annual Governance Statement. He or she will also normally attend when the Committee considers the draft internal audit plan and the annual accounts.

6.10 Any other directors (or similar) may be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that director.

6.11 The Chair of the Governing Body may attend, ex officio, any meeting each year in order to form a view on, and understanding of, the Committee’s operations.

6.12 The Audit Committee may recruit or co-opt additional members that are independent of the CCG Governing Body.

7. Quorum Rules and Responsibilities of Members

7.1 The meeting will be quorate when three members are present; at least one of which must be a lay member.

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

8. Reporting Arrangements

8.1 The Committee Chair shall report formally to the CCG Governing Body on its proceedings after each meeting on all matters within its duties and responsibilities. The Chair of the Committee shall draw to the attention of the Governing Body any issues that require disclosure to the full Governing Body, or require executive action. The Committee shall make recommendations to the Governing Body on any area within its remit where action or improvement is needed.
8.2 Items that are confidential or commercially confidential and any associated minutes will be reported to the Governing Body not in public.

9. Monitoring adherence to the Terms of Reference

9.1 The Group will report to the CCG Governing Body annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Assurance Framework, the completeness and effectiveness of risk management in the organisation and the integration of governance arrangements.

10. Review

10.1 These Terms of Reference will be reviewed on an annual basis or sooner if required with recommendations made to the CCG Governing Group for approval.

10.2 Any resulting changes to the terms of reference will be approved by the Governing Body.

11. Resources and support

11.1 The Committee will be supported by a Director of the CCG, who will be responsible for:

- overseeing of Committee agendas, minimising the duplication of discussion and decision-making
- assisting those chairing the Committee with preparation for meetings
- bringing together in accessible form the reports and information necessary to the support discussion and decision-making of the Committee
- producing and distributing minutes within five working days of meetings
- tracking progress on actions, identifying and rectifying any lapses in communication.

11.2 Meeting dates will be agreed on an annual basis and will not be changed without the permission of the Chair.

11.3 Agendas for the meeting will be distributed no less than seven days before the meeting.

11.4 Papers for the meeting will be distributed no less than five days before the meeting.

11.5 Any exceptions to this will require written notification to the Chair, and subsequent agreement on distribution arrangements.
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<tr>
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<td>Minor changes made for consistent formatting. Added version control box.</td>
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<td>09/01/2014</td>
<td>Additions to 3.1.2; 3.2.1; 3.4.1; 3.5.2</td>
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<td>2.3</td>
<td>4/11/2014</td>
<td>Paragraphs 3.1.1 and 3.2.1 minor changes to wording. Para 6.11 “ex officio” deleted. New paras 6.12, 3.3.2 and 8.2</td>
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