NHS

South East London

A meeting of the SEL PCT Boards* and Bexley Care Trust 21st July 2011

ENCLOSURE 10

NHS SEL ASSURANCE FRAMEWORK &
INDICATIVE CORPORATE RISK REGISTER

DIRECTOR RESPONSIBLE: Gill Galliano, Director of Development

AUTHOR: Sarah Gardner (Deputy Director Integrated Governance) & Ben Vinter (Integrated Governance Manager)

TO BE CONSIDERED BY: All

SUMMARY:
The Joint Boards are asked to consider

a) NHS SEL Assurance Framework
b) Indicative Risk Register

a) Following the last meeting of the Joint Boards an NHS SEL Assurance Framework has been developed and tested internally with the aim being to establish a system based on subsidiarity and a consistent line of sight on risks and emerging issues as they are aggregated through the organisation's reporting structures.

b) Pending the adoption of an NHS SEL Assurance Framework the Joint Boards are asked to note a refreshed indicative risk register which is based upon a review with all directorates following the last meeting of the Joint Boards.

The Cluster Management Board has met and discussed its approach to risk management, acknowledging that the environment (during the transition) was likely to continue changing which would in turn, influence the local response to risk.

KEY ISSUES:
This second iteration of the indicative risk register for NHS South East London identifies both strategic and operational risks from across NHS SEL.

All directorates have reviewed their risk profile aligned to the organisation's objectives and business plan. In addition an operational risk forum has also met to identify and discuss like risks identified and mitigations applied across NHS SEL.

The Cluster Management Board have agreed that the best mitigation to the risks inherent within the transition relies upon management of the interrelationship between the delivery and reform agendas. Solutions to which will be progressed within SEL through prioritising delegation to commissioning consortia thereby securing their ownership and leadership of delivery.

In line with the proposed framework before the Boards the indicative risk register sets out only risks scored at 15 or above or those flagged by executive directors as zero tolerance risks (staffing retention and safeguarding). Such exception reporting is based upon the principal of local oversight of both borough specific and wider directorate risks.

Future meetings of the Boards will be able to review a cumulative position of high level risks derived from embedded local approaches based upon common presentation, scrutiny and scoring of risks, controls and assurance.

The most significant areas of risks identified at this time are as follows;
- Impact of organisational change on staff retention and delivery (zero tolerance)
- Delivery of QIPP and operating plan
- Delivery of Primary Care agenda and management of Issues of Concern
- Emergency Planning
- Retaining a grip on finances and potential impact of tariff inflation
- Quality of care delivered by our commissioned providers
- Safeguarding (zero tolerance)

The Cluster Management Board have actively considered the scale of the potential challenges posed by recent announcements related to Southern Cross. We have a record of all NHS funded patients within SEL and know their current situation and location. The potential impact across the capital is currently being co-ordinated by the NHS London Joint Improvement Team and in collaboration with the Directors of Adult care in Local Government. As events, their consequences and associated actions become clearer a full risk review will be undertaken and consideration will be given to whether this needs an individual BSU response or a Pan Cluster response in conjunction with Local Government partners.

Significantly a previously high rated risk (PC4) related to a judicial review of the 2010 Secretary of State Directions allowing for termination of PMS contracts without reason

by serving six month notices has been de-escalated as a result of a judgement in favour of the Secretary of State. NHS SEL Primary Care directorate have, as a result, begun negotiations related to the introduction of a GMS contract in Greenwich.

Going forward risk and assurance will be managed at a local level, tracked and reported through identified risk leads (within each directorate and / or BSU), discussed at an operational forum prior to presentation of risks to the CMB. CMB will take decisions and make recommendations on the presentation of issues, as appropriate to the Boards or their committees.

BSU approaches to risk management will be overseen by the each MD with the local approach to risk management overseen by the relevant LCCC – such discussions may reflect, where appropriate, the implications of cluster held risks. Risks and assurance issues arising from cluster directorates will be owned by those directors.

Appendices

a) NHS SEL Assurance Framework
b) Current indicative NHSL SEL risk register

INVOLVEMENT:

The proposed NHS SEL Assurance Framework has been discussed by the Development Group and Cluster Management Board. The input of the Audit Chair has also been sought in lieu of anticipated review by the Joint Audit Committees in Autumn 2011.

All directorates have engaged in a process of both operational and strategic risk identification since the last meeting of the Joint Boards.

An operational risk forum has met to identify and discuss like risks identified and mitigations applied across NHS SEL.

Where LCCCs have met they will have reviewed developing BSU risk registers. Which subject to agreement of the NHS SEL Assurance Framework will be reviewed, going forward, in order to ensure incorporation of NHS SEL wide risks.

RECOMMENDATIONS:
The Boards are asked to:-

1. AGREE the NHS SEL Assurance Framework

2. NOTE the indicative risk register pending the adoption of an NHS SEL approach (to be applied by September meeting of the Joint Boards)

DIRECTORS CONTACT:
Name: Gill Galliano
E-Mail: g.galliano@nhs.net
Telephone: 020 7206 3332

AUTHOR CONTACT:
Name: Ben Vinter
E-Mail: ben.vinter@nhs.net
Telephone: 0203 049 4421

NHS

South East London

NHS SEL Assurance Framework

July 2011

A partnership of Primary Care Trusts in Bromley, Greenwich, Lambeth, Lewisham, Southwark and Bexley Care Trust

Chair: Caroline Hewitt Chief Executive: Simon Robbins

Document Control

Policy Reference No:	
Version Number:	4.0
Status	For Board Approval – July 2011
Author/Lead	Executive Director Risk Lead – Gill Galliano Ben Vinter / Sarah Gardner– NHS SEL Governance lead
Implementation Date	July 2011
Date of last review	June 2011
Date of next review	April 2012

Approval

Date	Approver	Role
27/5/11		Oliver Lake – Lead Director
9/6/11		Operational Risk Group – risk plenary
21/6/11		Development Group
21/6/11		Cluster Management Team
21/7/11		Joint Boards

Quality Review

Date	Approver	Role
26/5/11	SG	Deputy Director
6/6/11	OL	Director
9/6/11	GG	Exec Director – risk lead

Change Control

Date	Version	Author	Main Changes
25/5/11	1	BV	First draft
3/6/11	2	BV	Style, tone appendices
13/6/11	3	BV	Formatting
27//6/11	4	BV	Incorporate Development Group comments. LCCC role and commonality of reporting across boroughs / boards

Table of Contents

NHS SEL Risk and Assurance Framework

1. Purpose and principles of this framework

This document outlines the approach to risk management and board assurance that is in place across the South East London cluster of PCTs and Care Trust; Bexley Care Trust, Bromley PCT, Greenwich teaching PCT, Lambeth PCT, Lewisham PCT and Southwark PCT, to be collectively referred to within this documentation as NHS SEL.

The SE London Cluster (NHS SEL), collectively and individually, acknowledge that risk management is an ongoing process that supports delivery of both our strategic and operational objectives.

Risk can often be seen as something negative; describing unwelcome consequences and issues that need to be avoided. However NHS SEL, both as a whole and its constituent parts will only be able to deliver on its objectives and rise to the transformative challenges facing the NHS if prepared to acknowledge risk, pursue our strategies in a managed and controlled way, while also embracing the opportunities provided by innovation and creativity.

All of the SEL PCTs and Bexley Care Trust have had risk management embedded in their way of business and corporate structures. The Cluster now has a single management team and our previously familiar organisational forms have been subject to much change and upheaval. A process of both local and shared governance and assurance structures are in the process of development meaning it is imperative to minimise the potential for duplication through development of comparable standards, clarity of reporting and common assurance mechanisms.

This NHS SEL assurance framework will;

- Provide a clear definition of the approach and direction to be taken to manage risks and opportunities in an effective and efficient manner.
- Facilitate the Joint Boards awareness of all significant risks and allow them to allocate resources appropriately, in a prioritised way, to manage risk and ensure that NHS SEL and all its constituent parts meet its objectives.
- Provide a process of identification, assessment, control, elimination and transfer of risk across the cluster and within each BSU.
- Support commissioning processes that provide the services people need in a way that makes best use of financial resources, to nationally consistent standards of quality and safety.
- Provide the means by which the cluster can integrate risk management into its Directorates and processes and effectively manage the risks to delivery of business priorities.
- Protect the services, reputation and finances of NHS SEL and its constituent parts.

2. Introduction

The approach to risk management and board assurance as set out is in accordance with legislation, national and local guidance. It seeks to embed recognised and developed best practice through a process of ongoing review and improvement whilst underpinning the production of the annual Statement of Internal Control (SIC).

Through its adopted approach to risk management and board assurance, NHS SEL believes that it has in place a sound governance structure to serve its resident population. As part of this approach it will use effective risk management to ensure that all its corporate and principle objectives are met.

It will systematically identify, at all levels, those identified risks that could affect these objectives and take every reasonable step to control the risk. This will include a process to monitor, and if necessary improve, how risks are being managed and demonstrate this.

NHS SEL's leadership will employ effective techniques for risk management, supported by good information systems, discuss and share risk information amongst themselves and train and support all their staff to an appropriate level of expertise.

NHS SEL also requires that the organisations and people it commissions to provide health services or business support in the achievement of its objectives operate demonstrably effective risk management systems.

3. Purpose of risk management and board assurance

The establishment of effective risk management systems is recognised as being fundamental in ensuring good governance. Its aim is to continually improve the quality of health service commissioning through the identification, prevention, control and mitigation of risks. To do this, a systematic and consistent approach to risk management is required across NHS SEL's commissioning and other activities (common definitions are set out at **Appendix 1).**

The Boards ensure that they receive robust and independent assurances on the soundness and effectiveness of the systems and processes in place for meeting its objectives and delivering appropriate outcomes. The Boards therefore have overall responsibility for ensuring they have assurance that the process of risk identification, evaluation and control are effective. This is achieved through the management and application of the Board Assurance Framework (the agreed NHS SEL Joint Boards assurance framework (JBAF) template is appended at **Appendix 2)**. The Joint Boards assurance framework (JBAF) enables the SEL Cluster Management Board (executive) to be assured that the controls applied in the mitigation of risk are operating effectively.

4. Objectives

The objectives of the risk management and board assurance approach described in this document are:

1. Ensuring compliance with all standards and regulations that apply to health care for all commissioned services;
2. Ensuring a common and integrated approach to risk management across NHS SEL;
3. Implementation and management of a robust assurance framework that addresses risks at all levels of the organisation with relevant and appropriate escalation.

5. Description of terms and definitions

Risk management and assurance uses a number of terms and definitions that are necessary in order to communicate its meaning, interpretations and outcomes in a common way. The description of the terms, definitions and principles that the cluster will work toward is set out within the NHS SEL Risk Management and Assurance Toolkit which is available upon request from the NHS SEL Governance team.

6. The risk management structure

6.1 The risk management and assurance structure allows for risk to be captured, reported and managed in a consistent way across NHS SEL. It enables risks to be considered at an operational level and strategic level depending on the nature and severity of the risk as represented by an assessment of its likelihood of occurring, the potential area impacted by that risk and the consequences resulting from its potential occurrence.

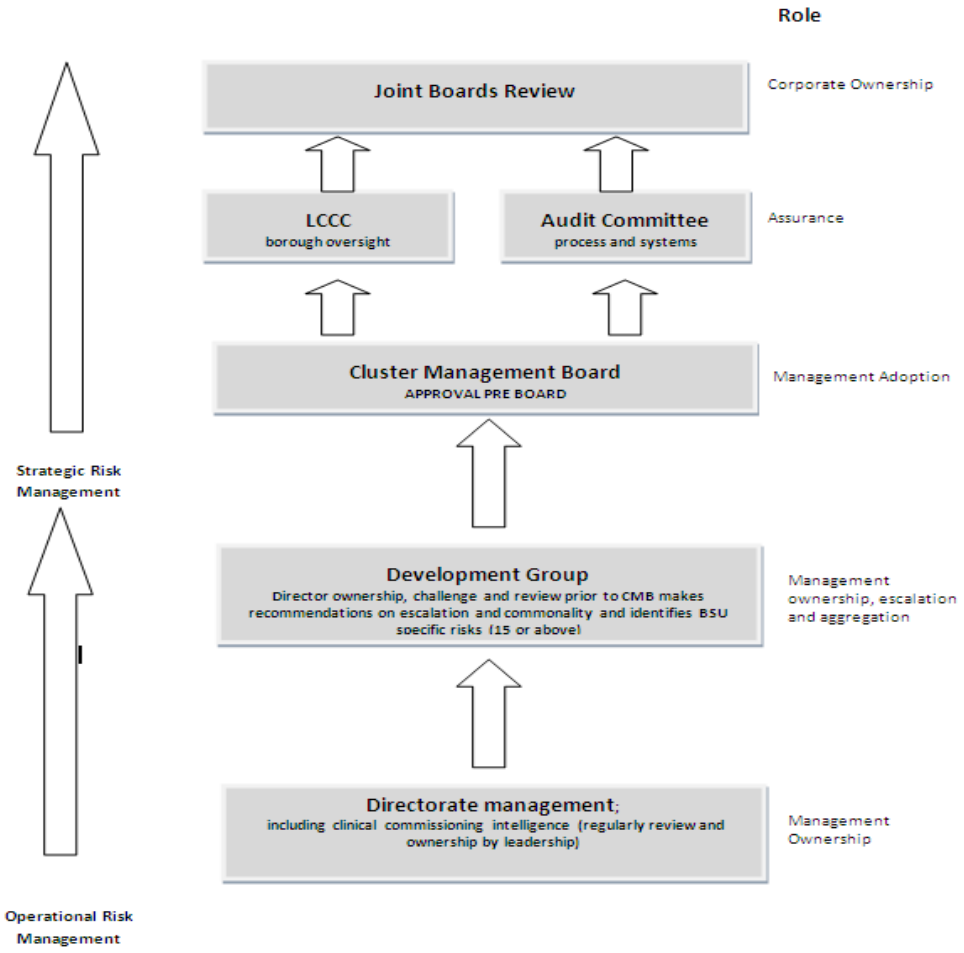


Fig 1

Figure 1 (above and **Appendix 3**) shows the high level linkages between operational risks, and NHS SEL's strategic risks and the level at which oversight takes place. As with most models of risk management the structure recognises the principle of escalation between the lowest reported level of risk (department / function) to the highest level of reported level of risk (JBAF). This provides for a transparent, owned and accessible approach with in-built oversight.

The roles of each group are further specified below;

Corporate Ownership (Joint Boards)
The Joint Boards own the organisational objectives, risks to delivery and assurance framework. The Boards must satisfy themselves that operational responsibility is being discharged such that the organisation might mitigate risk and has a reasonable chance of delivering upon it objectives. The Boards will be briefed on the challenge and scrutiny exercised by its committees in order to secure additional assurance.

The Boards will be briefed by exception on particular local risks or borough specific considerations for an NHS SEL wide risk where this is judged to have potential for local impact at a scored level of 15 or above.

Assurance (Audit Committee / LCCCs)
The Joint Audit Committees provide, collectively and individually, independent oversight of the governance and assurance processes on behalf of the organisations. This includes responsibility for reviewing and providing verification on the systems in place for internal control and risk management.

Each borough LCCC provides oversight, challenge and review of local issues, management response and interaction / dependencies with cluster activities. LCCCs will also review locally specific risks and recommend their escalation to the JBAF in line with the principles contained within this framework.

Management Adoption (Cluster Management Board)
Adopts and operationally assures draft versions of the Assurance Framework, prior to oversight by the Joint Boards or their committees.

Management ownership, escalation and aggregation (Development Group)
Forum of Cluster Directors and BSU MDs that reviews issues emerging from NHS SEL directorates, assesses congruence and identification of any cross BSU issues. Ensures all strategic risks have been identified, have been appropriately allocated and are being managed in accordance with NHS SEL's policy. Makes recommendations on escalation and commonality including identification of BSU specific risks (15 or above)

Operational Management (BSU and Directorate Structures)
All directors will have in place local risk management structures (in BSUs this will include aspects of capturing LCCC intelligence). All Directors and therefore their managers are responsible for; ensuring that appropriate and effective risk management processes are in place within for each department / function within their scope of responsibility; compliance to the SEL approach to risk management and board assurance; bringing to the attention of their director / department lead any significant

risks that have been identified where local control measures are considered to be inadequate.

6.2 Risk reporting and management

Risk registers are the mechanism by which to record identified risks and the details of the associated controls and assurances that are put in place to manage an individual risk to its agreed acceptable level.

Risk registers are used at each level of risk reporting. A core data set is required (to facilitate escalation to the JBAF which will be reviewed by the Joint Boards) with local adaptation of the adopted NHS SEL approach encouraged to facilitate local management. Risks escalated to a corporate level via the JBAF will require the completion of an Action Plan **Appendix 6** thereby capturing a higher level of detail and providing the required level of additional assurance. Local processes and approaches to secure enhanced assurance will not be specified within this documentation but may be developed under the stewardship of LCCCs.

The level of risk determined to be necessary for escalation from a local or directorate risk register to the JBAF is 15 or above with impact on one of more BSUs. An action plan will be completed for all risks rated as 15 or above, such reports will be offered to the Boards provided that they do not contain commercially sensitive or confidential information.

6.3 Duties (roles & responsibilities)

A prerequisite for the effective management of risk is the need for all staff, clinicians, boards and committees to be clear on, and to fully undertake, their specific duties in respect to their roles and responsibilities within the risk management structure. These are described in **Appendix 4.**

7. Risk reporting and risk ratings

7.1 Risk reporting process flow

Risks are reported and managed as shown in Figure 2 below (**Appendix 5**). This is aligned to, and is consistent with, the operational and strategic linkages identified in Figure 1 (appendix 3) and sets out applicable timescales of the reporting process.

It illustrates the risk identification, reporting, escalations and actions at each level of risk management process.

The organisational level at which risks are managed within Directorates is set out with local determination as to application of the risk management process and reporting on outcomes. All risks recorded as strategic and those operational risks assessed to be of sufficient severity to be escalated to the JBAF (and scored above 15 – see section 5.2) require completion of action plans (Appendix 6) and will be managed through the programme management process**.**

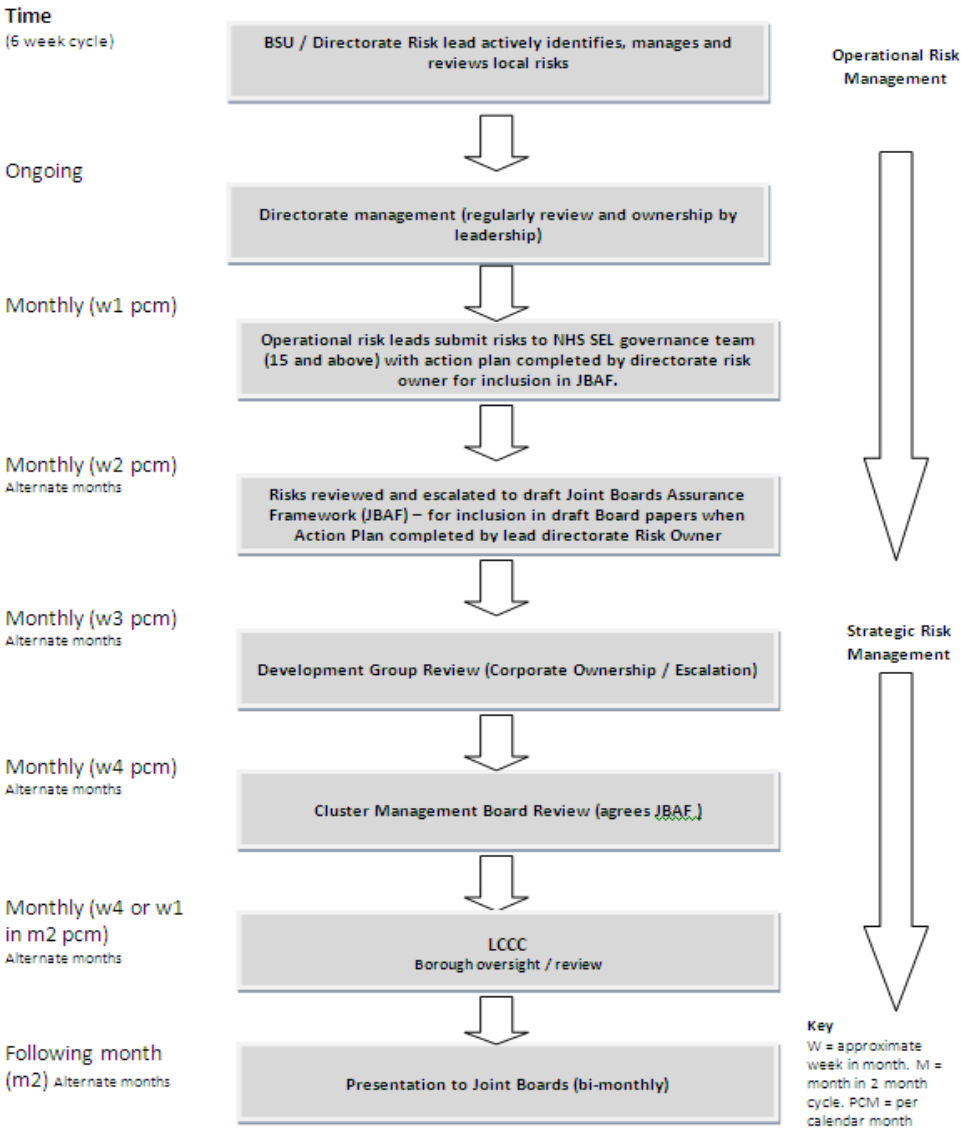


Fig 2

7.2 Risk ratings

Every identified risk has a chance of occurring therefore each risk will have its own potential likelihood. Similarly if the risk were to occur then it would have its own measure of impact (also known as a consequence). It is important to recognise that risk can never be eliminated with the aim of risk management being to progressively manage risk within

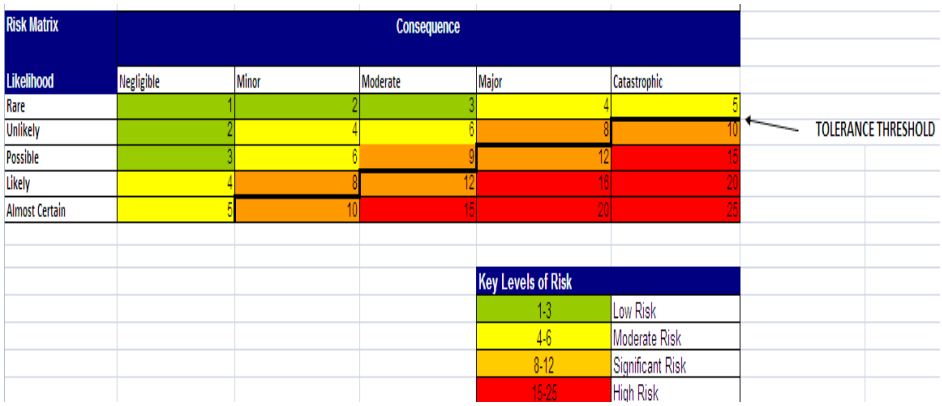
acceptable levels. The acceptable level of risk is known as the 'risk appetite' of a particular risk.

NHS SEL has determined the acceptable level of organisational risk to be '9'. That is the scoring at which NHS SEL finds a risk to be acceptable and less likely to be in need of regular monitoring or reporting. 9 is the preferred maximum, long term, target score for a risk.

Likelihood and impact are allocated a number between 1 and 5. The total risk score is the impact multiplied by the likelihood. Hence the risk score can lie between 1 (1x1) and 25 (5x5). The overall risk score determines the risk rating. This in turn determines the actions that are required to manage the particular risk.

As a minimum it is recommended that LCCCs review risks above the stated tolerance threshold (i.e 10 and above) though local preferences as to the extent of reporting may differ. While the Boards, having delegated borough oversight to each LCCC, will review risks of 15 and above.

Figure 3 (below) illustrates the risk matrix scoring and consequential risk rating methodology.



Risk Matrix	Consequence				
Likelihood	Negligible	Minor	Moderate	Major	Catastrophic
Rare	1	2	3	4	5
Unlikely	2	4	6	8	10
Possible	3	6	9	12	15
Likely	4	8	12	16	20
Almost Certain	5	10	15	20	25

TOLERANCE THRESHOLD

Key Levels of Risk	
1-3	Low Risk
4-6	Moderate Risk
8-12	Significant Risk
15-25	High Risk

7.3 Zero tolerance risks

The risk management and joint boards assurance process described in this document shows how those risks that are reported through the SEL Joint Boards BAF (JBAF) are determined. These are those high rated risks that impact all of NHS SEL PCTs and Bexley Care Trust and all those risks that are rated as being 'high'.

However there are a number of areas where the boards might benefit from being aware of an existing risk, regardless of risk rating at any particular point in time. These risks are referred to as 'zero tolerance' risks and are noted on the JBAF. An example of a zero tolerance risk is Safeguarding. Recommendations for classification of zero based risks come from directors and are assessed by the Development Group before endorsement by CMB.

Where a borough specific risk is reported by exception to the Boards and this is aligned but scored more highly (15 or above) than an identified NHS SEL risk then the NHS SEL wide risk will be reported as a zero tolerance risk in order to ensure that the Boards have sufficient context and access to all relevant information on the issue.

8. Independent assurance

8.1 External audit

External audit provides assurance that the JBAF is in place, in collaboration with the processes carried out by Internal Audit.

8. 2 Internal audit

Internal audit reviews the process for the maintenance and delivery of the JBAF and provides the assurance that it meets the requirements of the Department of Health. Internal audit also reviews other risk areas in line with an agreed annual audit plan and reports its findings to the audit committee.

8.3 NHS Litigation Authority (NHSLA)

The NHSLA perform an independent assessment against risk management standards, in order to establish the level of discount the NHS SEL receives in relation to its indemnity contribution schemes.

9. Reviews and updates

The approach NHS SEL adopts to manage risk and in providing board assurance as described within this documentation will be reviewed annually by both the Joint Audit Committee who will report to the Board upon its findings. An additional review relating to areas of best practice and practical application will be undertaken by the Governance team.

Appendix 1

A systematic approach to risk management

Risk is the threat that an event or action will adversely affect an organisation's ability to achieve its business objectives. Risk arises as much from the possibility that opportunities will not be realised as it does from the possibility that threats will materialise or that errors will be made.

Risk management is 'the culture, processes and structures that are directed towards the effective management of (such) potential opportunities and adverse effects' (Governance in the New NHS HSC1999/123)

It is a logical and systematic method of identifying, analysing, assessing, treating, monitoring and communicating risks in a way that will enable the organisation to minimise losses and maximise opportunities. Risk management as a process is based around judgments rather than definitive fact. It is an iterative process consisting of steps, which when taken in sequence, enable continual improvement in decision-making

The NHS SEL has adopted the principles of the Australia/New Zealand Risk Management Standard (AS/NZS 4360:1999) in its approach to risk management. This is a generic model for identifying, prioritising and dealing with risks in any situation – at local or corporate level. It comprises definition, scope and consequence of risk. It provides an effective means of controlling and mitigating the risks associated with the delivery of commissioned services, the achievement of corporate objectives and any other aspect of NHS SEL.

Printed on 29/03/2011

Appendix A

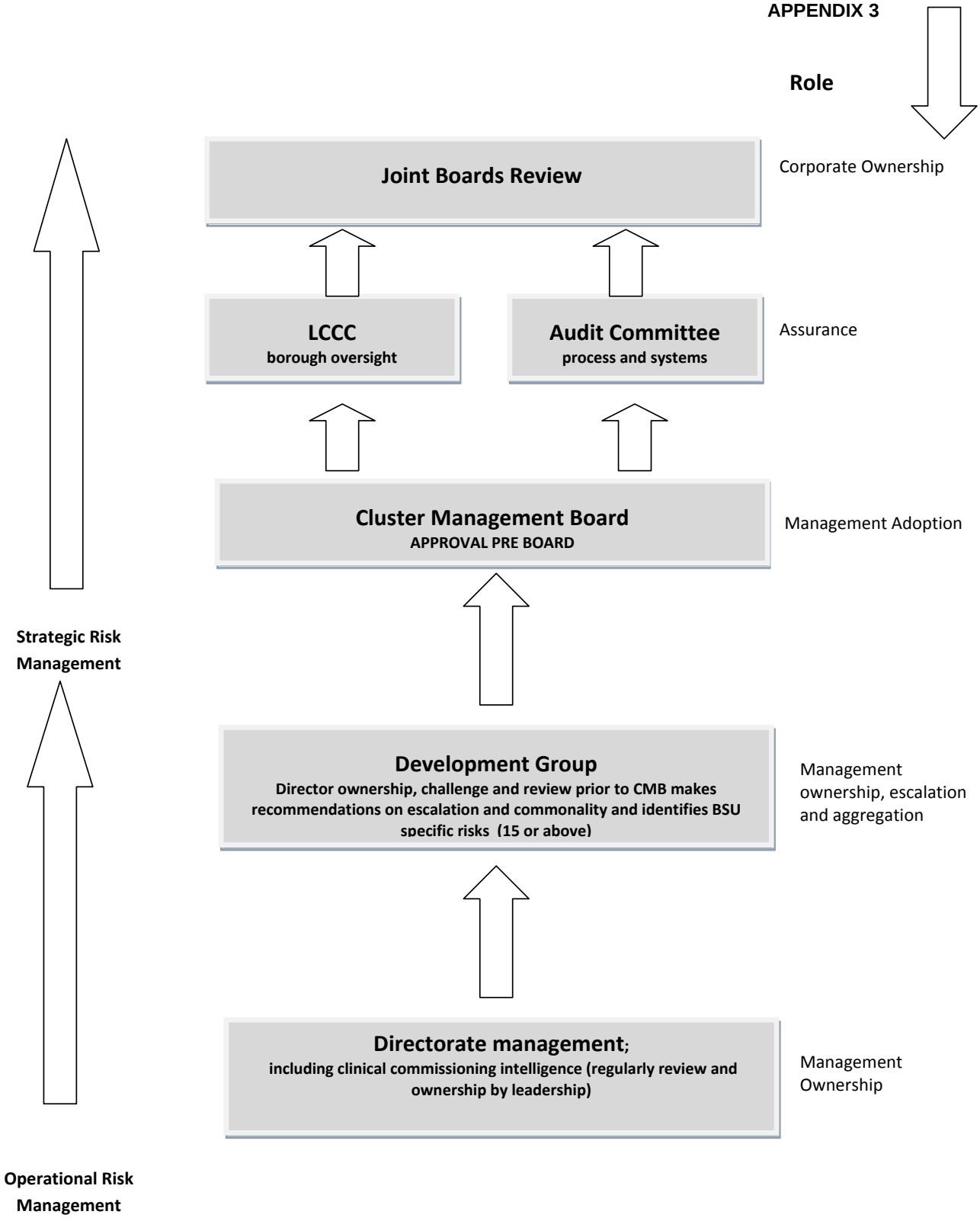
Risk Register		
Directorate		
Accountable Officer		
Last Review Date		

Corporate Objectives

EXECUTIVE SUMMARY - OPEN RISK ONLY

Identification						Risk Description and Assessment								Action Plan & Target		Status
Source Ref	Coprorate Objective	Work Stream	Date Raised	Risk Category	Risk Owner	Risk Description (There is a risk that....caused by.....leading to.....)	Inherent Risk	EXISTING CONTROLS ie. actions implemented where this is evidenced/documented any evidence risk is being controlled	Residual Likelihood	Residual Impact	Current Residual Risk	Acceptance Decision	Control Gap What still needs to be put in place	Action Plan Summary (Ongoing/Planned)	Target Residual Risk	Move-ment (Point)
EG. 1	2.1 To continue to improve as a World Class commissioner by ensuring that we achieve six level '3' competencies in our 11/12 rating and maintain or improve in all other areas.	COMPLIANCE - STATUTORY	39044	Legal & Compliance	Gill Gaillano	There is a risk of failure to comply with statutory requirements and deliver corporate objectives caused by insufficient management resource being made available leading to financial and performance failure	16	Flexible use of the corporate team, Sector discussions re cover of roles, Project plan and audit trail of Section 242, Provider reports meet requirements to save time, Sector functional discussions on core primary care functions,	Almost Certain	Catastro phic	25	Mitigate (See action plan)	Staff workshops dates agreed Staff Conference completed HR 1:1 meetings completed	1. Redesign of Statutory functions 2. Scheme of Delegation	8	0

APPENDIX 3


Role
Joint Boards Review
Corporate Ownership
LCCC
borough oversight
Audit Committee
process and systems
Assurance
Cluster Management Board
APPROVAL PRE BOARD
Management Adoption
Strategic Risk Management
Development Group
Director ownership, challenge and review prior to CMB makes recommendations on escalation and commonality and identifies BSU specific risks (15 or above)
Management ownership, escalation and aggregation
Directorate management;
including clinical commissioning intelligence (regularly review and ownership by leadership)
Management Ownership
Operational Risk Management

Appendix 4

Duties

- **Roles and Responsibilities**

It is important to differentiate between accountability and responsibility.

Responsibility	-	is the obligation to act or produce;
Accountability	-	is the obligation one assumes for ensuring these responsibilities are delivered. The person who is ultimately held to account if an activity or process is not delivered.

Thus, whilst many may be responsible for individual actions, accountability rests in the hands of those responsible for ***managing*** the cluster's objectives, strategies and risks.

- **Chief Executive** has overall responsibility for ensuring there is an effective risk management or assurance framework in place within the cluster, for meeting all statutory requirements, adhering to guidance issued by the Department of Health in respect of Governance and is required to sign the Statement on Internal Control. The Chief Executive is accountable to the Board.

- **All Directors and Managers**
  All levels of management must understand and implement the principles of the JBAF and this toolkit. All Directors/Directorate managers are responsible for: -

    - Ensuring that appropriate and effective risk management processes are in place within their designated area(s) and scope of responsibility.
    - Ensuring all staff are made aware of the risks within their work environment and of their personal responsibilities.
    - Preparing specific Directorate/Departmental policies and guidelines to ensure all necessary risk assessments are carried out within their directorate/department in liaison with appropriate identified relevant advisors where necessary.
    - Implementing and monitoring any identified and appropriate risk management control measures within their functions and scope of responsibility.
    - Ensuring that in situations where significant risks have been identified and where local control measures are considered to be potentially inadequate, Directors/ Directorate managers are responsible for bringing these risks to the attention of the Operational Risk Group
    - Ensuring that all staff are given the necessary information and training to enable them to undertake effective risk management practices.
    - Ensuring that a Risk Register is maintained for their area of responsibility.

- **All Employees** should understand the nature of risk and accept responsibility for risks associated with their area of authority. They are responsible for:-
    - Reporting incidents/accidents and near misses using the agreed channels.
    - Complying with all cluster Rules, regulations, guidance and instructions to protect the health, safety and welfare of anyone affected by the Cluster's business.
    - Complying with all rules, regulations, guidance and instructions to ensure the cluster carries out its business in a safe and proper manner.

- **Risk Management Governance Structure**

The Board has overall responsibility for:

- Ensuring that the cluster has a risk and assurance framework in place;
- It has identified all its key significant risks and they are been managed appropriately.
- Monitoring of the key risks will be done via the Joint Boards Assurance Framework. It needs to be satisfied that appropriate policies and strategies are in place and that systems are functioning effectively.

The Risk Committee (Cluster Management Board) shall be responsible:

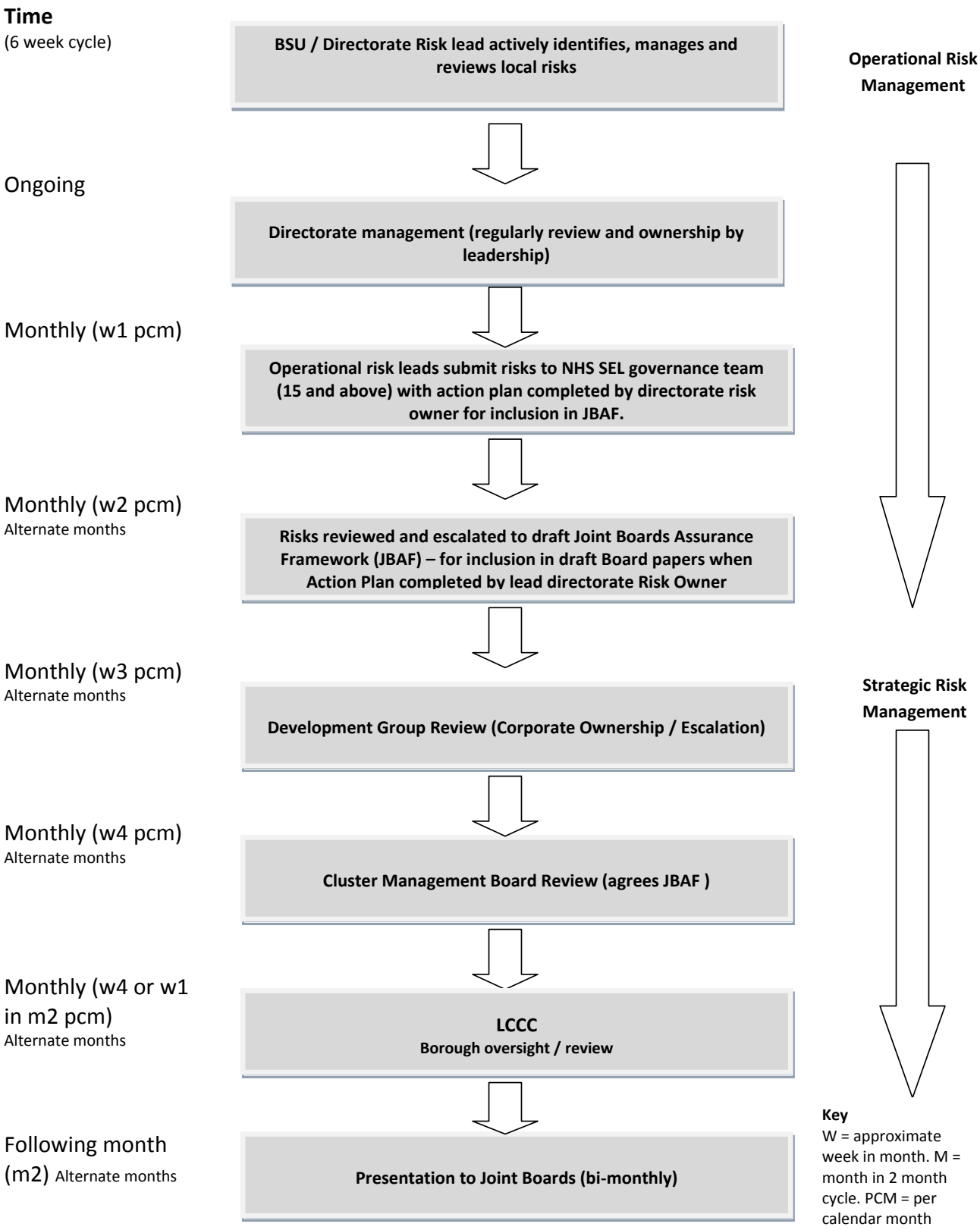
- For co-ordinating and overseeing the development and implementation of the Policy & Strategy across the cluster.
- It will oversee the development of the Joint Boards Assurance Framework and the maintenance of appropriate local risk register.
- On an alternate monthly basis it will review all significant risks on the register and new emerging risks that have escalated from the Directorates (via the Development Group).
- The Committee will monitor and ensure that the register reflects all the key risks with particularly high residual scores and that it remains a dynamic document.

The Audit Committee shall:

- Review the establishment and maintenance of an effective system of internal control and risk management.
- It will review the adequacy of the Joint Boards Assurance Framework and the structures, processes and responsibilities for identifying and managing key risks facing the Cluster .

Both the Board and the Risk Committee will be supported by the Development Group, LCCCs in each borough (reviewing the totality of local risks) and the governance team reporting to the Director of Corporate Affairs.

Appendix 5


Time
(6 week cycle)
BSU / Directorate Risk lead actively identifies, manages and reviews local risks
Operational Risk Management
Ongoing
Directorate management (regularly review and ownership by leadership)
Monthly (w1 pcm)
Operational risk leads submit risks to NHS SEL governance team (15 and above) with action plan completed by directorate risk owner for inclusion in JBAF.
Monthly (w2 pcm)
Alternate months
Risks reviewed and escalated to draft Joint Boards Assurance Framework (JBAF) – for inclusion in draft Board papers when Action Plan completed by lead directorate Risk Owner
Monthly (w3 pcm)
Alternate months
Development Group Review (Corporate Ownership / Escalation)
Strategic Risk Management
Monthly (w4 pcm)
Alternate months
Cluster Management Board Review (agrees JBAF)
Monthly (w4 or w1 in m2 pcm)
Alternate months
LCCC
Borough oversight / review
Following month (m2) Alternate months
Presentation to Joint Boards (bi-monthly)
Key
W = approximate week in month. M = month in 2 month cycle. PCM = per calendar month

EXCEPTION REPORT - RISK MANAGEMENT BOARD ASSURANCE

Date submitted	
Name of Risk Workstream	
Description of Risk	
Risk Owner	
Residual Risk Score	
Target Risk Score	
Date for achievement of Target Risk Score	

Current Controls	Gaps in Controls / Assurance
•	•

Action Plan Summary(date / by who)

1) .....
2) .....
3) .....
4) .....
5) .....
6) .....
7) .....
8) .....
9) .....
10) .....

Action	Priority	Resource	Contingency / Dependency	Progress	Evidence	RAG
1)						
2)						
3)						
4)						
5)						
6)						
7)						
8)						
9)						
10)						

Risk Identification								Risk Description and Assessment								Action Plan & Target						Status
Source Ref	Directorate	Corporate Objective	Work Stream	Date Raised	Risk Category	Risk Owner	Risk Description (There is a risk that…caused by……leading to……..)	Inherent Likelihood	Inherent impact	Inherent Risk	EXISTING CONTROLS ie. actions implemented where this is evidenced/documented note evidence of risk being controlled	Residual Likelihood	Residual Impact	Current Residual Risk	Acceptance Decision	Control Gap What still needs to be put in place	Action Plan Summary (Ongoing/Planned)	Target Likelihood	Target Impact	Target Residual Risk	Review Date	Movement (Point)	Status
DD2	Strategy & QIPP	2. Sustain an effective grip on finance, performance and QIPP	QIPP	14/04/11	Financial	Director of Operations	There is a risk that the National tariffs will increase at a rate higher than planned for, resulting in lower level of technical efficiency saving reducing the level of resource available for other investments	Almost certain	Major	20	Review programme of planned investments and instigate changes to the programme in areas of lower priority/lower return on investment 'Stocktake' operational review process in place. LCCCs established with process for review of QIPP Joint Performance, Finance & QIPP committee in place	Likely	Major	16	Mitigate (See action plan)	Developing Plan B's Up to month 2 data available	Lobby DH & NHSL Retain partnerships with local providers Secure pathway redesign	Possible	Major	12	Monthly		Open
DD4	HR	3. Proactively manage the transition to the new commissioning system.	Manage the workforce	01/06/11	People	Gill Galliano	There is a risk that NHSSEL will be unable to retain staff caused by the uncertainty of transition and substantial NHS change leading to capacity shortages and an inability to deliver services or retain organisational memory	Likely	Major	16	Delivering OD framework and work plan NHSL transition staff retention framework NHSL Business Plan in place, Directorate Objectives flowing now framing development of staff objectvies and appraisals	Possible	Major	12	Mitigate (See action plan)	Govt Pause resulting in uncertainty of timescales for transition CSO proposition End state for all parts of business yet to be fully defined	Lobbying NHSL / DH Collaboration with London Clusters	Possible	Major	12	Monthly		Open
Op4	Operations	2. Sustain an effective grip on finance, performance and QIPP	QIPP	14/04/11	Financial	Director of Operations	There is a risk of failing to deliver the operating plans caused by a lack of GP ownership, ineffective or no pathway redesign and demand management leading to a failure to invest to save intiaitves and associated loss of financial delivery.	Almost certain	Major	20	LCCC leadership and focus, BSU QIPP committees, Developing clinical OD plans. Monthly Director of Development GP Delegation and Development task group. Clear performance framework in place which securely identifies where accountability lies for delivery and which is regular monitored with corrective action taken as appropriate. Delegation report to May 11 Board. Quaterly Stocktakes meetings established. PMO function in place. Operational Group now in place and meeting	Likely	Major	16	Mitigate (See action plan)	Second cycle of of 'stock takes' at local level chaired by Director of Operations and with Director of Finance and Director of Performance becoming local 'recovery boards' if required. Clarity of directors' roles in QIPP (Finance, Development, Operations)	Additional initiatives or enhanced scale of existing initiatives may be required in-year.	Possible	Major	12	31/05/11		Open
F1	Finance	2. Sustain an effective grip on finance, performance and QIPP	Finance	01/06/11	Financial	Marie Farrell	There is a risk that reduced capacity and increased transition agenda leads to understatement of financial risk and insufficient focus leeading to poor monitoring and reporting	Almost Certain	Major	20	Plans are in place to migrate to common financial systems and reporting arrangements to strengthen reporting, ensure monitoring is undertaken on a timely basis and freeing up capacity to focus on strategic priorities .	Likely	Major	16	Mitigate (See action plan)	- mapping of budget to identify available resources and ensure appropriate budget is in place - Ensure appropriate resource in place to migrate to new standardised system - Development of arrangements to maintain capacity during transition	- Reconciliation of 10/11 outturn to 11/12 budgets. - Establish development agenda to retain key skills. - Appoint PM team	Unlikely	Major	8	Monthly		Open
F2	Finance	2. Sustain an effective grip on finance, performance and QIPP	Finance	01/06/11	Financial	Marie Farrell	There is a risk that current planning and strategic approach is not sufficiently robust to manage pressures across the SEL Health system and deliver sustainable legacy positions	Almost Certain	Major	20	4 year strategic plan in place with risk assessed QIPP	Likely	Major	15	Mitigate (See action plan)	- sensitivity analysis based on revisions to Operating Framework planning assumptions - modelling of impact on providers of worst case and alignment with Trust plans	- Review base case planning assumptions -sensitivity modelling of QIPP delivery - Analyse financial trend and identify additional savings needed to maintain underlying financial position.	Unlikely	Catastrophic	10	Monthly		Transferred
F3	Finance	2. Sustain an effective grip on finance, performance and QIPP	Finance	01/06/11	Financial	Marie Farrell	There is a risk that current structures and associated running costs are higher than will be available to fund sustainable and effective arrangements for future structures.	Almost Certain	Major	20	Envelope set for Pay and WTE Vacancy review panel in place	Almost Certain	Major	20	Mitigate (See action plan)	Current costs exceed original envelope. Discussions ongoing re running cost funding.	Reconciliation of 10/11 outturn to 11/12 budgets and identify gaps/opportunities. - Set targets for cost reductions via Clusters not achieved. Require significant cost reduction action plan	Unlikely	Major	8	Monthly		
PC1	Primary Care	1. Improve health, quality and maintain safety of local NHS services.	Primary care	03/05/11	Clinical	Director of PC	There is a risk that the identification of 45 live 'Issues of Concern' cases (10 of which are currently rated red) brought about by the establishment of a single PC team and aggregation of SEL issues leading to potential risk to the ability to provide universally applicable high quality primary care to our populations	Almost Certain	Catastrophic	25	Recruitment of an Issues of Concern Team. Creation of an Issues of Concern Register Establishment of Primary Care Decision Panel & Issues of Concern Group Part 2 May 2011 Boards brieifing 4NEDs identified to support swift establishment of IoC panles Monthly performance and review reporting and meeting structures established Reporting process to Joint Quality and Safety Committees established. IoC Panels have meet Closed 42 cases.	Almost Certain	Major	20	Mitigate (See action plan)	Staffing capacity to respond to potential future increases in total volume Non pay budgtes for progression of IoC cases remains to be defined New cases will be identified (11 new cases in last cycle)	Continued development of NHS SEL Protocols and Procedures for addressing Issues of Control. Regular review of current caseload, action plans and closure of cases where possible. Focus on reduction of overall volume to enhance staff capacity resiliance. targetted focus on high rated cases and actions plans in place for each case. Organisational OD Plan in development IoC team workplans in development	Almost Certain	Major	20	Monthly. 3 month target for greater control		Open
PC3	Primary Care	3. Proactively manage the transition to the new commissioning system.	Reform	03/05/11	Change	Director of PC	There is a risk of lost focus, capacity and resiliance to deliver challenging agenda for PC team caused by the merging of six PC operations into one, reduced workfore, whilst similtanously preparing for rapid transfer to National Commissioning Board in 12/13	Almost Certain	Major	20	Recruitment to Cluster Primary Care Directorate Development of workplans / staff workshops Participation in DH / NHSL forums Directorate objectives provide clarity on immediate priorities Development of NHS SEL Protocols and Procedures	Likely	Major	16	Mitigate (See action plan)	Cluster protocols and polices to be developed. Directorate objectives to be established Ability to influence compounded timescales and scale of multiple challenges Aligned impact on associated services e.g FHS	Team workplans in development Continued participation in relevant regional and national forums Work with directorate BSU colleagues to define optimal local solutions	Likely	Moderate	12	01/08/11		Open
PH 2	Public Health and all BSUs	Improve health, quality and maintain safety of local NHS services.	Public Health	01/05/11	Operations	DPH and all BSU MDs	Emergency Planning. Hazard: Level 2 or 3 (Mass casualty) incident; Risk of: services overwhelmed and services break down. Business Continuity during the Olympics is a potential challenge due to risk of mass casualty event or of high demand on services	Likely	Catastrophic	20	Emergency Prepardness Report to May 19th Board; Emergency Planning and Resilience Group Steering Group in place; Assurance assessment completed: Emergency Planning and Business continuity plan in place; Participation in NHSL Olympic Planning Groups; Cluster Director level on-call rota in place Established SEL Emergency Planning and Resilience steering Group	Possible	Catastrophic	15	Mitigate (See action plan)	Capacity issues arising from transition Re-establishment of borough planning and links between BSUs and LAs ; Completion of actions on action plan; Olympics Delivery (contingency) Group	Scope and define disitnct Olympic contingency plans	Possible	Catastrophic	15	01/08/11		Open

MD2	**Medical Directorate**	1. Improve health, quality and maintain safety of local NHS services.	Quality	06/07/11	Clinical	Medical Director	There is a risk that one or more of our providers will fail to deliver health services to the required level of quality outcomes caused by lack of organisational capacity, insufficient capture of data on quality indicators leading to instability of the system and insufficient capacity to respond and delivery high quality care for all.	Likely	Catastr ophic	**20**	Clinical Quality Groups meeting bimonthly with providers LCCCs Quality Working Groups Cluster Joint Quality and Safety Committee Regular Performance and Quality Report to Joint Boards NHS London scrutiny and support Centralised reporting of Serious Incidents	Possible	Major	**15**	Mitigate (See action plan)	Further development of quality metrics Agreed SI Cluster Reporting Process Tested cycle of Clinical Quality Group meetings	Agreed SI Process to Joint Boards (21/07/11) Mapping on Commissioned Services Quality Workshop planned Development of Quality Metrics – agree Dashboard for reporting	Unlikely	Catastrop hic	**10**	Monthly		Open
CN1	**Chief Nurse**	1. Improve health, quality and maintain safety of local NHS services.	Safeguarding	31/05/11	Legal & Compliance	Chief Nurse	There is a risk that Adult's Safeguarding arrangements may not be satisfactory caused by insufficient rigour of processes or assurnance therein and capacity during the transition leading to individuals potentially being placed in an unsafe environment or receiving uncontrolled care	Likely	Catastr ophic	**20**	Review learning from Childrens SG arrangements in light of government intent to enhance ASG arrangements Local adult SG panels in place LA policies and joint working arrangements in place LA leadership recognised across NHS SEL London response to LSGB recommendations CQC Inspection reports for Nursing Homes	Possible	Catastr ophic	**15**	Mitigate (See action plan)	One localised source for multiple NHS policies Expanding expectations and remit covering Learning Disabilites, Care Homes and Vulnearable adults	Development of single NHS SEL policy required Capacity review Develop QA process led by BSUs	Unlikely	Catastrop hic	**10**	01/08/11		Open
CN2	**Chief Nurse**	1. Improve health, quality and maintain safety of local NHS services.	Safeguarding	01/06/11	Legal & Compliance	Chief Nurse	There is a risk that Children's Safeguarding arrangements may not be satisfactory caused by insufficient rigour of processes and capacity during the transition leading to individuals potentially being placed in an unsafe environment or receiving uncontrolled care (high profile death with blame apportioned to public sector / health)	Possib le	Catastr ophic	**15**	Designated professionals in place or action plans in place where gap exists. Local policies and proceedures in place Providers quality assured as having appropriate policies and proceedures Review of lead nurse arrangements across cluster Reported on current status within BSUs to May Board - Fuller report relating to LSGB recommendation to July Board Workstream to manage consequences of organisational change / cluster opportunities Community Services subjected to SIT review with associated action plans in place	Unlikely	Catastr ophic	**10**	Mitigate (See action plan)	Munroe Review recommedations Training and development needs of primary care clinicians 1 borough designated doctor post currently vacant Common reporting expectations with designated professional Review outputs from pending serious case reviews	Review of Munroe Recommendations Training and Development workplan for PC to be developed with PC Recruitment for designated Dr underway with plan be in place. Review of SLAs in place with providers	Rare	Catastrop hic	**5**	01/08/11		Open
CN3	**Chief Nurse**	1. Improve health, quality and maintain safety of local NHS services.	Safeguarding	01/06/11	Legal & Compliance	Chief Nurse	There is a risk that Children's Safeguarding arrangements may not be satisfactory caused by insufficient rigour of processes and capacity during the transition leading to individuals potentially being placed in an unsafe environment or receiving uncontrolled care (child death involving NHS blame not apportioned but repuational risk encountered)	Almost Certai n	Moder ate	**15**	Designated professionals in place or action plans in place where gap exists. Local policies and proceedures in place Providers quality assured as having appropriate policies and proceedures Review of lead nurse arrangements across cluster Reported on current status within BSUs to May Board - Fuller report relating to LSGB recommendation to July Board Workstream to manage consequences of organisational change / cluster opportunities Community Services subjected to SIT review with associated action plans in place	Unlikely	Catastr ophic	**10**	Mitigate (See action plan)	Munroe Review recommedations Training and development needs of primary care clinicians 1 borough designated doctor post currently vacant Common reporting expectations with designated professional Review outputs from pending serious case reviews	Review of Munroe Recommendations Training and Development workplan for PC to be developed with PC Recruitment for designated Dr underway with plan be in place. Review of SLAs in place with providers	Rare	Catastrop hic	**5**	01/08/11		Open

South East London

A meeting of the SEL PCT Boards* and Bexley Care Trust
21st July 2011

ENCLOSURE 11

ENCLOSURE 11

DELIVERING EQUALITIES

DIRECTOR RESPONSIBLE: Gill Galliano, Executive Director of Development

AUTHOR: Valerie Richards, Equalities Officer NHS SEL

TO BE CONSIDERED BY: All

SUMMARY:
The aim of this paper is to introduce the Equality Delivery System (EDS) in NHS South East London Cluster and explain how the adoption of the EDS will improve quality and ensure compliance with statutory duties of the Equality Act (2010) and the statutory duty to consult and involve patients, communities and other local interests (NHS Act 2006 and Equality Act). In particular we want to emphasise the importance of Clinical Commissioning Groups considering using the EDS in planning and delivering their work in the future.

KEY ISSUES:

Background

The NHS Equality and Diversity Council (EDC) was formed in 2009 with representatives from the NHS, Department of Health and other interests. Chaired by Sir David Nicholson, the EDC reports to the NHS Management Board and supports the NHS to deliver services that are fair, personal and diverse to promote continuous improvement. Major EDC products in 2011 are the EDS and guidance on the Equality Act 2010.

The EDS requires NHS organisations in collaboration with locally interested parties and identified needs to analyse and measure/assess "grade" their performance, and set defined equality objectives, supported by an action plan. Performance against the selected objectives should be annually reviewed. These processes will be integrated within NHS SEL Cluster mainstream business planning.

Summary of issues
The Equality Delivery System will provide an accurate assessment of how well we are delivering on our equality duties. It will highlight areas of weakness which will feed into the local planning process and action plans. It will provide evidence which can be used to demonstrate compliance with the Equality Act through the objectives and outcomes of the EDS. The EDS is also described in the Equality Impact Assessment accompanying the Health and Social Care Bill 2011 as "a tool that will support commissioners and providers in achieving their equality outcomes, linking these clearly to health outcomes."

Any risks and actions and mitigations taken to minimise these
The most important risk at this time is with regard to insufficient awareness of EDS and its implementation within the Central Team and BSU Directorate levels. We will work to raise the profile of the EDS working with the Equality Leads in the Business Support Units (BSUs), ensuring there is awareness and actions are carried out. A number of other potential risks have been identified including the risk of not achieving good engagement, not ensuring all equality target groups are being given genuine outcomes, focusing on costs and not benefits and lack of buy-in from senior managers, risk re Pathfinder Delegation and CSO development. We will use the corporate assurance framework to mitigate the risks.

Consequences of no decision being taken
NHS London is overseeing the implementation of the EDS into NHS organisations in London. A key milestone in the process is that there must be explicit "buy-in" from current NHS Boards by 31 July 2011; the deadline will be missed if a decision is not taken at NHS SEL Joint Boards meeting on 21 July 2011. A copy of the report to the Board and the TOR of the Cluster Corporate Equalities Group approved by the Joint Boards is required to be sent to the NHS London Equalities Lead by 31 July 2011.
.
Reason for timeliness / submission now
Approval of the terms of reference for the Cluster Corporate Equalities Group that will be responsible for providing assurance to the Joint Boards of implementation of the EDS will give authorisation for work of the workplan to commence. There are a series of key milestones that require action and with deadlines that start at the end of July 2011 as described in Appendix 1.

Finance considerations
There are no direct financial implications arising from this new framework. However, there will be ongoing resource implications in terms of:

- developing and implementing an ongoing community engagement exercise around developing equality objectives and prioritised actions and assessing organisational performance against these
- participating in a regional grouping cluster of NHS Trusts to share good practice and peer support
- reducing barriers to accessing primary care services should improve early diagnosis and intervention, potentially moving NHS expenditure more "upstream".

However, it should be noted that as organisations meet the Equality Act 2010 duty, the above cost implications would be incurred regardless. NHS South East London Cluster organisation and/or legacy organisations will be at risk of legal challenge if it fails to meet its duties under equality legislation, or if it knowingly or unknowingly allows discrimination to occur.

Legal considerations
The EDS does not replace legislative requirements for equality; rather it is designed as performance and quality assurance mechanism for the NHS and a means by which NHS organisations are helped to meet the requirements of the Equality Act (2010) and the NHS Act (2006). Both the Equality & Human Rights Commission and the Government Equalities Office have endorsed draft EDS proposals.

Performance considerations
This will not be part of the routine NHS London Performance targets. The forecasted London Regional progress on EDS implementation in May 2011 rated the whole of London as Red (not started/insufficient progress). Actions are required to move us from Red to Green including "buy-in from current NHS Boards". If NHS SEL Cluster performance does not progress in line with the planned delivery of the EDS for London, this will become an exception report and a recovery plan will be required. This has been communicated to Shaun Stoneham – NHS SEL Cluster Performance Lead who will ensure performance is monitored appropriately.

Staffing considerations –
Contact has been made with Una Dalton, Director of Human Resources at South East London with a view to agreeing how to meeting the EDS objectives and outcomes that relate to empowered, engaged and well-supported staff.

Equalities considerations
Implementation of the EDS will have a positive impact on equality.

Appendices included with this paper
- Appendix 1 NHS SEL Cluster Equality Delivery System Implementation Plan 2011-12
- Appendix 2 EDS outcomes and objectives framework

Background information available on the website
- Appendix 3 Cluster Corporate Equalities Group – Terms of Reference
- NEDC EDC EDS Factsheet - April 2011
- EDS Factsheet - London regional contacts

COMMITTEE INVOLVEMENT:
- The Cluster Management Board discussed this report on 21 June 2011 and with feedback and revisions agreed to approve this paper.

PUBLIC AND USER INVOLVEMENT:
- The EDC carried out extensive engagement and consultation that took place in the North

ENCLOSURE 11

West of England. It is based upon the views of 700 people covering patient, staff and other interests at 35 engagement events in 2010 and early 2011. When the EDS regional consultation events are concluded in 2011, it is estimated that over 2,000 people will have contributed to the EDS design.

- Within the SEL Cluster we are aiming to finalise a consultation and engagement plan by 31 August and begin a consultation and engagement exercise in September 2011. As part of this we will engage with stakeholders at the NHS SEL Stakeholder Reference Group.

IMPACT ASSEESMENT: N/A

RECOMMENDATIONS:

The board (s) is asked to:-

1 The Board is recommended to note the proposal to adopt the NHS EDS and to approve the development and implementation of the EDS and the implementation plan.
2 To agree to establish the Cluster Corporate Equalities Group (CCEG) as a mechanism to implement the EDS and that the CCEG will be chaired by Gill Galliano, Executive Director of Development as the executive Equalities lead for the Cluster.
3 To note the terms of reference of the Cluster Corporate Equalities Group and formalise the CCEG reporting directly to the Cluster Board in line with best practice and the requirements of the EDS.

DIRECTORS CONTACT:

Name: Gill Galliano, Executive Director of Development, NHS SEL
E-Mail: g.galliano@nhs.net
Telephone: 020 7206 3342

AUTHOR CONTACT:

Name: Valerie Richards, Equalities Officer, NHS SEL
E-Mail: valerierichards@nhs.net
Telephone: 020 3049 4167

*SEL PCT Boards = Boards of Lambeth Primary Care Trust, Southwark Primary Care Trust, Lewisham Primary Care Trust, Bromley Primary Care Trust and Greenwich Teaching Primary Care Trust.

1 The Equality Delivery System Process

1.1 The EDS requires NHS organisations in collaboration with local interests to analyse and grade their performance, and set defined equality objectives, supported by an action plan. Performance against the selected objectives should be annually reviewed. These processes should be integrated within mainstream business planning.

1.2 There are 18 Outcomes in total, grouped under four Objectives:

1. Better health outcomes for all
2. Improved patient access and experience
3. Empowered, engaged and inclusive staff
4. Inclusive leadership

1.3 As a result of this analysis, NHS organisations, again in discussion with local interests, will confirm their Equality Objectives for the coming business planning period (as required by the Equality Act) and agree a limited number of priority actions. Performance against the selected priorities should be annually reviewed. These processes should be integrated within mainstream NHS business planning.

1.4 NHS Commissioning Board, and that the grades for both NHS commissioners and providers shall be published nationally. The Care Quality Commission (CQC) will take account of concerns highlighted by the EDS through the Quality Risk Profiles it maintains on all registered NHS providers.

1.5 The system is designed to enable compliance with the requirements of the Equality Act 2010 and it will apply to all NHS organisations, including GP Consortia and Foundation Trusts. It may also be applied, through contracts, to all those healthcare organisations that are not a part of the NHS, but which may work to contracts issued by NHS commissioners.

2 Accountability and Related Systems

2.1 The main drivers for developing and implementing the Equality Delivery System are compliance with the Equality Act 2010 and the requirements of the White paper, '*Equity and Excellence: Liberating the NHS'* .

2.2 The EDS is referenced within the NHS Operating Framework for 2011/12 with the strong emphasis that NHS Boards will need to comply with the Equality Act 2010 and its specific public sector duties, that will come into force in force in 2011 by implementing the EDS developed by the NHS EDC to maintain progress and demonstrate compliance with the Act. It is referred to in the Department of Health's Cluster Implementation Guidance stating that SHAs and clusters should ensure that all statutory equality duties are handled clearly, explicitly and effectively through the new arrangements.

2.3 The EDS system brings together equality aspects of QIPP (Quality, Innovation, Productivity and Prevention), CQC (Care Quality Commission), and the NHS Outcomes Framework and it incorporates the regulatory functions of the Equality and Human Rights Commission.

2.4 Local Involvement Networks (LINks) and their successors (Health Watch), or an equivalent local body, will help NHS organisations to engage with local interests. Agreed Equality Objectives, priorities and grades will be shared with Local Authority Overview and Scrutiny

Committees and Health and Wellbeing Boards. They will also be forwarded for review by the NHS Commissioning Board or Care Quality Commission and it has been stated that the NHS Commissioning Board will use the EDS as a part of the authorisation and performance management of future General Practice Commissioning Consortia.

2.5 The Equality Delivery System component has been incorporated into the Key Lines of Enquiry (KLOE) for assuring Pathfinder applications are aligned with the NHS London criteria for delegation set out in the London GP Consortia development programme.

2.6 The Equality Delivery System is also consistent with and complimentary to the Equality Framework for Local Government.

3 How does this fit with the organisations Operational Planning Process?

3.1 The EDS will form part of the organisation's strategic and annual business cycle and help guide future planning and resource allocation.

4 Next steps

4.1 Subject to the Board's approval, Gill Galliano, Executive Director of Development, the Equalities Lead for the NHS SEL Cluster will work closely with NHS London via Carol Byrne, Governance Manager, External Assurance and Valerie Richards, Equalities Officer, Project Manager for the implementation of the EDS. There is a London EDS implementation plan with milestones that are set out as part of the NHS SEL Cluster EDS Implementation Plan 2011-12 (Appendix 1).

5 Recommendations

The Board is recommended to:

5.1 To note the proposal to adopt the NHS EDS and to approve the development and implementation of the EDS and the implementation plan.

5.2 To agree to establish the Cluster Corporate Equalities Group (CCEG) as a mechanism to implement the EDS and that the CCEG will be chaired by Gill Galliano, Executive Director of Development as the executive Equalities lead for the Cluster.

5.3 To note the terms of reference of the Cluster Corporate Equalities Group and formalise the CCEG reporting directly to the Cluster Board in line with best practice and the requirements of the EDS.

NHS SEL Cluster Equality Delivery System Implementation Plan 2011-2012

Appendix 1

	2011								2012			
	MAY	**JUNE**	**JULY**	**AUG**	**SEPT**	**OCT**	**NOV**	**DEC**	**JAN**	**FEB**	**MAR**	**APRIL**
Equality Delivery System DH timetable	Develop EDS Guidance	Approval/ sign off from national Equality and Diversity Council	Finalised EDS guidance	EDS Publish Guidance	EDS Formally launched			Expect NHS organisations to provide analysis of compliance against equality duties	Review analysis of compliance			
Regional progress on EDS implementation as at May 2011			Buy-in from current NHS Boards		Buy-in from emerging GP consortia and PCT Clusters Communication s plan	Engagement / involvement GPs and GP consortia	Engagement / involvement Voluntary/ community sector; LAs; LINKS Patients and carers NHS Staff and Staffside					
NHS SEL Cluster Reporting and Decisions to be made	BSU Leads identified: Peter Buck (Bexley), Paula Morrison (Bromley), Sharon Davidson (Greenwich), Sarah Corlett (Lambeth), Mike Hellier (Lewisham), Malcolm Hines (Southwark)	Cluster Corporate Equalities Group (CCEG) TOR and NHS SEL Cluster Governance Working Group TOR agreed at preliminary meetings.	Implementation of EDS report, Cluster Corporate Equalities Group (CCEG) TOR and NHS SEL Cluster Governance Working Group TOR agreed at Cluster Board.				**Board Reporting Requirements** Cluster Board to receive an update of progress report, plus Equality objectives from Strategy and QIPP leads (**24 November)**		Cluster Board to receive an update of progress report **(26 January)**		Cluster Board to receive an annual review **(29 March)**	

ENCLOSURE 11

	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APRIL
Consultation and Engagement of local interests		Develop evidence base to inform consultation		Finalise consulta-tion and engage-ment plan and documents	Launch consultation and engagement			Close consultation	**Provide consultation feedback to local interests/stakeholders. Complete first draft of equality objectives**		**Review feedback and revise objectives**	
Cluster Corporate Equalities Group (CCEG) and NHS SEL Commissioners Governance Working Group Actions			NHS SEL Cluster to draft objectives for transition from Single Equality Schemes (SESs) to integrated SED for EDS Each BSU has drafted plans to move from current system to new system.	Each BSU moves to new system; Clinical Commissio-ners / Clinical Consortia are made aware of the EDS and their responsibi-lities. LINks(or Health Watch), LAs, OSCs, HWBs are briefed on what their part in the process will be.	Cluster-wide Single Equality Scheme will be drawn up by integrating the 6 SESs from BSUs. Cluster and BSUs identify their local interests with whom organisational performance will be graded in partnership.	Equality objectives are identified as part of mainstream business planning processes including tackling health inequalities. Cluster Board meeting to receive an update of progress report, plus Equality objectives from Strategy and QIPP leads (24 November) Cluster and BSUs in collaboration with local interests should analyse and grade organisational equality performance and identify 4-5 equality priority action for the following financial year (2012/13)			New systems are in place; BSUs have a 4-year Equality Strategy and an Annual Improvement Plan; Local interests have been fully engaged and EDS grades have been agreed upon; Clinical Consortia are supported to finalise their Strategies and Plans. Cluster Board meeting to receive an update of progress report (26 January) The Board , via LINks (or HealthWath) should send their ratings of performance and priority actions to Local Authority Overview and Scrutiny Committees and (in due course) to Health and WellBeing Boards		Grades reported to EDS Programm e Office and the NHSCB (1 March) Cluster Board meeting to receive an annual review (29 March)	Using the EDS, all NHS bodies will have published their Equality Objectives and related priority actions as required by the Equality Act 2010. Trusts and Clinical Consortia implemen t their Strategies and Plans and fully review by March 2013. Detailed action plan with milestone s to be complete d for 2013 by 31st March 2013

Appendix 2

EDS OBECTIVES AND OUTCOMES

The analysis of the outcomes must cover each protected group, and be based on comprehensive engagement, using reliable evidence

Objective	Narrative	Outcome
1. Better health outcomes for all	The NHS should achieve improvements in patient health, public health and patient safety for all, based on comprehensive evidence of needs and results	1.1 Services are commissioned, designed and procured to meet the health needs of local communities, promote well-being, and reduce health inequalities
		1.2 Patients' health needs are assessed, and resulting services provided, in appropriate and effective ways
		1.3 Changes across services are discussed with patients, and transitions are made smoothly
		1.4 The safety of patients is prioritised and assured
		1.5 Public health, vaccination and screening programmes reach and benefit all local communities and groups
2. Improved patient access and experience	The NHS should improve accessibility and information, and deliver the right services that are targeted, useful, useable and used in order to improve patient experience	2.1 Patients, carers and communities can readily access services, and should not be denied access on unreasonable grounds
		2.2 Patients are informed and supported so that they can understand their diagnoses, consent to their treatments, and choose their places of treatment
		2.3 Patients and carers report positive experiences of the NHS, where they are listened to and respected and their privacy and dignity is prioritised
		2.4 Patients' and carers' complaints about services, and subsequent claims for redress, should be handled respectfully and efficiently
3. Empowered, engaged and well-supported staff	The NHS should Increase the diversity and quality of the working lives of the paid and non-paid workforce, supporting all staff to better respond to patients' and communities' needs	3.1 Recruitment and selection processes are fair, inclusive and transparent so that the workforce becomes as diverse as it can be within all occupations and grades
		3.2 Levels of pay and related terms and conditions are fairly determined for all posts, with staff doing the same work in the same job being remunerated equally
		3.3 Through support, training, personal development and performance appraisal, staff are confident and competent to do their work, so that services are commissioned or provided appropriately
		3.4 Staff are free from abuse, harassment, bullying, violence from both patients and their relatives and colleagues, with redress being open and fair to all
		3.5 Flexible working options are made available to all staff, consistent with the needs of patients, and the way that people lead their lives
		3.6 The workforce is supported to remain healthy, with a focus on addressing major health and lifestyle issues that affect individual staff and the wider population

Objective	Narrative	Outcome
4. Inclusive leadership at all levels	NHS organisations should ensure that equality is everyone's business, and everyone is expected to take an active part, supported by the work of specialist equality leaders and champions	4.1 Boards and senior leaders conduct and plan their business so that equality is advanced, and good relations fostered, within their organisations and beyond
		4.2 Middle managers and other line managers support and motivate their staff to work in culturally competent ways within a work environment free from discrimination
		4.3 The organisation uses the NHS Equality & Diversity Competency Framework to recruit, develop and support strategic leaders to advance equality outcomes

South East London

A meeting of the SEL PCT Boards* and Bexley Care Trust
21st July 2011

ENCLOSURE 12

Minor Amendments to the Corporate Governance Framework

DIRECTOR RESPONSIBLE: Marie Farrell, Director of Finance / Gill Galliano, Director of Development

AUTHOR: Ben Vinter, Integrated Governance Manager

TO BE CONSIDERED BY: All

SUMMARY:
At their first meeting the Joint Boards adopted a suite of governance documents including common Standing Orders, Standing Financial Instructions and a Schemes of Delegation.

Clarifications have now been made to a limited number of areas following comments from Board members. Board members also requested a review of documentation for consistency of language.

KEY ISSUES:
A number of amendments have been made as requested;

Standing Orders;
- Fig 1 - Bexley membership has been amended to reflect current legal advice. Resulting in non executive Board membership of; Chair, Audit Chair, 2 Cllr members, 2 'home' NEDs, 2 cross appointed NEDs
- 5.2 '*formal*' *REPLACING 'all'* meetings of the LCCCs will be held in public
- Consistency of language and terms throughout
- Numbering throughout
- Alignment and formatting throughout

Standing Financial Instructions -

- Updating the figures relevant to the general position on quotations
- Removing / replacing references to external bodies / assessments that are no longer relevant
- Changing the nomination for lead Security Management from a non Executive to an Executive role.

This is a summary report, reporting amendments made at the Boards' request only, all financial, legal, risk and other applicable considerations having been reported, as appropriate, at the time of full reporting to the Boards (May) and when accompanied by full documentation.

Copies of the revised and complete documentation can be obtained via the NHS SEL governance team or the NHS SEL website.

A definition of terms has been appended to the Corporate Governance Framework and is set out below;

Primary Care Trusts (PCTs) / Care Trust – *are terms applied only where formal reference, duties, functions or powers are referenced which relate to statute that established or directed PCTs or Care Trusts to perform specific tasks and therefore remain the statutory functions through which NHS SEL operates. PCTs / Care Trusts were established to commission healthcare services with local partners to ensure that local health and social care needs are met*.

Cluster – *a management term used to describe the establishment of a single management team spanning multiple PCTs / Care Trusts and the introduction of cross appointed governance arrangements.*

NHS South East London (NHS SEL) – *term by which we refer to our cluster arrangements*

The Joint Boards – *refers to a meeting of each of the NHSL SEL Boards taking place simultaneously and considering shared business*

Boards –*plural reference to each of the Boards in NHS SEL as individual entities*

Board – *singular reference to one Board from within NHS SEL*

Business Support Unit (BSU) – *six distinct borough focused support units established to deliver locally appropriate healthcare and support the development of local GP pathfinders*

Statutory bodies – *those bodies established, regulated or imposed by or in conformity with laws passed by a legislative body, e.g. Parliament*

Establishment order – *statute that applies further legislation to an existing Parliamentary Act*

Regulations – *legal restrictions promulgated by a government authority with a view to the*

implementation of policy statements

Functions – *a role which must be carried out under legislation*

Strategic Health Authority (SHA) – *bodies created by the government in 2002 to manage the local NHS on behalf of the secretary of state. As of July 1 2006, there are 10 SHAs covering England.*

COMMITTEE INVOLVEMENT:
The core documentation has previously been circulated and adopted by the Joint Boards.

PUBLIC AND USER INVOLVEMENT:
The report references minor amendments being made to documentation which sets out process and provides clarity to the public and service users as to the management of the organisation's business.

IMPACT ASSEESMENT: N/A

RECOMMENDATIONS:
The Boards are asked to:-

- NOTE the revisions in line with their previous request.

DIRECTORS CONTACT:

Name: Gill Galliano
E-Mail: g.galliano@nhs.net
Telephone: 020 7206 3332

AUTHOR CONTRACT:

Name: Ben Vinter
E-Mail: ben.vinter@nhs.net
Telephone: 020 30494421

*SEL PCT Boards = Boards of Lambeth Primary Care Trust, Southwark Primary Care Trust, Lewisham Primary Care Trust, Bromley Primary Care Trust and Greenwich Teaching Primary Care Trust.

South East London

A meeting of the SEL PCT Boards* and Bexley Care Trust 21st July 2011

ENCLOSURE 13 **USE OF NHS SEL PCT / CARE TRUST SEALS**
DIRECTOR RESPONSIBLE: Simon Robbins
AUTHOR: Ben Vinter, Integrated Governance Manager
TO BE CONSIDERED BY: All
SUMMARY: This report sets out the use of the NHS SEL PCTs and Care Trust seals since the last meeting of the Boards or where not previously reported from 1/4/11.
KEY ISSUES: None other than those set out within the appendix.
COMMITTEE INVOLVEMENT: N/A
PUBLIC AND USER INVOLVEMENT: N/A
IMPACT ASSEESMENT: N/A
RECOMMENDATIONS: The Board(s) are asked to:- • Note the specified use of PCT / Care Trust seals.

ENCLOSURE 13

DIRECTORS CONTACT:
Name: Oliver Lake
E-Mail: oliver.lake@nhs.net
Telephone: 020 7206 3332

AUTHOR CONTACT:
Name: Ben Vinter
E-Mail: ben.vinter@nhs.net
Telephone: 020 3049 4421

*SEL PCT Boards = Boards of Lambeth Primary Care Trust, Southwark Primary Care Trust, Lewisham Primary Care Trust, Bromley Primary Care Trust and Greenwich Teaching Primary Care Trust.st

NHS

South East London

REGISTER OF SEALED DOCUMENTS

Reported since last meeting of the Joint Boards on 19th May 2011

DATE	DOCUMENT	SIGNATORIES	PCT / Care Trust
No Use of seal			Bexley
No Use of seal			Bromley
1/4/11	Novation of i) Loan worker devices contract with Reliance to Oxleas FT fpr GCHS transfer ii) Decontamination contract with Synergy to Oxleas FT	Annabel Burn Graham Elvy	Greenwich
18/4/11	Novation of maintenance agreement for PCT property to Oxleas FT	Annabel Burn Graham Elvy	Greenwich
18/4/11	Deed of assignment of leasehold properties Rusthall Lodge and airfield Health centre from South London Healthcare Trust and Greenwich PCT	Annabel Burn Graham Elvy	Greenwich
4/5/11	Novation to allocate Software to Oxleas FT	Annabel Burn Graham Elvy	Greenwich
21/4/11	Novation for NHS Facilities Management SLA	Geoff Price / Marie Farrell	Lewisham

ENCLOSURE 13

20/5/11	Extension (6 month) to Hetherington Road GP Practice contract (lease extension)	Simon Robbins	Lambeth
11/5/11	S106 planning consent for Whitford Sheldon Building	Simon Robbins / Marie Farrell	Southwark

South East London

A meeting of the SEL PCT Boards* and Bexley Care Trust 21st July 2011

ENCLOSURE 14

LONDON SPECIALISED COMMISSIONING GROUP

DIRECTOR RESPONSIBLE: Jane Schofield, Director of Operations

AUTHOR: Sue McLellen, Chief Operating Officer, London SCG & Peter Kohn, Strategy, Planning and Development Director, London SCG,

TO BE CONSIDERED BY: All

SUMMARY:
The London SCG is a joint committee of the 31 London PCTs; commissioning a portfolio of specialised services on their behalf, in line with the national arrangements. The portfolio is composed largely of services listed in the Specialised Services National Data Set (SSNDS edition 3) but also includes services like HIV outpatients and sexual health which are commissioned on a London only basis. The majority of the £859m budget is for commissioning services for London but the SCG also commissions £112m on behalf of neighbouring SCGs.

The governance arrangements for the SCG will be subject to the national transition programme. Specialised services will be commissioned in the future by the NHS Commissioning Board.

The Establishment Agreement between the SCG and the 31 London PCTs requires updating to take account of new governance arrangements in London. The table shows all changes between the two documents and highlights the exact wording change. The key changes are to do with altered governance, with the 'Sector' JCPCTs having being replaced by Clusters, and consequent need for change to the membership of the SCG Board. QIPP has been added as a responsibility and the SSNDS edition has been updated.

These changes were discussed at the SCG Board on the 20th June and approved subject to the changes included in this finalised version.

KEY ISSUES:
The Establishment Agreement between the SCG and the 31 London PCTs requires updating to take account of new governance arrangements in London. Changes have been indicated in the attached table.

COMMITTEE INVOLVEMENT:
Considered by the London Specialised Commissioning Group Board – 20th June 2011

PUBLIC AND USER INVOLVEMENT: N/A

IMPACT ASSEESMENT: N/A

RECOMMENDATIONS:
The board (s) is asked to agree the following recommendations:

- **Agree** the proposed revisions to the London Specialised Commissioning Group on behalf of the constituent PCTs.

DIRECTORS CONTACT:
Name: Jane Schofield
E-Mail: JaneSchofield1@nhs.net
Telephone: 07951 123561

AUTHOR CONTACT:
Name: Sue McLellen
E-Mail: sue.mclellen@londonscg.nhs.uk
Telephone: 0207 869 8390

Name: Peter Kohn
E-Mail: Peter.Kohn@londonscg.nhs.uk
Telephone: 0207 869 5146

*SEL PCT Boards = Boards of Lambeth Primary Care Trust, Southwark Primary Care Trust, Lewisham Primary Care Trust, Bromley Primary Care Trust and Greenwich Teaching Primary Care Trust.

FINAL DRAFT
London Specialised Commissioning Group

ESTABLISHMENT AGREEMENT
FOR
LONDON SPECIALISED COMMISSIONING GROUP

1. Introduction

1.1 The London Specialised Commissioning Group (London SCG) is a committee established by the following 31 Primary Care Trusts (PCTs), hereafter referred to as 'Member PCTs':

Barking and Dagenham	Barnet
Bexley Care Trust	Brent Teaching
Bromley	Camden
City and Hackney Teaching	Croydon
Ealing	Enfield
Greenwich Teaching	Hammersmith and Fulham
Haringey Teaching	Harrow
Havering	Hillingdon
Hounslow	Islington
Kensington and Chelsea	Kingston
Lambeth	Lewisham
Newham	Redbridge
Richmond and Twickenham	Southwark
Sutton and Merton	Tower Hamlets
Waltham Forest	Wandsworth Teaching
Westminster	

1.2 The London SCG is established as a joint committee of each of the Member PCTs in accordance with Regulations 9 and 10 of the National Health Service (Functions of Strategic Health Authorities and Primary Care Trusts and Administrative Arrangements) (England) Regulations 2002 (the "2002 Regulations") and shall have such powers and functions as are set out in this Agreement (including the power to delegate where specified in this Agreement).

The Member PCTs therefore acknowledge that the London SCG is subject to any directions, which may be made by the London Strategic Health Authority or by the Secretary of State.

2. Functions of the Specialised Commissioning Group

2.1 The London SCG has been established in accordance with the Regulations to enable the Member PCTs to make collective decisions on the review, planning, procurement and performance monitoring of agreed services, these include Specialised Services as set out in the Specialised Services National Definitions Set (2002) or any revision thereto as well as any other service as agreed by the Member PCTs, commissioned on behalf of the relevant populations of the Member PCTs and set out in Appendix 1 of this agreement. Services

commissioned nationally by the National Specialised Commissioning Group are excluded from this Agreement.

2.2 The functions of the London SCG are undertaken in the context where NHS commissioning is increasingly focussed on developing care standards and the quality assurance of provider services and delivering Quality, Innovation, Productivity and Prevention for all services.

2.3 The London SCG forms part of the collective working arrangements in place in London as between the Member PCTs and NHS London to ensure consistency of strategic planning of specialised services with other services so as to maintain integrity of the care pathway for patients.

2.4 The London SCG will undertake the following functions:-

- reporting to the Member PCTs in relation to its performance and operations;
- to plan, including needs assessment, procure and performance monitor Specialised Services, and other services as defined and agreed by Member PCTs, to meet the health needs of Member PCTs' populations;
- to undertake reviews of Specialised Services and other agreed services, manage the introduction of new services, drugs and technologies and oversee the implementation of NICE and/or other National guidance or standards relating to Specialised Services and other agreed services;
- to undertake formal consultation and take decisions on service configuration proposals for specialised services and other agreed services for which it has delegated powers, in accordance with sections 242 and 244 of the National Health Service Act 2006 and any other relevant legislation and/or guidance;
- to designate providers to ensure that Specialised Services and other agreed services are provided to the highest clinical standard, represent value for money and are accessible to everyone that needs them and to avoid unplanned, unsafe proliferation of specialised services provision;
- to coordinate a common approach to the commissioning of Specialised Services and other agreed services from providers in the London SCG area and elsewhere;
- to manage the budget (pooled from PCT allocations) for commissioning Specialised Services and other agreed services, be held accountable for its use, and develop financial risk sharing arrangements;
- to develop, negotiate, agree, maintain and monitor service level agreements/ contracts for Specialised Services and other agreed services from providers in the London SCG area and elsewhere;
- to develop the most appropriate ways of engaging patients and the public and clinicians in the work of the London SCG;
- to monitor and fund the costs of non-contractual activity (NCA) for those services agreed by Member PCTs;
- to provide a coordinated Specialised Services Commissioning input to clinical networks, local commissioning groups/fora and partnerships, and coordinate service development plans with PCTs and their practice-based commissioners in the London SCG area;
- to maintain close links with PCTs and providers, and other statutory authorities, including those within the criminal justice system, in the London SCG area;

- to work closely with each Cluster's collaborative commissioning arrangements in London to ensure that there is a close link with the commissioning of acute services at Cluster level and collaborative commissioning initiatives in London;
- to work in partnership with other SCGs and act as lead commissioner on behalf of other SCGs where agreed by those SCGs and their PCTs;
- to be a member of the National Specialised Commissioning Group (NSCG) and take account of its decisions.

3. Principles upon which the London SCG is based

3.1 The London SCG will support Member PCTs in striving to reduce the inequalities in access to and delivery of services for the populations the Member PCTs serve.

3.2 The London SCG will seek to share skills, knowledge and/or appropriate resources for the benefit of the total population served.

3.3 The London SCG will utilise the funds made available to it by Member PCTs to commission agreed services and support its management costs in a transparent and cost effective way, ensuring that the financial risks to individual Member PCTs of unforeseen/unplanned activity are minimised.

3.4 Commitments made by the London SCG, its collaborative commissioning consortia and by London SCG representatives acting on behalf of the London SCG under agreed terms of reference/management protocols, will be binding on all Member PCTs until the London SCG agrees otherwise.

3.5 The London SCG will review, plan, develop and monitor the agreed services in partnership with clinicians, providers and service users.

3.6 The London SCG will maintain close working links with service providers, clinical networks and other commissioners or commissioning groups, fora and partnerships.

3.7 A standard facilitation/arbitration procedure will apply when disputes between Member PCTs arise.

3.8 The London SCG and the collective work of the PCTs will be subject to performance management arrangements by the SHA (NHS London).

3.9 The Member PCTs acknowledge that notwithstanding their groupings within the six London Clusters (the"Clusters") all applicable legal responsibilities and obligations vested in the PCTs remain vested in such PCTs.

4. Committee membership of the London SCG

4.1 The committee members of the London SCG will comprise:

4.1.1 a London SCG chair, who is appointed by a process agreed by the joint chairs of the PCTs in each respective cluster;

4.1.2 3 PCT NEDS and 3 PEC representatives (who are also GPs) being one from each Cluster;

4.1.3 6 Cluster leadership team representatives, being one from each Cluster; and

4.1.4 the Senior Responsible Officer for specialised commissioning in London;

4.2 Meetings of the London SCG will be chaired by the London SCG chair (appointed pursuant to paragraph 4.1.1 above). If the London SCG chair is unable to attend any meeting, then the meeting will be chaired instead by a PCT non-executive director (who is a member of the committee appointed pursuant to paragraph 4.1.2).

4.3 In the absence of any nominated committee representative, an identified alternative individual from the same background (ie a PEC representative (who is also a GP) or a leadership team representative) may be invited to attend.

4.4 Two patient and public engagement representatives will attend as observers with speaking rights

4.5 The London SCG will meet at least 4 times per annum of which at least two meetings will be held in public although members of the public may be excluded from such public meetings for reasons specified in the Admission to Public Meetings Act 1960. Subject always to the Admission to Public Meetings Act 1960, meetings to approve formal consultation documents and to take decisions arising from consultation will always be held in public.

4.6 The quorum for a meeting will be 6 London SCG committee members appointed pursuant to paragraph 4.1 above provided that such committee comprises a minimum of 3 Cluster leadership team representatives and 3 PCT NEDs/PEC representatives.

4.7 If any committee member appointed pursuant to paragraph 4.1 above becomes aware of any conflict of interest which has or is likely to have an adverse effect on the London SCG decision (acting reasonably), this shall be declared to other committee members and they shall take such action under this Agreement as is deemed necessary.

4.8 The Chief Operating Officer of the London SCG (henceforth known as the London SCG Chief Officer) will be entitled to attend all meetings and shall act as secretary to the meeting

5. Conduct of the Meetings and Delegations of Business

5.1 The London SCG Chief Officer as secretary to the London SCG will be responsible for giving notice of the London SCG meetings, such notice (which will be accompanied by an agenda and supporting papers) shall be sent to Member representatives no later than 7 days before the date of the meeting. When the Chair shall deem it necessary in the light of urgent circumstances to call a meeting at short notice, the notice period shall be such as he/she shall specify.

5.2 The London SCG's aim is to always achieve collective decision making in a collaborative manner through consensus. The London SCG will have a collective responsibility to try to resolve and minimise any local challenges or any disproportionate impact of regional decisions on any one PCT or Cluster.

If the London SCG does need to take a formal vote on any issue, the majority of the voting committee members in attendance will apply and such decisions shall bind the Member PCTs provided that (a) any change to this Agreement shall require a unanimous decision of the Member PCTs and (b) any increase in the financial commitments of a Member PCT under this Agreement or to the London SCG shall require the consent of a Member PCT.

5.3 Minutes of each meeting of the London SCG shall be circulated with the agenda for the next meeting and their approval shall be considered as an agenda item.

6. Accountability of the London SCG

6.1 A) At SCG Level

Each Primary Care Trust is accountable through its statutory responsibilities to use its resources to improve the health of its population. For a number of services, this can only be achieved by working with other PCTs. The London SCG is established on this basis of a shared approach to commissioning.

6.1.1 The London SCG is a joint committee of each of the Member PCTs and the London SCG can:

- commit the resources which have been agreed to be allocated to the London SCG by Member PCTs (pursuant to this Agreement);
- decide commissioning policy;
- undertake consultation and take decisions as a result on proposals for service change;
- commission research / reviews to inform decisions;
- agree, review and update action plans;
- commission and monitor service level agreements /contracts between Member PCTs and between the London SCG (acting through its Host PCT) and other service providers.

6.1.2 In order to ensure that time is allowed for committee members (appointed pursuant to paragraph 4.1 of this Agreement) to consult within their own Clusters and constituent PCTs forming part of the relevant Cluster and with other key stakeholders, wherever possible, adequate notice will be given of proposals to change commissioning policies, commit resources and/or decisions of the London SCG to enter into service agreements and contracts (acting through the Host PCT).

6.2 B) At Pan-SCG Level

In order to discharge its duties on behalf of Member PCTs, the London SCG will be responsible for representing Member PCTs' interests in commissioning

specialised services, or other services as agreed by the London SCG, that span a number of SHA areas and/or require a national commissioning approach. Such responsibility will be discharged through service specific groups/networks agreed by the London SCG in conjunction with other SCGs and/or through the National Specialised Commissioning Group (NSCG).

6.2.1 The London SCG will agree appropriate arrangements for representation in order to ensure that the London SCG's views are properly taken into account in reaching a decision at pan-London SCG or NSCG level.

6.2.2 London SCG will take into account decisions taken at NSCG level.

7. Funding Arrangements

7.1 Each Member PCT will contribute an annual subscription to the London SCG, based on the London SCG's commissioning portfolio of services and the management costs of supporting such commissioning. Subscriptions are to be paid on a monthly basis before the end of each month and no later than the 16th day of the relevant month. Member PCTs indemnify the host PCT from any financial liability arising from the hosting of this service with the host's liability limited to its share of the portfolio of services and management costs as per any other member.

7.2 The baseline subscription value is as per the schedule in Appendix 2. The subscriptions include both the cost of the services commissioned by the London SCG and the management costs of the London SCG.

7.3 Adjustments to the subscriptions may be required for the following reasons:

- to reflect annual inflationary and other generic and service specific cost pressures (e.g. NICE guidance, Working Time Directives, etc);
- in-year over or under performance against provider service agreements/contracts;
- agreed changes to the London SCG commissioning portfolio or the portfolio of service providers covered by the subscription arrangements and agreed investments to support service improvements, developments or other changes reflected in the Operating Plans of each PCT;
- changes in PCT cash limited allocations that affect the services covered by these subscription arrangements;
- national or local initiatives which impact upon the services covered by the subscription arrangements;
- other technical changes.

7.4 It is recognised that the London SCG operates these services within a risk-sharing, Host PCT arrangement to ensure that the budget is in financial balance at the year-end and that no financial liability, risk or benefit resides with the Host PCT. Therefore, any net under-spend against the London SCG budget will need to be returned to Member PCTs and any net over-spend will need to be funded by Member PCTs on the basis of agreed shares.

7.5 Notwithstanding the provisions within 7.4, the London SCG will endeavour to manage the totality of the subscription, the shared or pooled budget, within an agreed financial plan, any changes to the plan, and therefore the subscription, which may be required during the financial year, will be submitted to the Member PCTs for consultation prior to agreement by the Member PCTs. Changes will be made using agreed methodologies that support the principles of appropriate risk sharing and equity between Member PCTs.

7.6 All services included in the subscription arrangements, will be operated as a pool resource within each service specific consortia until such time as the London SCG can operate a pooled resource equitably for all services and Member PCTs (i.e. with over performances on one contract/service level agreement offset by under performances on others). Until then, adjustments for over and or under performance will be made only on the consortia specific budgets. Any alternative methodology will only be used following approval by the London SCG.

7.7 The commissioning portfolio of the London SCG as specified in this Agreement in Appendix 1 will only be changed following a revision to the Specialised Services National Definitions Set (2002) or by the agreement of London SCG and Member PCTs.

8. Procurement of Agreed Services

8.1 The London SCG will determine which services/products should be procured, (these will be known as the agreed services and will be included in the list of services set out in Appendix 1) and from which provider(s).

8.2 The providers of agreed services may be:

- NHS Foundation Trusts (NHSFT);
- NHS Trusts;
- Other NHS Bodies;
- Local Government Authorities and agencies;
- Independent sector providers or suppliers;
- Charities and voluntary sector providers
- Social Enterprises

8.3 The providers of agreed services may not be restricted to the United Kingdom.

8.4 The principles underpinning and the functions of, the London SCG are to support collaborative procurement of the agreed services including:

- approving the range of agreed services;
- maintaining close working and contractual relationship between the Member PCTs;
- operating with transparency, openness and maximum good faith;
- obtaining best value for the agreed services by assessing clinical effectiveness, cost effectiveness and patients' and carers' views;
- ensuring that the requirements of Patient Choice are met;
- agreeing and managing risk sharing arrangements;

- negotiating and agreeing service level agreement/contracts and from time to time negotiating and agreeing variations of specifications and service level agreement/contract terms;
- coordinating and planning for changes in demand and in the financial and investment requirements of Members and reflecting these changes in service level agreements/contracts and any variations to ;
- setting the initial annual budget for each service level agreement/contract;
- agreeing any in-year variations with the provider and consequential adjustments between the Member PCTs if the total London SCG budget over or under performs;
- monitoring the provider's performance under each service level agreement/contract, including activity and patient outcomes, specification requirements and standards, waiting times and other targets;
- carrying out annual or other reviews with the provider, as required under each service level agreement/contract;
- agreeing referral, discharge and other protocols with the provider for each service level agreement/contract;
- establishing any links and/or reporting networks with other PCT consortia, other SCGs, or the NSCG.

8.5 The Member PCTs jointly delegate their respective functions for the procurement of agreed services to the London SCG, which (acting through the Host PCT) will establish collaborative commissioning and managerial arrangements to negotiate, agree and manage all aspects of service level agreements/contracts for the agreed services on such terms and for such purposes as agreed by the London SCG (acting through the Host PCT).

8.6 Agreed service level agreements/contracts will be signed on behalf of the Host PCT and for all other Member PCTs, in accordance with the delegated financial limits set by the Host PCT's Standing Financial Instructions.

8.7 The Host PCT will collect from all other Member PCTs their subscriptions monthly and pay the aggregate amounts to the providers of agreed services on behalf of all Member PCTs. All Member PCTs must not cease these payments under any circumstances and if there is a dispute must follow the facilitation and arbitration process in paragraph 13.

8.8 Each Member PCT will be provided by London SCG staff with a statement for each service level agreement/contract on a monthly basis showing:

- actual London SCG activity and cost against agreed planned London SCG activity and cost;
- forecast London SCG annual activity and cost against agreed planned London SCG annual activity;

In addition

- a quarterly report for the London SCG will be provided on London SCG commissioned services.

8.9 The London SCG will provide each Member with an annual statement summarising for each service level agreement/contract:

- actual London SCG activity and cost against agreed planned London SCG activity and cost for the previous year;
- allocation of actual activity and of actual cost by individual Member for the previous year;
- progress on annual contract reviews;
- effect of risk sharing arrangements.

8.10 Whilst the London SCG will endeavour to act on behalf of all the PCTs working collaboratively, each Member remains responsible for performing and exercising its statutory duties and functions for delivery of the agreed services to its population and its patients, including:

- assessing individual patient cases;
- referrals;
- patient complaints and complaints procedures;
- individual contract exclusions (where appropriate);
- emergencies;
- managing waiting lists;
- managing independent patient appeals (supported by the London SCG).

8.11 In 8.10 above, it may be appropriate for the London SCG to support and act on behalf of the Member PCTs if the Member PCTs so agree, this will not negate each Member's statutory responsibility to ensure the delivery of appropriate healthcare services to its population.

9. Host Primary Care Trust

9.1 One of the Member PCTs will be designated, by agreement, as the Host PCT for the London SCG.

9.2 The responsibilities of the Host PCT are:

- to appoint and employ such officers as may be required to support London specialised services commissioning and provide all necessary corporate services and management support as may be required, including the collection of subscriptions from Member PCTs and the making of payments to providers of the agreed services;
- to be the legal entity, which enters into service level agreements/contracts for services commissioned by the London SCG and to ensure that the individuals appointed and employed to support the functions of the London SCG carry out those tasks, which are stated in this Agreement to be obligations of the London SCG;
- to have in place Standing Orders, Standing Financial Instructions and other appropriate governance arrangements and Schemes of Delegation necessary to enable the London SCG's functions to be carried out
- to hold the management budget for London specialised services commissioning and make payments and receive income as necessary;

- to be authorised to appoint lawyers and other professional advisors and to agree the terms and conditions of their engagement and give them instructions from time to time on behalf of the London SCG.

9.3 The London SCG shall adopt the Standing Orders, Standing Financial Orders and relevant Schemes of Delegation of the Host PCT.

9.4 A management charge, as agreed with the London SCG, would be payable to the Host PCT from the management budget for the costs incurred in acting as the Host PCT

10. Ways of working

10.1 The London SCG will ensure that there are appropriate management arrangements to support London specialised services commissioning.

10.2 The London SCG will, through the nominated Host PCT, appoint and employ such staff as may be required to undertake specialised services commissioning and will act on its behalf on an operational basis

10.3 The Lead Chief Executive for Specialised Commissioning together with 6 representatives being one for each Cluster (appointed pursuant to paragraph 4.1.3 above), the London SCG Chief Officer, Finance and Information Director and Public Health Director will form an executive team ("Executive Team"). The Executive Team shall be chaired by the Lead Chief Executive for Specialised Commissioning.

10.4 A Senior representative of South East Coast and East of England SCGs will be invited to attend the Executive Team for all items, where services are commissioned on their behalf.

10.5 The London SCG Chief Officer shall be the Lead Officer for staff employed on specialised services commissioning and will act as secretary to the London SCG. The London SCG Chief Officer will be accountable to the Chief Executive of the Host PCT and Lead Chief Executive for specialized commissioning.

10.6 The London SCG will work with the Clusters to ensure that its commissioning is coordinated with Cluster Commissioning Strategy Plans. The 6 Cluster representatives will ensure that there is regular liaison to and from their constituent PCTs.

10.7 The London SCG Chief Officer shall act within the delegated authority agreed by London SCG and within the SFIs/SOs of the Host PCT (but for the avoidance of doubt the London SCG Chief Officer shall not be permitted to act in such a way as could amount to a further delegation of the delegated authority referred to in this paragraph 10.7).

10.8 As part of the London SCG's membership of the NSCG and in its working in partnership with other SCGs, the Specialised Services Commissioning Team will be required to undertake and/or lead work and/or act as Lead Commissioner on behalf of some or all SCGs with the agreement of those SCGs and their PCTs.

11. Involvement of Service Providers and Clinicians

11.1 The London SCG will ensure that all arrangements established for London SCG's strategy development will demonstrate how they are involving clinicians and the relevant service provider(s).

11.2 The London SCG will ensure that there are appropriate arrangements for public health input into such arrangements.

12. User Involvement

12.1 The London SCG will ensure that all arrangements established for London SCG's strategy development will demonstrate how they are involving service users in the planning and commissioning process.

13. Facilitation and Arbitration

13.1 Facilitation and/or arbitration may be required in the following circumstances:

13.1.1 the Lead Chief Executive (on behalf of the Host PCT) requests facilitation because an impasse has been reached between the London SCG (or the relevant officer representing the SCG) and one or more providers of the service

13.1.2 the Lead Chief Executive (on behalf of the Host PCT) requests facilitation because an impasse has been reached between the London SCG and one or more of its Member PCTs.

13.2 Where facilitation or arbitration is required with a provider then the parties agree that any dispute arising out of any aspect of contract shall be resolved in accordance with the provisions of clause 28 of the Main Contract

13.3 Where facilitation or arbitration is required between the London SCG and one of more of its member PCTs, a standard facilitation/arbitration procedure will apply

13.4 In the event of a dispute between two or more SCGs, the NSCG will be invited to facilitate and/or arbitrate according to its own facilitation/arbitration process.

14. Communication

14.1 Leadership Team representatives of each Member PCT will act as the overall communication link to their health communities supported by the London SCG. The Executive Team, in particular will ensure regular communications with Clusters to ensure close linkage with acute services commissioning.

14.2 A London SCG Annual Report will be produced for Member's Boards within six months of the end of the financial year.

14.3 The Specialised Services commissioning staff will provide a common link between appropriate clinical networks and/or commissioner and provider service review groups who will each develop a communication process as part of their work.

APPENDIX 1

Specialised Services National Definition Set – 3rd edition unless otherwise indicated

Definition No. 1: Specialised cancer services (adult)

Definition No. 2: Specialised services for blood and marrow transplantation (all ages)

Definition No. 3: Specialised services for haemophilia and other related bleeding disorders (all ages)

Definition No. 4: Specialised services for women's health

Definition No. 5: Assessment and provision of equipment for people with complex physical disability

Definition No. 6: Specialised spinal services (all ages)

Definition No. 7: Specialised rehabilitation services for brain injury and complex disability (adult)

Definition No. 8: Specialised neurosciences services (adult)

Definition No. 9: Specialised burn care services (all ages)

Definition No. 10: Cystic fibrosis services (all ages)

Definition No. 11: Specialised renal services (adult)

Definition No. 12: Specialised intestinal failure and home parenteral nutrition services (adult)

Definition No. 13: Specialised cardiology and cardiac surgery services (adult)

Definition No. 14: No third edition definition

Definition No. 15: Cleft lip and palate services (all ages)

Definition No. 16: Specialised immunology services (all ages)

Definition No. 17: Specialised allergy services (all ages)

Definition No. 18: Specialised services for infectious diseases (all ages)

Definition No. 19: Specialised services for liver, biliary and pancreatic medicine and surgery (adult)

Definition No. 20: Medical genetic services (all ages)

Definition No. 21: No third edition definition

Definition No. 22: Specialised mental health services (all ages)

Definition No. 23: Specialised services for children

Definition No. 24: Specialised dermatology services (all ages)

Definition No. 25: No third edition definition

Definition No. 26: Specialised rheumatology services (all ages)

Definition No. 27: Specialised endocrinology services (adult)

Definition No. 28: No third edition definition

Definition No. 29: Specialised respiratory services (adult)

Definition No. 30: Specialised vascular services (adult)

Definition No. 31: Specialised pain management services (adult)

Definition No. 32: Specialised ear services (all ages)

Definition No. 33: Specialised colorectal services (adult)

Definition No. 34: Specialised orthopaedic services (adult)

Definition No. 35: Specialised morbid obesity services (all ages)

Definition No. 36: Specialised services for metabolic disorders (all ages)

Definition No. 37: Specialised ophthalmology services (adult)

Definition No. 38: Specialised haemoglobinopathy services (all ages)

Further details of each specialised service can be found on the Department of Health website:
http://www.dh.gov.uk/specialisedservicesdefinitions/

Other services commissioned by the SCG on behalf of member PCTs

HIV (all ages) –Treatment and care following diagnosis

Sexual Health – Sexual assault referral centres (Havens). Hosting sexual health programme team

Practitioner Health Programme

Screening – Newborn and Bowel screening programmes. Hosting London screening improvement programme team

Appendix 2

London Specialised Commissioning Group Operating Plan - 2011/12

Category		Value £'000
Services	Adult BMT	39,737
	Bowel Cancer	4,134
	Burns	20,267
	CAMHS	10,611
	Child & Young People Oncology & BMT	12,229
	Cleft Lip & Palate	8,017
	DSPD	16,759
	Eating Disorders	4,794
	Forensic Mental Health	81,863
	Gender Dysphoria	1,074
	Genetics	19,443
	Haemophilia	97,730
	High Secure Service	49,536
	HIV	251,650
	Major Trauma	10,855
	Mental Health for the Deaf	2,834
	Neuro Rehabilitation	22,368
	Newborn Screening	4,642
	NICU	74,971
	PICU	55,722
	Specialised Psychotherapy	1,394
	Specialist Mental Health	1,642
	Specialist Non Contract Activity	2,886
	Specialist Pharmacy	2,974
	Spinal	8,672
	WEMS	2,009
Management & Network Costs (incl Special Projects)	AIAU	422
	NICU Corporate Cost	2,466
	NICU Local Investment	1,002
	Other London Management Income	31
	Practitioner Health Programme	1,012
	SCG Management Budget	5,488
	Sexual Health	1,488
Sub Total		**820,722**
New Services (estimated value)	Renal	170,000
	SCBU	68,000
	Child & Young People Oncology & BMT	9,070
	Forensic Mental Health	38,600
	CAMHS	668
	Stereotactic Radiosurgery	1,000
Grand Total		**1,108,060**

Appendix 3 – Glossary

Executive Team	Means the executive team referred to in paragraph 10
Member PCTs	Member PCTs are the Primary Care Trusts (31 in London)
London SCG	London Specialised Commissioning Group. The Joint Committee established as a Board by the 31 PCTs to oversee commissioning arrangements for specialised services
London SCG Chief Officer	London SCG Chief Operating Officer
Specialised Services	Services as defined in the Specialised Services National Definition Set (2002) (as amended from time to time)
London SCG Executive Team	London Specialised Commissioning Executive Team, which supports the commissioning of specialised services for London
Host PCT	PCT who will employ the London SCT and host the financial trading accounts for all SCG pooled budgets.
SHA	Strategic Health Authority
Cluster	From June 2011, clusters of PCTs have been formed which have the following features: • A single Chief Executive, accountable for quality, finance, performance, QIPP and the development of commissioning functions across the whole of the cluster area; • Supported by a single executive team for the cluster. • are sustainable until the proposed abolition of PCTs at the end of March 2013;

Appendix 4 – Signatures

North Central London

SIGNED ……

For and on behalf of
Barnet PCT
Camden PCT
Enfield PCT
Haringey Teaching PCT
Islington PCT

Inner North East London

SIGNED ……

For and on behalf of
City & Hackney Teaching PCT
Newham PCT
Tower Hamlets PCT

Outer North East London

SIGNED ……

For and on behalf of

Barking & Dagenham PCT
Havering PCT
Redbridge PCT
Waltham Forest PCT

North West London

SIGNED ……

For and on behalf of
Brent Teaching PCT
Harrow PCT
Ealing PCT
Hillingdon PCT
Hounslow PCT
Hammersmith and Fulham Teaching PCT
Kensington & Chelsea PCT
Westminster PCT

South East London

SIGNED ……

For and on behalf of

Bexley Care Trust
Bromley PCT
Greenwich Teaching PCT
Lambeth PCT
Lewisham PCT
Southwark PCT

South West London

SIGNED ……

For and on behalf of
Croydon PCT
Kingston PCT
Richmond & Twickenham PCT
Sutton & Merton PCT
Wandsworth PCT

Proposed Amendments to London SCG Establishment Agreement

Current		Revised (agreed at LSCG Board June 2011)
1A	**Background in relation to the Sector JCPCTs and relationship between London SCG and each Sector JCPCT**	Section 1A not included in revised Agreement
1A.1	After the initial establishment of the London SCG in 2008, the Member PCTs in the 6 sectors in London (being the sectors set out in the first column in Appendix 3A) (each a "Sector") established joint committees in order to foster greater co-operation and collaboration (particularly in relation to commissioning decisions) between the relevant Member PCTs in each Sector (each such committee a "Sector JCPCT").	
1A.2	Each Sector JCPCT has a chair and a chief executive. Without prejudice to the terms of the establishment of such Sector JCPCT, the Member PCTs acknowledge that certain powers have been delegated to the Sector JCPCTs.	
1A.3	Following the initial establishment of the London SCG and also the establishment of the Sector JCPCTs, each Member PCT acknowledges and agrees that it would be beneficial to amend the committee membership of the London SCG to reflect the operation of the Sector JCPCTs in relation to the London SCG and to (inter alia) entitle the Sector JCPCTs to appoint the committee members of the London SCG.	
1A.4	Each Member PCT in a Sector agrees that, for the purposes of this Establishment Agreement and the operation and functions of the London SCG only, their	

Sector JCPCT is established as a joint committee of each of the boards of the Member PCTs in that Sector in accordance with the 2002 Regulations and that such Sector JCPCT (and, in turn, the relevant chief executive and/or chair of such Sector JCPCTs) shall have delegated to it, him or her (as the case may be) (including the power to delegate but only where such further delegation is specified in this Agreement): (a) the power to appoint the committee members of the London SCG as contemplated by paragraph 4 below; (b) in the case of the chairman of each Sector JCPCT only, the power to make decisions in relation to process for the appointment of the relevant committee members of the London SCG as contemplated by paragraph 4 below; (c) the power to appoint a chief executive to represent each Sector for the purposes of the executive team as contemplated by paragraph 10 below; (d) for the purposes of the London SCG only and subject always to paragraph 1A.5 below the power to and on the behalf of the relevant Member PCT: a. manage the financial performance in any particular financial year of the London SCG in order to assist the London SCG to remain within budgets set for that particular year; and b. review and receive reports from the London SCG in relation to its operations and performance.	

1A.5 For the avoidance of doubt, the establishment and delegation set out in paragraph 1A.4 above shall not include the delegation to the Sector JCPCT of any ability to increase the financial commitment of a Member PCT under this Establishment Agreement or to the London SCG without the consent of that Member PCT.	
2. Functions of the Specialised Commissioning Group 2.2 The functions of the London SCG are undertaken in the context where NHS commissioning is increasingly focussed on developing care standards and the quality assurance of provider services. 2.3 The London SCG forms part of the collective working arrangements in place in London as between the Member PCTs and NHS London. 2.4 The London SCG will undertake the following functions:- ▪ reporting to the Sector JCPCTs and Member PCTs in relation to its performance and operations; ▪ to work closely with each Sector's collaborative commissioning arrangements in London to ensure that there is a close link with the commissioning of acute services at Sector level and collaborative commissioning initiatives in London;	**2. Functions of the Specialised Commissioning Group** 2.2 The functions of the London SCG are undertaken in the context where NHS commissioning is increasingly focussed on developing care standards and the quality assurance of provider services and delivering Quality, Innovation, Productivity and Prevention for all services. 2.3 The London SCG forms part of the collective working arrangements in place in London as between the Member PCTs and NHS London to ensure consistency of strategic planning of specialised services with other services so as to maintain integrity of the care pathway for patients 2.4 The London SCG will undertake the following functions:- ▪ reporting to the Member PCTs in relation to its performance and operations; ▪ to work closely with each Cluster's collaborative commissioning arrangements in London to ensure that there is a close link with the commissioning of acute services at Cluster level and collaborative commissioning initiatives in London;
3. Principles upon with the London SCG is based No section 3.9	**3. Principles upon with the London SCG is based** 3.9 The Member PCTs acknowledge that notwithstanding their groupings within the six London Clusters (the"Clusters") all applicable legal responsibilities and obligations vested in the PCTs

	remain vested in such PCTs.
4. Committee membership of the London SCG	**4. Committee membership of the London SCG**
4.1 The committee members of the London SCG will comprise:	4.1 The committee members of the London SCG will comprise:
4.1.1 a London SCG chair, who shall be a PCT Chair/NED who is appointed by a process agreed by the chairs of the Sector JCPCTs and the Host PCT;	4.1.1 a London SCG chair, who is appointed by a process agreed by the joint chairs of the PCTs in each respective cluster;
4.1.2 3 PCT chairs and/or non-executive directors together with 3 PEC chairs and/or representatives, who shall be nominated by the Sectors (acting through the Sector JCPCT) and agreed by the London SCG chair and lead Chief Executive to provide a non-executive and independent clinical perspective; and	4.1.2 3 PCT NEDS and 3 PEC representatives (who are also GPs) being one from each Cluster;
4.1.3 the lead Chief Executive for London specialised commissioning	4.1.3 6 Cluster leadership team representatives, being one from each Cluster; and
	4.1.4 the Senior Responsible Officer for specialised commissioning in London;
4.2 Meetings of the London SCG will be chaired by the London SCG chair (appointed pursuant to paragraph 4.1.1 above). If the London SCG chair is unable to attend any meeting, then the meeting will be chaired instead by a PCT Chair or non-executive director (who is a member of the committee appointed pursuant to paragraph 4.1.3).	4.2 Meetings of the London SCG will be chaired by the London SCG chair (appointed pursuant to paragraph 4.1.1 above). If the London SCG chair is unable to attend any meeting, then the meeting will be chaired instead by a PCT non-executive director (who is a member of the committee appointed pursuant to paragraph 4.1.2).
4.3 In the absence of any nominated committee representative, an identified alternative individual from	4.3 In the absence of any nominated committee representative, an identified alternative individual from the same

the same background (ie Chief Executive, Chair/NED or PEC Chair) may be invited to attend.	background (ie a PEC representative (who is also a GP) or a leadership team representative) may be invited to attend.
4.4 No change .	4.4 No change
4.5 No change	4.5 No change
4.6 The quorum for a meeting will be 6 London SCG committee members appointed pursuant to paragraph 4.1 above provided that such committee Member PCTs comprising a minimum of 3 PCT Chief Executives and 3 PCT Chair/NEDs/PEC Chairs.	4.6 The quorum for a meeting will be 6 London SCG committee members appointed pursuant to paragraph 4.1 above provided that such committee comprises a minimum of 3 Cluster leadership team representatives and 3 PCT NEDs/PEC representatives.
5. Conduct of the Meetings and Delegations of Business	**5. Conduct of the Meetings and Delegations of Business**
5.2 The London SCG's aim is to always achieve collective decision making in a collaborative manner through consensus. The London SCG will have a collective responsibility to try to resolve and minimise any local challenges or any disproportionate impact of regional decisions on any one PCT or Sector.	5.2 The London SCG's aim is to always achieve collective decision making in a collaborative manner through consensus. The London SCG will have a collective responsibility to try to resolve and minimise any local challenges or any disproportionate impact of regional decisions on any one PCT or Cluster.
5.3 The London SCG may delegate tasks to such individuals, sub-committees or individual committee members, as it shall see fit provided that any such delegations are recorded in a Scheme of Delegation and are governed by terms of reference.	
5.4 The London SCG may also delegate commissioning responsibility, including procurement, to another SCG and/or commissioner, as it shall see fit provided that any such delegation is recorded in a Scheme of Delegation.	

6. Accountability of the London SCG **6.1 A) At SCG Level** 6.1.2 In order to ensure that time is allowed for committee members (appointed pursuant to paragraph 4.1 of this Agreement) to consult within their own Sectors and constituent PCTs forming part of the relevant Sector and with other key stakeholders, wherever possible, adequate notice will be given of proposals to change commissioning policies, commit resources and/or decisions of the London SCG to enter into service agreements and contracts (acting through the Host PCT).	**6. Accountability of the London SCG** **6.1 A) At SCG Level** 6.1.2 In order to ensure that time is allowed for committee members (appointed pursuant to paragraph 4.1 of this Agreement) to consult within their own Clusters and constituent PCTs forming part of the relevant Cluster and with other key stakeholders, wherever possible, adequate notice will be given of proposals to change commissioning policies, commit resources and/or decisions of the London SCG to enter into service agreements and contracts (acting through the Host PCT).
8. Procurement of Agreed Services 8.8 Each Member PCT will be provided by London SCG staff with a statement for each service level agreement/contract on a monthly basis showing: ▪ actual London SCG activity and cost against agreed planned London SCG activity and cost; ▪ forecast London SCG annual activity against agreed planned London SCG annual activity;	**8. Procurement of Agreed Services** 8.8 Each Member PCT will be provided by London SCG staff with a statement for each service level agreement/contract on a monthly basis showing: ▪ actual London SCG activity and cost against agreed planned London SCG activity and cost; ▪ forecast London SCG annual activity and cost against agreed planned London SCG annual activity;
10. Ways of working 10.3 The Lead Chief Executive for Specialised Commissioning together with the 6 PCT chief executives nominated by the Sectors (pursuant to paragraph 4.1 above), the London SCG Chief Officer, Finance and Information Director and Public Health Director will form an executive team ("Executive Team"). The Executive Team shall be chaired by the Lead Chief Executive for Specialised Commissioning.	**10. Ways of working** 10.3 The Lead Chief Executive for Specialised Commissioning together with 6 representatives being one for each Cluster (appointed pursuant to paragraph 4.1.3 above), the London SCG Chief Officer, Finance and Information Director and Public Health Director will form an executive team ("Executive Team"). The Executive Team shall be chaired by the Lead Chief Executive for Specialised Commissioning.

10.5 The London SCG Chief Officer shall be the Lead Officer for staff employed on specialised services commissioning and will act as secretary to the London SCG. The London SCG Chief Officer will be accountable to the Chief Executive of the Host PCT and Lead Chief Executive.	10.5 The London SCG Chief Officer shall be the Lead Officer for staff employed on specialised services commissioning and will act as secretary to the London SCG. The London SCG Chief Officer will be accountable to the Chief Executive of the Host PCT and Lead Chief Executive for specialized commissioning.
10.6 The London SCG will work with the Sectors to ensure that its commissioning is coordinated with Sector Commissioning Strategy Plans. The 6 PCT Chief Executives will ensure that there is regular liaison to and from the sectors and their constituent PCTs.	10.6 The London SCG will work with the Clusters to ensure that its commissioning is coordinated with Cluster Commissioning Strategy Plans. The 6 Cluster representatives will ensure that there is regular liaison to and from their constituent PCTs.
10.7 The London SCG Chief Officer shall act within the delegated authority agreed by London SCG and within the SFIs/SOs of the Host PCT.	10.7 The London SCG Chief Officer shall act within the delegated authority agreed by London SCG and within the SFIs/SOs of the Host PCT (but for the avoidance of doubt the London SCG Chief Officer shall not be permitted to act in such a way as could amount to a further delegation of the delegated authority referred to in this paragraph 10.7).
13. Facilitation and Arbitration	**13. Facilitation and Arbitration**
13.1 Facilitation and/or arbitration may be required in the following circumstances:	13.1 Facilitation and/or arbitration may be required in the following circumstances:
13.1.1 the Lead Chief Executive (on behalf of the Host PCT) requests facilitation because an impasse has been reached between the London SCG (or the relevant officer representing the SCG) and one or more providers of the service if the provider is not a Foundation Trust;	13.1.1 the Lead Chief Executive (on behalf of the Host PCT) requests facilitation because an impasse has been reached between the London SCG (or the relevant officer representing the SCG) and one or more providers of the service
13.2 Where facilitation or arbitration is required, the following process will be followed:	13.2 Where facilitation or arbitration is required with a provider then the parties agree that any dispute arising out of any

Stage 1 – Facilitation A meeting is held which includes the following: ▪ 2 commissioners (Director level) ▪ Up to 2 provider representatives (for 13.1.1 above) OR 2 PCT representatives (for 13.1.2 above) ▪ An appropriate Director from the SHA ▪ Chief Officer of the SCG Specialised Services Commissioning Team The meeting will be chaired by the relevant SHA Director and involve expert clinical advice where appropriate. If resolution is reached, the process will conclude here. **Stage 2 – Arbitration** Both the commissioners and/or providers involved in the dispute will produce a joint statement of facts as well as a separate report setting out their positions and submit them to the SHA. The SHA may invite the commissioners and/or the providers to present their positions or they may choose to decide on the basis of the information submitted. The decision of the SHA will be binding.	aspect of contract shall be resolved in accordance with the provisions of clause 28 of the Main Contract
13.4 In the event of disputes between the London SCG and any Foundation Trust, the procedures set out in the contract should be followed.	13.3 Where facilitation or arbitration is required between the London SCG and one of more of its member PCTs, a standard facilitation/arbitration procedure will apply

14. Communication 14.1 Chief Executives (or their representatives) of each Member PCT will act as the overall communication link to their health communities supported by the London SCG. The Executive Team and the 6 Chief Executives (appointed pursuant to paragraph 4.1), in particular will ensure regular communications with Sectors to ensure close linkage with acute services commissioning.	**14. Communication** 14.1 Leadership Team representatives of each Member PCT will act as the overall communication link to their health communities supported by the London SCG. The Executive Team, in particular will ensure regular communications with Clusters to ensure close linkage with acute services commissioning.
APPENDIX 1 **Specialised Services National Definition Set – 2nd edition unless otherwise indicated**	**APPENDIX 1** **Specialised Services National Definition Set – 3rd edition unless otherwise indicated**
Appendix 2 – London Specialised Commissioning Group Operating Plan - 2009/2010	**Appendix 2 – London Specialised Commissioning Group Operating Plan - 2011/2012**
Appendix 3 – Glossary Changes to terminology **Appendix 3A London PCTs Sector Arrangements**	**Appendix 3 – Glossary** Changes to terminology **No Appendix 3A**
Appendix 4 – Signatures 31 PCT signatures required	**Appendix 4 – Signatures** 6 Cluster Chief Executive signatures required

South East London

A meeting of the SEL PCT Boards* and Bexley Care Trust
21st July 2011

ENCLOSURE 15

ENCLOSURE 15

"ANY WILLING PROVIDER" ARRANGEMENTS FOR COMMUNITY GYNAECOLOGY AND COMMUNITY DERMATOLOGY SERVICES

DIRECTOR RESPONSIBLE: Angela Bhan, Bromley BSU MD

AUTHOR: Ben Vinter, Integrated Governance Manager, NHS SEL

TO BE CONSIDERED BY: Bromley Primary Care Trust Board

SUMMARY:
This report notifies Bromley PCT Board of a decision taken upon advice by the Chair through Chair's Action for reasons of urgency and desire to start the commissioning cycle.

KEY ISSUES:
The key issues were considered by the Chair and lead NEDs with appropriate advice sought and have not been made publically available as they have been assessed to be commercially sensitive in their nature.

COMMITTEE INVOLVEMENT:
The Chair took this decision upon the advice of the Bromley management team and in consultation with the lead Bromley NEDs – Harvey Guntrip and James Gunner.

PUBLIC AND USER INVOLVEMENT: N/A

IMPACT ASSEESMENT: N/A

RECOMMENDATIONS:
The Board is asked to:-

- NOTE the Chair's Action

DIRECTORS CONTACT:

Name: Angela Bhan
E-Mail: angela.bhan@bromleypct.nhs.uk
Telephone: 01689 880687

AUTHOR CONTACT:

Name: Ben Vinter
E-Mail: ben.vinter@nhs.net
Telephone: 0203 049 4421

*SEL PCT Boards = Boards of Lambeth Primary Care Trust, Southwark Primary Care Trust, Lewisham Primary Care Trust, Bromley Primary Care Trust and Greenwich Teaching Primary Care Trust.

NHS Bromley

Chair's Action

As set out within NHS SEL's common Standing Orders the powers which the Board has retained to itself within the Standing Orders (section 6.2) may in emergency be exercised by the Chief Executive and the Chairman after having consulted at least two Non-Officer members. The exercise of such powers by the Chief Executive and Chairman shall be reported to the next formal meeting of the Board in public session for ratification.

"Any Willing Provider" arrangements for community gynaecology and community dermatology services

Context;

A 'commercial in confidence' report has been supplied to the Chair including recommendations regarding successful bidders.

The report recommends that a number of providers following the Board's adoption of an AWP framework in January 2011 and a procurement during April and May 2011 covering;

- Gynaecology Clinical Assessment (triage)
- Gynaecology Community Service
- Dermatology Community Service

Supporting Documentation;

Bromley PCT hope to start these new arrangements, which will contribute to QIPP targets, on 1 July. There is no Joint Board meeting before then, and the contract values are in excess of limits delegated to the LCCC, means Joint Board Chair's action to approve the contract awards is required.

Consideration of the matters contained within the paperwork have been taken forward by the two 'home' Bromley NEDs. Their considerations have been made available to Caroline Hewitt.

Further Action required:

Bromley PCT will wish to report the outcome of this Chairs Action to the next appropriate meeting of its LCCC

ENCLOSURE 15

Reporting

A notice of this decision will be provided to the next meeting of the PCT Board on 21 July 2011.

Supporting NED / ED input;

Confirmed with James Gunner and Harvey Guntrip (lead non executive directors) – 7/6/2011.

7 June 2011

Bromley PCT **Date**
Chair

CAROLINE HEWITT

NHS

South East London

A meeting of the SEL PCT Boards* and Bexley Care Trust
21st July 2011

ENCLOSURE 16

NHS GREENWICH PHARMACEUTICAL NEEDS ASSESSMENT

DIRECTOR RESPONSIBLE: David Sturgeon, Director of Primary Care

AUTHOR: Jill Webb, Assistant Director of Primary Care
AUTHOR: David Long, Head of Pharmacy and Optometry, Bexley, Bromley & Greenwich

TO BE CONSIDERED BY:
1. Greenwich Teaching Primary Care Trust

SUMMARY:
This Paper recommends the final draft of NHS Greenwich Pharmaceutical Needs Assessment for publication. The document has been prepared to meet the requirements of the National Health Service (Pharmaceutical Services and Local Pharmaceutical Services) (Amendments) Regulation 2010, which require PCTs to prepare and publish a PNA by 1st February 2011.

The national deadline of 1st February 2011 to publish PNA's was delayed to allow Greenwich TPCT to properly evaluate the stakeholder and public responses at the end of the consultation period. However, a draft version of the document was published on the 1st of February 2011, which has reduced the likelihood of potential challenges.

The proposal to adopt the Greenwich PNA at the July 2011 Board meeting will enable the PNA to inform and support the Trust's:

- Commissioning plans for pharmaceutical services
- Decision making process in relation to market entry (this has been deferred at a national level)

The PNA identifies areas where Greenwich TPCT current commissioning could be improved and where there are opportunities to use pharmacists and pharmacy network in the future to deliver the vision for Greenwich of excellent healthcare, locally delivered. These areas include:

ENCLOSURE 16

- Smoking Cessation service provides strong coverage and compares favourably to neighbouring PCTs, but uptake could be increased through better patient referrals.
- Emergency Hormonal Contraception Service – Better marketed to the target age group (15-20 years).
- Better publicity of the different Enhanced Services provided by Greenwich Community Pharmacies.
- Services to support young people, including more support for alcohol misuse and in the provision of oral contraceptives.
- For residents of Greenwich in the age group (40-69), there is a need and demand for NHS Health Checks, currently a pilot, to be rolled out across the PCT.
- Weight management service, blood pressure and community diabetic services were also highlighted as a response from the public consultation process.

Annex 1 sets out the summary of the key findings.

FINACIAL CONSIDERATION:
Nationally, it was envisaged that with effect from Feb 2011, PNAs would have been the basis for control of entry for community pharmacy. However legislation has currently been delayed.

Should the PCT decide to commission any of the above services from Community Pharmacists, this is likely to result in some cost pressures, which should be offset by savings at a later stage.

LEGAL CONSIDERATIONS: N/A currently

ACCESS TO THE FULL PNA:
Available on request and, following Board approval, will be posted on the NHS SE London internet.

COMMITTEE INVOLVEMENT:
- The PNA Steering Group made up form the following;
  - Head (Joint) of Medicines Management
  - Senior Finance Manager
  - Senior Public Health consultant
  - Head of Sexual health
  - Head of Communications department
  - Representative from BBG LPC
  - Associate director for Goal 2 programme

- Community Pharmacy Advisors (joint)
- Prescribing advisors

PUBLIC AND USER INVOLVEMENT:
During the development of the PNA the public was engaged during the period of the public consultation process in line with the requirements of the PNA development process. This included Patient questionnaires drawn from;

- Online
- From Community Pharmacies within Greenwich
- Greenwich Council libraries, and their web site
- Through engagement with patient focus groups
- And by randomly selected patients via direct postal

In total 1490 responses were received, representing 1% of the population of Greenwich. From these responses key messages have been pulled together and have been incorporated into the PNA and areas for potential improvement.

IMPACT ASSESSMENT:
The PNA Steering Group for Greenwich felt that as the purpose of the Pharmaceutical Needs Assessment was to identify areas where our current commissioning could be improved and to help reduce health inequalities for all residents of Greenwich, that the public consultation process would include and involve a widespread involvement of different stakeholders. It was therefore concluded that a full Equality Impact Assessment was not necessary.

The PNA has been designed to ensure there is equity of provision of pharmaceutical services across Greenwich. The purpose of the PNA has been to identify gaps in service provision, so that NHS Greenwich can address the issues identified and commission pharmaceutical services based on the health needs of the population.

NHS SEL will during this financial year review NHS Greenwich's PNA with a view to adapting it from a Needs Assessment tool to a commissioning plan, where appropriate.

RECOMMENDATIONS:
The Board is asked to:

- Agree the final PNA document for publication on the SEL London Cluster/Greenwich internet.
- Endorse the need to consider whether our current commissioning could be improved in specific areas identified in the summary section above.

DIRECTORS CONTACT:
Name: David Sturgeon
E-Mail: David.Sturgeon@nhs.net
Address: 1 Lower Marsh, Waterloo, London SE1 9NT
Telephone: 0203 049 3950

AUTHOR CONTACT:

Name: Jill Webb
E-Mail: Jill.Webb3@nhs.net
Address: 1 Lower Marsh, Waterloo, London SE1 9NT
Telephone: 0203 049 6767

Name: David Long
E-Mail: d.long@nhs.net
Address: 1 Lower Marsh, Waterloo, London SE1 9NT
Telephone: 0203 049 6771

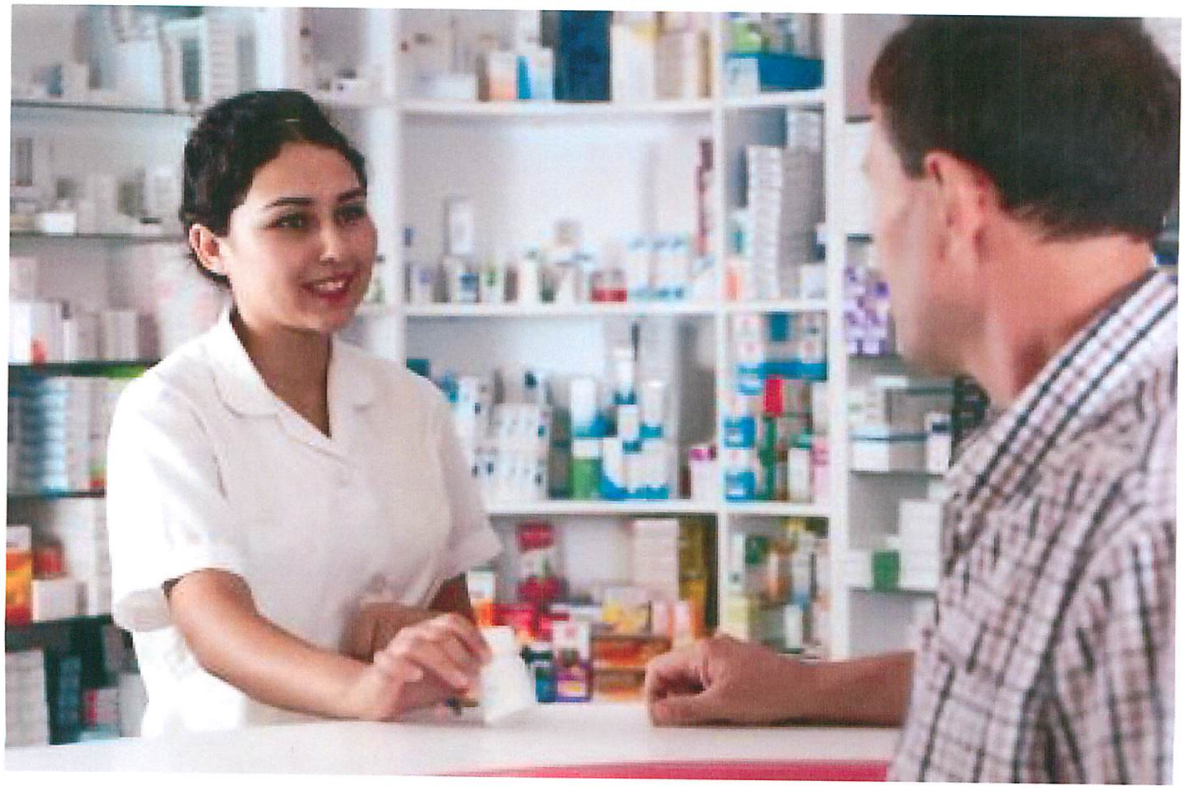
*SEL PCT Boards = Boards of Lambeth Primary Care Trust, Southwark Primary Care Trust, Lewisham Primary Care Trust, Bromley Primary Care Trust and Greenwich Teaching Primary Care Trust.

Pharmaceutical Needs Assessment

NHS Greenwich
Final Document
April 2011

NHS Greenwich

Experian



ENCLOSURE 16

Executive summary

NHS Greenwich's vision is to ensure better health and well-being by promoting a healthy society and developing services which are clinically-led and responsive to patient choice.

Our community pharmacies are crucial partners in helping to achieve this vision and effect real change. Safe and high quality services are the highest priorities for NHS Greenwich and patient opinion is essential to ensure that services improve in line with patient experience.

The statutory requirement to publish a Pharmaceutical Needs Assessment (PNA) by the 1st February 2011 has offered an opportunity for us to reflect upon our priorities and goals which are outlined in the Joint Strategic needs assessment, and to highlight the contribution that pharmaceutical services can make in the achievement of these goals. We are mindful of the impending regulatory changes to the Control of Entry regulations which mean that, in the future, a PNA will become the mechanism for determining market entry for community pharmacy services. Without a robust PNA (developed in accordance with the regulatory requirements) in place NHS Greenwich may be unable to effectively manage pharmaceutical services in the future to satisfy the needs of Greenwich residents or utilise the exceptional skills available in pharmacies.

In undertaking the Pharmaceutical Needs Assessment the PCT reviewed national guidance which tells us what services pharmacies can provide, and by extension, what a good pharmaceutical service looks like. We have taken account of local needs as described in the Joint Strategic Needs Assessment, and the views of the public through the results of a local patient questionnaire.

We have looked at this in the context of the NHS Greenwich local strategic priorities and asked local people about their general use and perceptions of community pharmacies; ease of access and getting services and products. We also asked about people's awareness of extended services other than prescriptions and over the counter medication and how pharmacies can improve services to meet the needs of our population.

This PNA has assessed the supply and need and demand. It has then looked to identify the gaps which exist between the two and to put forward recommendations for actions to address these gaps and most effectively commission new services in the future.

The PNA has been prepared at a time of significant change in the NHS. The July 2010 White Paper, "Equity and excellence: liberating the NHS", proposes radical reform of NHS services, including commissioning and is likely to have an impact on how pharmaceutical services are planned and utilised in the future.

At the time of producing this document the Government is consulting on its proposals and it is too early to say how they will affect the PNA or pharmaceutical services. While we expect that some aspects of pharmaceutical services will be managed by the proposed NHS Commissioning Board, there is likely to be further opportunity for greater local commissioning through public health and GP consortia in the future.

Understanding supply

- Greenwich enjoys excellent coverage in terms of its pharmacies and GP surgeries with over two thirds of wards providing more than two pharmacies per 10,000 of the population. .
- Pharmacies have made considerable investment into NHS Greenwich's infrastructure with the provision of targeted services; they are self-financing so do not place any burden on NHS.
- The pharmacy workforce has a broad range of skills from trained dispensing technicians through to independent and supplementary prescribers.
- All essential services are offered, with low uptake in particular of repeat dispensing services by residents, although these are dependent on other health professionals to be successful.
- In general, Greenwich pharmacies provide a high quality of service.
- Pharmacies are contracted to provide pharmacists during opening hours.
- A high proportion of pharmacies open outside the core 9am – 5pm weekday hours particularly in the north of the PCT and majority are open on Saturdays.
- The majority provide hand-washing facilities either within the pharmacy or close by and provide a private consultation room.
- Just under a fifth of pharmacies do not provide a consultation area with disabled access, this will need to be addressed.
- The PCT provides a wide range of enhanced and advanced services.
- A high proportion of pharmacies provide: EHC services, Chlamydia testing and treatment, smoking cessation and minor ailments.
- Seasonal influenza vaccination service (IVS) is also provided by a high proportion of pharmacies, although some services are private and therefore not commissioned by the PCT.
- Palliative Care, which is a selected service designed to address end of life care concerns is required by a limited number of individuals and therefore is only offered in a select number of pharmacies.
- The NHS Health Check is currently a pilot scheme and therefore only offered within five pharmacies but with good potential to expand.

Understanding need

- Approximately 233,000 people live in Greenwich. The borough has a slightly smaller proportion of working age population compared to the London average.
- A large proportion of the pensionable population is concentrated in the south of Greenwich whilst the majority of households with children are located in the north.
- Black or Black British, Chinese and mixed ethnic groups are highly represented.
- Greenwich has excellent public transport networks which support mobility and enable easy access to the PCT's pharmacies.
- Claimant rates are high in Greenwich compared to London averages.
- People in Greenwich often experience poorer health than is typical across London and England.
- Greenwich has a high proportion of smokers resulting in a number of smoking related illnesses.
- Cardiovascular disease will remain a substantial issue for Greenwich.

- Drug and substance misuse in Greenwich remains broadly in line with national averages. Alcohol consumption is rising in Greenwich compared to the rest of the country.
- Teenage pregnancy and Chlamydia rates have increased in Greenwich.
- The rates of people who are obese and overweight are increasing in Greenwich and the rest of the country and this can result in a range of health conditions including diabetes.
- The health needs of the prison population must also be taken into account and will require dedicated pharmacy support.
- The population of Greenwich is due to increase at a faster rate than is typical of London as a whole.
- For the most part population growth is expected to be concentrated in the north of Greenwich.
- All age groups will witness an increase in population.
- The largest absolute increase in population is within the 40-69 age group followed by over 65s and 15-24.
- A key factor in determining this growth is the 2012 Olympics and associated re-development
- As a result of austerity measures there is the potential for major job losses in Greenwich, which could contribute to further increases in local deprivation linked to a variety of health issues.

Understanding demand

- A key demand of over two thirds of residents is that they can walk to their local pharmacy which is within 5 to 10 minutes away.
- A high proportion (75%) want their pharmacy to be located close to their home or their GP surgery (50%), fewer want their pharmacy to be close to work (12%).
- Quality of individual service is important to residents. 41% want to deal with the same pharmacist each time, and a quarter would like the pharmacist to be familiar with their condition.
- Greenwich residents want to use their pharmacy to get prescribed medicine (91%), to buy over the counter medicine without prescription (59%) and to get advice from the pharmacist (47%).[1]
- Less than a third of residents want to use their pharmacy for the other services that it provides, this is likely to be due to a lack of awareness that these services are offered.
- Of those services that residents do demand, the key ones are: medicine use reviews, minor ailments service and blood pressure testing (indicating that there is a demand for the NHS Health Check Service which is currently a pilot scheme).
- There is demand for EHC Services but they need to be better marketed and their accessibility increased in order to appeal to younger groups.
- There is strong awareness of Smoking Cessation Services but there need to be improvements in referrals to these services to enhance uptake.

[1] People could choose more than one options, this is the reason for the percentages not summing to 100.

Identifying gaps

- It is vital that existing supply and current and future need / demand is taken into account in order to identify where the gaps are.
- NHS Greenwich is extremely well provided for by pharmacies with total coverage by pharmacies and GP surgeries of 99.9% of the population and there is sufficient capacity in the network to deal with future demand as a result of predicted population growth.
- Greenwich benefits from a skilled and varied workforce, however they must adapt to the increased demand for enhanced services close to home and ensure that they have the necessary specialist skills.
- For the prison population within HMP Belmarsh, although there has been progress, there remain gaps in terms of provision which need to be addressed.
- The majority of pharmacies provide their service in more than one language and have hand-washing facilities and a private consultation room.
- A high proportion of pharmacies do operate outside their core 9am – 5pm weekday hours, however there are fewer pharmacies open longer hours in the south of the PCT, largely due to economic viability, but there could be scope to enhance access.
- There is room to improve disabled access for a number of pharmacies.
- There is excellent coverage and uptake of Chlamydia testing and treatment services for young people which ranks favourably against neighbouring PCTs.
- EHC Services provide a strong service within 15 minutes walk-time of the target group people (15-24), there is however scope to better market this service to young people.
- The PCT needs to keep abreast of additional services to support young people including more support for alcohol misuse and in the provision of oral contraceptives.
- In terms of provision for middle aged groups (40-69), there is a need and demand for the NHS Health Checks, currently a pilot, to be rolled out across the PCT.
- Older People are fairly well catered for within the PCT, but given an increasingly ageing population the PCT must keep abreast of increased demand for these services.
- There is adequate coverage in terms of provision for deprived communities in many areas, but there is certainly scope to expand this further and to enhance uptake by residents.
- Smoking Cessation service provides strong coverage and compares favourably to neighbouring PCTs, but uptake could be increased through better patient referrals.
- The provision of needle and syringe exchange enhanced service could be enhanced and developed further.
- There is a strong coverage of the Supervised Administration of Methadone enhanced service.

Taking action

- Greenwich pharmacies provide all essential services and the majority provide advanced services
- The majority of NHS Greenwich's enhanced services provide a good service and are easily accessible to those that require them
- A limited number of enhanced services may require expansion or development to optimise their delivery
- NHS Greenwich has produced a comprehensive set of requirements for new contract applications based on the need and demand analysis
- NHS Greenwich is also working on a number of additional activities to further develop the network of pharmacies and to ensure that high quality and accessibility of services is maintained

South East London

NHS SOUTH EAST LONDON PCT/CARE TRUST BOARDS

DATE OF MEETING: 28thth JULY 2011

ENCLOSURE 17

CHAIR'S REPORT

Farewell to Simon Robbins

Simon Robbins our Chief Executive will be retiring at the end of August after 30 years service, and over 20 years as a Chief Executive and leadership roles in both commissioning and provision.

Simon's tiresome hard work in establishing NHS South East London has laid some very firm foundations upon which we can look to build; he was key in developing the Borough-based model of commissioning support which has gained the support of stakeholders across South East London, in particular with our GP leadership. I know I speak for all our senior management team as well as myself when I say that we have enjoyed working with him, thank him for his huge contribution to improving local services and wish him all of the very best in his retirement.

Appointment of new Chief Executive for NHS South East London

I am delighted to announce that Andrew Kenworthy will be joining NHS South East London as our new Chief Executive. Andrew will be joining us from NHS Nottingham City and Nottinghamshire County Commissioning Cluster, where he is currently Chief Executive. Andrew has substantial experience of working at a senior level within the NHS in London, having previously been Chief Executive of Kensington & Chelsea Primary Care Trust.

Andrew's track record and experience will enable South East London to stay focused and deliver our objectives during the current reforms. He will lead us forward to provide better outcomes for patients in South East London, and better value for money for the NHS. Andrew will be joining NHS South East London at the beginning of the autumn, and is looking forward to meeting board members in due course.

Embedding the culture of NHS South East London

I continue to spend much of my time on embedding the new arrangements for NHS South East London. I have been meeting with Non Executive Directors to discuss and agree objectives. These are aligned with the overall objectives for the cluster for delivery, reform and legacy. All members of the board need to continue to exemplify our approach as a single team working across the whole of South East London.

I now have in place a timetable to spend a day a month in each borough on rotation – and I would like to thank colleagues internal and external who have taken time to meet and share key issues in our boroughs.

Appointments to Bexley Care Trust

I am pleased to announce that Harvey Guntrip and Susan Free will be appointed to Bexley Care Trust Board. For clarity I can confirm the Care Trust non-executive membership is as follows:

Chair – Caroline Hewitt
Audit Chair – Steven Corbishley
Vice Chair – Keith Wood
Non Executive Director (Council Nominee) – Cllr Eileen Pallen
Non Executive Director (Council Nominee) - Cllr John Davey
Non Executive Director – Paul Cutler
Non Executive Director – Susan Free
Non Executive Director – Harvey Guntrip

Caroline Hewitt
caroline.hewitt1@nhs.net
020 3049 4067

South East London

NHS SOUTH EAST LONDON PCT/CARE TRUST BOARDS

DATE OF MEETING: 21st JULY 2011

ENCLOSURE 18

CHIEF EXECUTIVE'S REPORT

Greenwich GPs achieve pathfinder status

I am very pleased to announce that the Department of Health have confirmed 'Greenwich Health' as a GP pathfinder, meaning that that now all six of our Clinical Commissioning Groups have achieved pathfinder status. This represents a key milestone in the development of Clinical Commissioning in South East London and I would like to congratulate GPs in all six boroughs for their leadership in taking this agenda forward.

Staff engagement on developing Commissioning Support Services

I recently visited all six boroughs and the central team to open up a discussion about the options for commissioning support in the future. The objective for the sessions was to explain to colleagues what commissioning support is, how it may be provided in the future and to seek their views on how they would like to be engaged.

Whilst in many cases there are still more questions than answers, I am clear that demonstrating a track record of high quality, responsive commissioning support through the transition is the right way to prepare for any future as a provider of commissioning support services. These sessions were the start in a programme of staff engagement that will continue as the policy environment becomes clearer to ensure that our staff have are in as strong a position as possible to participate in the future of commissioning support.

It is our intention to delegate 100% of commissioning to Clinical Commissioning Groups by the 1st April 2012. We intend to align the cluster commissioning support services to support this and allow a period of shadow working that will ensure GPs are fully practised in the commissioning cycle and place colleagues in the best position to provide commissioning support after 2013.

Future Forum report and government response

The Future Forum report was published on the 13th June, followed by the government's response 14th June. Their report, the government's response and subsequent proposed amendments to the Health and Social Care bill are available using the link below.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_127444

The key changes proposed will be to improve accountability, reinforce the NHS constitution, widen membership/strengthen governance of Clinical Commissioning Groups (CCGs) and strengthen Health and Well Being Boards (CCGs will have to agree strategy with Health and Wellbeing Boards and their membership can be determined locally). The timetable for authorisation of CCGs has been relaxed to allow for a staged authorisation process, Clinical Senates will be introduced to provide area-wide clinical reviews of service configuration. Additionally, a new duty to promote research will be introduced across the NHS.

The role of Healthwatch has also been reviewed as well as strengthened duties to involve patients and the public for CCGs, Monitor and the National Commissioning Board. There will be a duty to promote choice and integration as well as a redefined role for Monitor, only to introduce competition to improve quality and to reduce the risk of private providers 'cherry-picking' services. There will be changes in the proposed Foundation Trust timeline and proposals to make changes to education and training arrangements will be reviewed.

Information governance

Following well-publicised incidents about the loss of confidential data in other parts of the NHS, I have emphasised to staff and would like to remind the board that the confidential treatment of patient sensitive data is apriority. We all have an absolute duty to ensure that confidential data is handled appropriately.

We have put in place procedures to ensure that laptops or other remote devices are appropriately encrypted and reinforced the message that any contravention of these requirements will result in immediate disciplinary action.

South East London

Feasibility study for work with South West London

Whilst we have established strong, borough focussed commissioning support in South East London, it is becoming increasingly clear that in order to sustain that focus it may be necessary to understand if there are some commissioning support services which can be aggregated across a wider footprint e.g. across south west and south east London without losing a local focus, which also provides for economies of scale.

Following conversations with GP leaders across South London, we have committed to undertake a short feasibility study across south London to assess whether this local and aggregated model makes sense and is affordable. Our aim is to have a costed prototype by the end of July, which can then be explored in more depth with GP colleagues.

A personal vote of thanks

This will by my final board meeting at NHS South East London.

I would like to take this opportunity to thank all of my colleagues for their support over the past few years from across all of the PCTs and Trusts in South East London and beyond.

Whilst I have faced a number of challenges during my tenure as Chief Executive, I have always found them enjoyable and have valued the strong partnerships that we have in South East London between clinicians, executive and non-executive colleagues and our stakeholders that reinforce our collective commitment to improve the quality of local health services.

I wish you all the very best for the future.

Simon

Simon Robbins
simon.robbins1@nhs.net
0203 0494389

NHS

South East London

A meeting of the SEL PCT Boards* and Bexley Care Trust 21st July 2011

ENCLOSURE 19

ENCLOSURE 19

HUMAN RESOURCES UPDATE

DIRECTOR RESPONSIBLE: Una Dalton, Director of Human Resources

AUTHOR: Una Dalton, Director of Human Resources

TO BE CONSIDERED BY: All

SUMMARY:
This paper sets out an update for Board members on Human Resources during the first quarter of 2011.

KEY ISSUES:

1. A summary of the impact of organisational change

During 2010/2011 we managed a significant organisational change programme in order to deliver management cost savings. As part of the change process approximately 500 staff were formally placed at risk of redundancy and issued with notice to that effect. 100% of staff at risk actively took part in the process to secure suitable alternative employment within the new structures and staff support and advice was made available throughout the process.

As a result of the change process we have managed two appeals relating to options for suitable alternative employment (now resolved) and one claim to Employment Tribunal (with an expected date for hearing in July/August 2011).

In terms of the impact on staffing numbers the following table summarises the impact of change:

Total workforce numbers across the 6 PCTs as at 1st September 2010 (wtes*)	1164*

Total workforce numbers across Cluster as at 1st April 2011 (wtes)	831
Overall reduction in staffing numbers (wtes)	333
Breakdown of reductions (wtes)	87 vacant posts deleted 42 staff left - MARs*** 87 staff left - Voluntary Redundancy 48 staff left - Compulsory Redundant 29 Non Executive Directors terms ended 35 staff transferred to Provider Arms 6 resignations/retirements/staff still at risk
	*whole time equivalent ** This figure excludes a number of key groups not affected by the change process such as FHS and hosted services ***MARs = mutually agreed resignation scheme attracting a reduction in benefits compared to compulsory redundancy

We continue to have a small number of staff who remain at risk of redundancy, with end of employment dates due in July/August 2011. We will continue to work with this group to seek suitable alternative employment and to avoid compulsory redundancy wherever possible.

We have invited a mixed group of staff including those made redundant over the past few months to take part in a review of our management of the organisation change process. To date we have received 24 completed questionnaires and we will submit an update on this work to the July meeting of the Employment and Remuneration Committee including any recommendations in terms of action.

2. Vacancies in the current structure

Upon completion of the change process we had 80 vacancies in the new BSU/Cluster structures. At the request of the Management Board we have established a vacancy panel to review all requests to fill vacant posts or to make any change to the payroll (grade changes etc). This panel meets on a fortnightly basis and includes the following membership:

- Gill Galliano, Director of Transition (Chair)
- Andrew Eyres, Managing Director, Lambeth
- Marie Farrell, Director of Finance, IT and Estates
- Una Dalton, Director of Human Resources

We have actively managed all vacancies and the following table sets out an update of the current position:

Vacant posts filled since 1 April 2011	14
Vacant posts currently on NHS jobs	19
Advertisements closed and awaiting a selection process	23
Posts agreed by Vacancy panel – awaiting processing	7

3. Sickness absence and turnover

We will present a regular update on sickness absence rates and turnover figures from the September Board meeting and at each subsequent Board meeting held in Public. If Board members would like to receive any other regular workforce information in public please email Una Dalton at una.dalton@lambethpct.nhs.uk

4. Staff Engagement

Ongoing staff engagement will be fundamental for us to succeed during the transition period. We are in the process of establishing a Cluster wide Staff Partnership Forum to take forward our discussions with staff and their trade unions. The first meeting of the forum will take place on 2nd August and it will report into the Cluster Employment and Remuneration Committee.

5. Training and Development

We have made significant progress in the development of personal development plans for all staff. At the point of writing this report 65% of staff have completed and submitted a copy of their agreed personal development plan following the annual appraisal meeting.

The Human Resources team will use this information to develop a Cluster wide training and development plan to address development needs and to set out our approach to talent management during the transition period. A further update on this work will be included in the HR update at the September Board meeting.

6. Retention and Exit Scheme

The Employment and Remuneration Committee received an update on the development of a RET scheme (retention scheme) in June 2011. Further guidance on this scheme is expected from the Department of Health over the coming weeks and we will provide an update on this work as soon as possible.

7. Human Resources (HR) Transition Framework

The Department of Health have published Human Resources (HR) Transition Framework guiding our work over the transition period. This document will be considered by the Employment and Remuneration Committee and the new Joint Staff Partnership forum in July/August 2011.

8. Employment and Remuneration Committee

The Cluster Employment and Remuneration Committee will meet in late July and will focus on the following items for consideration:

a. Senior management pay and terms and conditions of employment
b. Remuneration for Clinical engagement across the Cluster
c. RETs
d. HR Framework

An anonomised report on the work of the Committee work will be published in March 2012.

COMMITTEE INVOLVEMENT:

- Employment and Remuneration Committee – June 2011

PUBLIC AND USER INVOLVEMENT: N/A

ENCLOSURE 19

IMPACT ASSEESMENT:

- A review of the overall impact of organisation change on staffing structures is planned for August 2011.

RECOMMENDATIONS:

The board (s) is asked to:-

- Note the report

DIRECTORS CONTACT:

Name: Una Dalton
E-Mail: una.dalton@lambethpct.nhs.uk
Telephone: 020 3049 4153

AUTHOR CONTACT:

Name: Una Dalton
E-Mail: una.dalton@lambethpct.nhs.uk
Telephone: 020 3049 4153

*SEL PCT Boards = Boards of Lambeth Primary Care Trust, Southwark Primary Care Trust, Lewisham Primary Care Trust, Bromley Primary Care Trust and Greenwich Teaching Primary Care Trust.

NHS

South East London

A meeting of the SEL PCT Boards* and Bexley Care Trust
21 July 2011

ENCLOSURE 20

NHS SEL LOCAL CLINICAL COMMISSIONING COMMITTEES
HIGHLIGHT REPORT AND DRAFT MINUTES

DIRECTOR RESPONSIBLE: Gill Galliano, Director of Development

AUTHOR: Ben Vinter, Integrated Governance Manager

TO BE CONSIDERED BY: All

SUMMARY:
The Joint Boards are asked to consider

a) The highlight reports of each of the meetings of the Local Clinical Commissioning Committees
b) The approved minutes of each of the Committees

KEY ISSUES:
The key issues as considered by each of the Boards' Committees are set out within the enclosed highlight report prepared on behalf of each Chair.

INVOLVEMENT: As stated

RECOMMENDATIONS:
The Boards are asked to:-

1. NOTE the highlight reports
2. NOTE receipt of the minutes of each LCCC

ENCLOSURE 20

DIRECTORS CONTACT:
Name: Gill Galliano
E-Mail: g.galliano@nhs.net
Telephone: 020 7206 3332

AUTHOR CONTACT:
Name: Ben Vinter
E-Mail: ben.vinter@nhs.net
Telephone: 0203 049 4421

NHS

South East London

A meeting of the SEL PCT Boards* and Bexley Care Trust
21 July 2011

NAME OF COMMITTEE: Bexley Clinical Commissioning Cabinet Formal Meeting

DATE OF COMMTTEE: 23 June 2011

PRINCIPLE FOCUS:

- Update on proposed BCC service redesign programmes with Bromley & Greenwich
- Quality Issues relating to Commissioned Services
- GP Visits
- Delegation of Budgets to BCCC
- Bexley QIPP Schemes
- Draft MPET Proposal
- Allocation of £2
- Bexley Business Plan
- Communications & Patients Improvement update/launch of Patient Council

ISSUES ARISING:

- Issues regarding IVF service
- Consultant follow up appointments
- Financial impact on the outcome of SLHT Arbitration decisions and concerns raised regarding the performance management of the contract regarding Bexley responsibilities (challenge process) by NHS SELDN
- Bexley QoF issues being processed by David Sturgeon, NHS SELDN
- Options for Cluster Informatics
- The Month – NHS Modernisation – special issue June

RECOMMENDATIONS MADE:

- Bexley Clinical Quality Assurance Group Terms of Reference approved
- Dressing Pilot Brief Proposal approved
- Appointment of PEC Nurse to be progressed

ENCLOSURE 20

COMMITTEE CHAIR: Name: Bill Cotter (on behalf of Howard Stoate)
LEAD DIRECTOR: Name: Dr Joanne Medhurst/Pamela Creaven E-Mail: joanne.medhurst@nhs.net/pamela.creaven@bexley.nhs.uk Telephone: 020 8298 6275/6212

*SEL PCT Boards = Boards of Lambeth Primary Care Trust, Southwark Primary Care Trust, Lewisham Primary Care Trust, Bromley Primary Care Trust and Greenwich Teaching Primary Care Trust.

ENCLOSURE: A
Formal Clinical Cabinet Meeting:
Agenda Item

NHS
South East London

DRAFT BEXLEY BUSINESS SUPPORT UNIT FORMAL CLINICAL CABINET MEETING

23 JUNE 2011

DANSON ROOM, 221 ERITH ROAD, BEXLEYHEATH, KENT DA7 6HZ

PRESENT:

Dr Bill Cotter (Acting Chair)	Clinical Cabinet Member, Clocktower
Dr Sid Deshmukh	Clinical Cabinet Member, Frognal
Dr Varun Bhalla	Clinical Cabinet Member, North Bexley
Theresa Osborne	Chief Financial Officer Bexley BSU
David Parkins	Clinical Quality Lead Bexley BSU
Dr Gunen Ucyigit	Clinical Cabinet Member, Salaried GPs
Keith Wood	Bexley NED (Vice Chair)
Paul Cutler	Bexley NED

IN ATTENDANCE:

Cllr John Davey	Bexley NED
Beth Hill	Clinical Cabinet Special Advisor Bexley BSU
Clare Ross	AD of Service Redesign & Commissioning Bexley BSU
Jon Winter	Head of Communications, Engagement & Complaints Bexley BSU
Mary Stoneham	Corporate Office Manager (notes) Bexley BSU
Annie Gardiner	Head of Patient Experience & Complaints (Items 67 & 71 only)

APOLOGIES:

Dr Howard Stoate	Clinical Cabinet Chair
Pamela Creaven	Joint Managing Director & Public Health Lead Bexley BSU
Dr Joanne Medhurst	oint Managing Director & Medical Director Bexley BSU
Cllr Eileen Pallen	Bexley NED

55/11 MINUTES OF FORMAL CLINICAL CABINET MEETING HELD ON 21 APRIL 2011
The minutes were agreed as an accurate record.

56/11 MATTERS ARISING (not on the agenda)

- **49/11 – Quality Report**
  Agreed that a paper was required to clarify GP/continuing care processes/ responsibilities/financial payments and responsibilities at the next Informal/Formal Clinical Commissioning Cabinet meetings.
  Action: JM/TO

57/11 DECLARATIONS OF INTEREST
The meeting noted the Declarations of Interest for the Bexley Clinical Commissioning Cabinet (BCCC) and agreed that they would be placed on a display board in the corridor at 221 and placed on the Bexley BSU website/intranet as part of the Public Meeting papers and GP Zone Intranet.
Action: MS

58/11 BEXLEY CLINICAL COMMISSIONING CABINET TERMS OF REFERENCE (BCCC)

ENCLOSURE 20

The meeting paper detailed the Terms of Reference and Membership of the Bexley Clinical Commissioning Cabinet which is an executive committee of the Joint Board for Bexley Care Trust approved by the Joint Board on 19 May 2011. The meeting noted that these Terms of Reference should be reviewed initially after six months and then annually.

During discussion it was explained that recruitment to the PEC Nurse post needed to be undertaken immediately to enable nurse representation at the next Formal BCCC meeting.
Action: BH
Sandra Wakeford, Chair of the Patient Council would be an Observer at Public BCCC meetings. Members considered that the BCCC should start to consider how local GPs could feed local knowledge up to the Consultant to be appointed to the BCCC. It was acknowledged that budget responsibility and control needed to be agreed and reflected in the voting rights for the BCCC and clarification was needed on budget responsibility eg BSU/Sector as soon as possible.

59/11 UPDATE FROM CHAIR OF BEXLEY CLINICAL COMMISSIONING CABINET
Apologies received from Dr Howard Stoate as attendance required at an urgent SELDN Commissioning Workshop.

60/11 UPDATE FROM BEXLEY CLINICAL COMMISSIONING GPS
Dr Bill Cotter gave brief updates on:
- IVF funding of services which had transferred to Cluster on 1 April 2011 and would now be commissioned for Bexley patients at Kings or Guys Hospitals which would have a financial implication for Bexley. SLHT would remain responsible for patients already on the waiting list. The GPs were concerned at the length of time patients were on the waiting list before they received an appointment.
- out patients follow up appointment process needed discussions to take place with GP/Consultants and agree a process to highlight areas of good clinical practices.
- outcome of the arbitration process and the capacity of Cluster to negotiate on behalf of Bexley Commissioning relating to SLAs/QIPP/breakeven and performance management processes. Drs Cotter and Bhalla would meet with Cluster regarding assurance that the clinical governance targets in the SLHT contract were monitored and reported back appropriately to the Bexley.
Action: Drs Cotter/Bhalla

Theresa Osborne confirmed that Cluster would be responsible for acute SLA and any financial overspend during 2011/12 and the achievement of Cluster QIPP initiatives.

Dr Bhalla gave a brief update on the BCCC planned work with Bromley & Greenwich in service redesign programmes to deliver improved patient care in the community in line with the White Paper. Proposed redesign of clinical pathways in diabetes was already taking place and Round Tables meetings were planned for example MSK, dementia and elderly care and patient involvement in the redesign meetings would be a key component. A patient event was scheduled in July to look at options to post operative rehabilitation at QMS at Bexley Civic Offices.

Dr Deshmukh gave brief updates on:
-overview following a Cluster Informatics Meeting on the options being considered going forward the Sector for which a decision would need to be made at the July Formal Meeting.
Action SD
- update on discussions at the Frognal Locality Meeting regarding QoF payments. The meeting agreed that the Managing Directors would write to Cluster regarding the contract/relationship management position. The BCCC agreed to hold a GP Event and invite David Sturgeon and Gill Webb for discussions on primary care issues.
Action: JW

61/11 UPDATE FROM BEXLEY BSU MANAGING DIRECTORS
Apologies received Manager Director's as attendance required at urgent SELDN Commissioning Workshop.

62/11 BEXLEY CLINICAL QUALITY ASSURANCE GROUP TERMS OF REFERENCE
David Parkins presented the Terms of Reference and membership of the Clinical Quality Assurance Group as a sub-group of the Bexley Clinical Commissioning Cabinet.

Bexley Clinical Commissioning Cabinet **APPROVED** the Bexley Clinical Quality Assurance Group Terms of Reference.

63/11 WOUND DRESSINGS
David Parkins presented the Dressing Pilot Brief Proposal which would change the supply route of dressings for DNs and produce savings from reduced waste of dressings dispensed to a patient that cannot be reused. The proposal changes the supply route of dressings from community pharmacy to central store supplied by NHS supply chain.

Bexley Clinical Commissioning Cabinet **APPROVED** Option 3
NHS supply route used for all formulary items from all DN bases for a 6 month trial.

64/11 UPDATE ON TOTAL HEALTH
Deferred to the next Formal Bexley Clinical Commissioning Cabinet Meeting.

65/11 FINANCE UPDATE ON ANNUAL ACCOUNTS AND OUTTURN POSITION
Theresa Osborne provided a brief summary on the Financial Update on Annual Accounts and 2010/11 Outturn Position.

The Bexley Clinical Cabinet **NOTED** the points detailed in the report; the achievement of all statutory financial duties for 2010/11 with a surplus of £486k; and the unqualified audit conclusions on the 2010/11 Annual Accounts and submission to the Department of Health within prescribed timescales.

66/11 QIPP
Theresa Osborne summarised a tabled document on QIPP Schemes & Financial

Update which had been adjusted following discussions with the Cluster Commissioning Team. The £10,203k QIPP target is the amount of QIPP required to make the planned 1% surplus as per the Operating Framework. The meeting agreed the need to continue to stringently monitoring agreed QIPP Schemes and actively consider new QIPP schemes.

67/11 COMMISSIONED SERVICES QUALITY REPORT

David Parkins gave a brief summary on the Quality Report Quarter 4 (Jan-Mar 2011) that examined the key quality domains relating to services commissioned by Bexley BSU, NHS South East London (BBSU) and identified the quality assurance process that has been developed for monitoring these services. The report summarised the red indicators from the dashboards and remedial actions taken.

Annie Gardiner discussed the key data summarised the Complaints & PALS Report (Section 6).

The meeting discussed;

- concerns regarding the A&E and Maternity increased attendances at Darenth Valley and the need to ensure West Kent staff participation in the Quality Group Meeting process
- need to ensure SLAs are agreed aligned to finance and quality jointly
- flow of information to BSUs from Cluster
- clarification of process for feeding up to Cluster urgent quality issues (Varun Bhalla to email David Parkins with three areas of concern)

The Cabinet noted the report, which had also been received by the BCCC Clinical Quality Assurance Group who had agreed that quality concerns identified by the report are, or have been actively addressed through the appropriate groups.

68/11 SUMMARY OF GP VISITS AND ISSUES TO DATE

Clare Ross explained that the GP Visits and Issues to Date Report provided feedback from the 10 practice visits which had taken place. The revised processes implemented would build upon the close links between Bexley BSU and its primary care partners which has generated a number of key priorities. The issues detailed in the report are being dealt with and actions agreed to address them.

A new template is currently being drafted to improve the process and will be circulated to practices when finalised following approval from the Clinical Cabinet GPs. An event was organised in July for GPs and Practice Managers to meet with the relevant BSU Staff to discuss issues regarding to the practice visits. The Cabinet agreed that GP Visits would be reported on a monthly basis to the Formal Meetings.
Action: CR

69/11 MPET PROPOSAL –DRAFT

Beth Hill presented the tabled MPET Proposal on funds used to learn new skills for developing strategies to address commissioning and financial sustainability. The focus of this programme is designed to enable GPs and other clinical leaders to lead the commissioning process through clinical expertise networks.

Beth explained that the paper was a working draft for discussion with NEDs/GPs/ Senior Managers and consider the whether to apply through Phase 1 to proceed on an individual Bexley basis or to through a co-ordinated approach through Phase 2 with Bexley/Bromley/Greenwich as Bromley & Greenwich were ready to apply for Phase 1.

Following discussion the Cabinet decided that Bexley should proceed on an individual basis through Phase 1. Beth agreed to email the full set of requirements to Cabinet members.
Action: BH

70/11 UPDATE ON £2 PER HEAD ALLOCATION

Beth Hill presented the tabled paper on £2 Per Head Development Money and asked the Cabinet to note. Theresa Osborne stated that there may be a need for Finance backfill while staff covered additional work. The Cabinet agreed that the detail should be agreed by the BSU Strategic Management Team.

71/11 Communications & Patient Improvement Update (under Item 67/11)

- **Complaints Update**
  Patient Council Launch & Feedback
  Annie Gardiner gave a verbal precise of recent patient engagements iand the Patient Council Launch.

72/11 Any Other Business

- **Delegation of Budgets**

Beth Hill presented a tabled paper on the Delegation of Budgets and explained that the final document would be presented to the July SELDN Joint Board Meeting and BCCC needed to provide sufficient evidence to meet the criteria for the four sections set out by the South East London Cluster.

The Cabinet considered that Bexley should follow the Lambeth Model template which had been submitted to NHS London and agreed that this needed further discussion was needed at the next Informal/Formal Clinical Cabinet meetings to meet the deadline for submission to the Joint Board. **Action: BH**

The Cabinet noted the progress, way forward and time table for delegation of budgets to the Bexley Clinical Commissioning Cabinet to be discussed at the Joint Board Meeting on 21 July 2011.

- **BCCC Agenda for Formal Meeting on 28 July**
  Action: MS/JW/BH to discuss
- **AGM Agenda and arrangements**
  Action: MS to arrange pre meeting with JH/BH and then discuss at next Cabinet Meeting
- **BCT Annual Report**
  Approved by Cluster Audit Committee has been sent to Communications Department.
  Action: JW

- **Consultation Deadline for CQC Registration**
  Action: JM
- **Bexley Business Plan**
  Action: BH to draft (to follow Lambeth template) integrated with to BSU objectives and tactical plan to deliver prospectus targets and agreed by the end of week
- **The Month – NHS Modernisation – special issues June 20 June 2011**
  Action: BH to discuss further with GPs further next week

73/11 DATE OF NEXT FORMAL BEXLEY CLINICAL COMMISSIONING CABINET MEETING – 28 JULY 2011 – DANSON ROOM 221

NHS

South East London

A meeting of the SEL PCT Boards* and Bexley Care Trust
21 July 2011

NAME OF COMMITTEE: Draft Bromley LCCC Minutes
DATE OF COMMITTEE: 23 June 2011
PRINCIPLE FOCUS: • First meeting of the Committee - with limited, development agenda
ISSUES ARISING: • Endorsed governance arrangements • Received early monitoring reports on finance, performance, quality, QIPP, learning disability services and commissioning group development and considered what the Committee will need in future • Endorsed proposals for Equality Delivery System
RECOMMENDATIONS MADE: The Board is asked to receive and note the draft minutes.
COMMITTEE CHAIR: Name: Dr Angela Bhan E-Mail: angela.bhan@bromleypct.nhs.uk Address: Bassetts House Telephone: 01689 880683 :
LEAD DIRECTOR: Name: Keith Fowler E-Mail: keith.fowler@bromleypct.nhs.uk Address Bassetts House Telephone: 01689 880601

ENCLOSURE 20

*SEL PCT Boards = Boards of Lambeth Primary Care Trust, Southwark Primary Care Trust, Lewisham Primary Care Trust, Bromley Primary Care Trust and Greenwich Teaching Primary Care Trust.

MINUTES OF THE MEETING
OF THE LOCAL CLINICAL COMMISSIONING COMMITTEE
OF BROMLEY BUSINESS SUPPORT UNIT
HELD ON THURSDAY 23 JUNE 2011
IN THE HARRY LYNE ROOM AT THE BECKENHAM BEACON

Present:	Jim Gunner	Chair
	Dr Angela Bhan	Managing Director
	Anna Bennett	Interim Head of Finance
	Meredith Collins	Director of Commissioning
	Dr Mike Collins	GP Clinical Commissioner
	Sonia Colwill	Director of Prescribing and Quality
	Harvey Guntrip	Non Executive Director
	Dr Nada Lemic	Director of Public Health
	Dr Ruchira Paranjape	GP Clinical Commissioner
	Dr Andrew Parson	Clinical Commissioning Lead
	Terry Rich	Director of Adult and Community Services (LBB)
In Attendance:		
	Keith Fowler	Secretary to the PCT Board

01/11 **APOLOGIES FOR ABSENCE, ANNOUNCEMENTS AND DECLARATIONS OF INTEREST**

Apologies were received from Dr Jackie Tavabie, Dr James Heathcote and Dr Sarah Stoner.

There were no declarations of conflicts of interest associated with the meeting agenda.

02/11 **URGENT BUSINESS**

There was none.

GOVERNANCE ARRANGEMENTS

03/11 **TERMS OF REFERENCE OF THE LCCC**

The Committee received and noted the terms of reference as ratified by the Joint Boards of NHS South East London on 19 May 2011.

Angela Bhan said that consideration was being given to the appointment of the nurse member of the Committee. It was agreed that this

appointment should be made on a sessional basis. Further advice would be sought from Donna Kinnair, Director of Nursing, NHS South East London.

The Committee also noted that, following the recent "Listening Exercise" the Government had proposed that membership of the Clinical Commissioning Groups should include a doctor not from a local provider unit, and two lay members.

It was agreed to review membership in September when the new requirements were clearer. **Action: AB, KF**

04/11 **DRAFT TERMS OF REFERENCE - QUALITY WORKING GROUP**

Keith Fowler introduced draft proposals for a Quality Working Group to support and provide assurance to the LCCC. Angela Bhan said that the Group would need to bring together and monitor outputs from all providers which would then need to be fed up through the LCCC to the Joint Boards.

The Committee agreed that Sonia Colwill, Director of Prescribing and Quality should chair the Group, and noted that she also was a member of the Quality and Safety Committee of the Joint Boards. The Committee also agreed a suggestion from Terry Rich that Aileen Stamate, the Quality Assurance Manager from LBB, should be a member. **Action: KF**

It was agreed that all commissioned services should be covered in the Group's remit, with the possible exception of primary care providers for whom responsibility was with the Cluster. Ruchira Paranjape said that it was important for the Group to receive feedback from local GPs on provider quality, in addition to the other inputs.

The Committee also agreed that there needed to be patient representation, and proposed that a representative from Bromley LINk (and subsequently Healthwatch) attend to give their evidence. **Action: KF**

It was agreed that the Working Group should meet bi-monthly and report to the subsequent LCCC meeting. The arrangement would be reviewed in September.

STRATEGY

05/11 **EQUALITY DELIVERY SYSTEM**

Angela Bhan presented proposals to replace the existing Equality and Diversity arrangements with a new Equality Delivery System in line with latest guidance for the NHS. It would require the BSU to publish equality impact assessments on areas of change to meet current legislative

requirements. There would continue to be mandatory training requirements. It was agreed that an opportunity would be explored for the LCCC to receive a training session before a future scheduled meeting. **Action: Paula Morrison**

The Committee noted and endorsed the development of the new Equality Delivery System as proposed.

06/11 **IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES**

This item was deferred until the next meeting. Angela Bhan explained that the plan had been approved by the Mental Health Executive and the Clinical Commissioning Executive, but that the funding stream required further clarification before presentation to the Committee.

OPERATING PLAN 2011/12

07/11 **FINANCE REPORT**

Anna Bennett presented a report to the end of Month 2. She said that information was limited due to the timing of activity data which was only now being monitored for month 1. Therefore, the report was based on agreed contracts and estimates. There were no significant issues to highlight at this stage and the full year projection was in line with the PCT budgets and plans submitted to the Department of Health.

There had been a change to the budget subsequent to its initial agreement. The PCT was now required to achieve a surplus of £5.99 million, an increase of £995k which included the return of the 2010/11 surplus.

Reported QIPP savings in the first two months were largely based on estimates because of the lack of activity data at this stage. However, the projection was that the PCT was on target.

The Committee received and noted the report.

08/11 **CONTRACT AND PERFORMANCE REPORT**

Meredith Collins said that the timing of the meeting had led to difficulties obtaining information for his report but that, at this stage, there was evidence of an issue regarding A & E performance across South East London, and of an issue at South London Healthcare NHS Trust (SLHT) with regard to the 18 weeks waiting time target.

Angela Bhan said that there had been a 25% increase in A & E attendances at the Princess Royal University Hospital (PRUH) from the end of April to June which was not abating. These included quite sick patients and admissions were increasing. This was an unexpected trend

at this point in the year when attendances would normally be at their lowest level. It could not be attributed to any epidemic, and admission avoidance schemes were also in place. The causes were being investigated. There might have been some changes in admission criteria. Terry Rich said that LBB and the PCT were looking to achieve some savings from admission avoidance, and was concerned that the hospital might be relaxing admission criteria to fill available beds. Meredith Collins said that this could be an issue for South East London rather than just for Bromley. Mike Collins said that meaningful comparisons were required based on admissions per 1,000 head of population. Jim Gunner was concerned about the quality of the data being provided. This was set to improve over the next month as a result of work being done by the Cluster.

Meredith Collins said that although challenges were being generated in Bromley in response to the data, a deliberate decision had been taken historically not to raise challenges against King's and Guy's. This approach had now been reviewed and challenges would be made in future.

The Committee noted that from Table 1 on page 2 of the report, acute activity levels were slightly below budget at this stage, plus there were a number of challenges ongoing with SLHT.

With regard to referral to treatment waiting times, Jim Gunner noted that Queen Mary's Hospital, Sidcup (QMS) was considered an elective treatment centre. Meredith Collins said that it was seen as such by the Bexley Campus Group. Jim Gunner said that QMS should not be seen as a resource only for Bexley, but needed to take account of a wider remit.

The Committee also noted that with regard to community care, monthly contract management meetings were taking place with Bromley Healthcare in addition to monthly quality review group meetings. The Committee agreed that the BSU had a big interest in this new social enterprise organisation which had GP as governors. It therefore need to monitor progress closely.

The Committee received a very comprehensive report from the mental health provider, which showed some under activity at this early stage. Oxleas were proposing to close a ward at their Bromley unit and the Mental Health Board wanted to know how the saving would be reinvested in the service. Angela Bhan said that the savings should be used in Bromley and could provide for additional group therapy opportunities. She was concerned, however, that the savings would contribute to the required savings of the Foundation Trust overall. Terry Rich said that the reason given for the closure was lack of demand and asked whether this reflected GPs' experience. Andrew Parson said that challenging patients were continuing to be cared for in nursing homes and elsewhere. Nada

Lemic considered that it was premature to say that there was any spare capacity.

It was noted that there would be a programme of engagement on the proposed closure, although not a formal consultation. The Committee agreed that the views of GPs would need to be fed into this. Terry Rich said that the proposals would be presented to the Overview and Scrutiny Committee, but only for information. He remained concerned that the proposal didn't square with the increasing needs for people with dementia. Angela Bhan said that people should not become inpatients inappropriately, for example, if they were waiting for EMI beds of which there was a shortage.

It was agreed that Angela Bhan would feed back the Committees concerns to Oxleas. **Action: AB**

The Committee received and noted the report.

09/11 **QIPP STATUS REPORT**

Meredith Collins presented the first QIPP update report and invited comments on the format and presentation. The Committee noted that the main QIPP Plan was built into the contracts, and that the achievement of some of this, e.g. the risk share with Oxleas, was easy to measure. However, other parts of the plan relied upon admission avoidance and needed to stay on target. With the impact of increased A & E admissions it would be difficult to see to what extent the schemes were working.

The report included a reassessment of the original Plan with the risks taken out, as, for example, with the revised impact of Referral Management. The assessment was therefore now more realistic. The alternative Plan B comprised objectives for next year, which could be brought forward to this year if required.

Harvey Guntrip enquired whether SLHT was reviewing its waiting lists to ensure that patients still needed treatment. Meredith Collins said that there was an incentive for SLHT to do this.

The Committee received and noted the report.

10/11 **QUALITY REPORT**

Sonia Colwill tabled the report. She said that more clarity was required on what the LCCC needed to include in its reports, and what the Joint Boards would need to receive. Sonia Colwill assured the Committee that despite the changes in the NHS locally, the quality groups which had been established as part of the contract management process for SLHT, Oxleas and Bromley Healthcare were continuing to meet. The SLHT

Clinical Quality Group now had wider GP clinical commissioning representation which contributed to the engagement of primary and secondary care clinicians in this agenda. However, there was at present a lack of clarity about the arrangements for primary care quality. There were no significant new trends in the data provided.

Angela Bhan suggested that an exceptional summary analysis was required for the LCCC. She said that the Clinical Quality Group for SLHT needed to be revitalised and was concerned that issues would continue to arise on which the BSU needed to remain sighted.

Ruchira Paranjape said that the service quality group for MSK met monthly and that this needed to also feed into the governance process. It was agreed that indicators from the increasing multiplicity of providers needed to feed into the Quality Working Group which would bring significant issues to the attention of the LCCC. Andrew Parson said that that the Community Quality Group needed to be extended beyond Bromley Healthcare.

Angela Bhan said that clarification on the systems of contract monitoring in respect of care pathways needed to be included in the report to the August meeting of the Committee. Primary care quality monitoring was a responsibility of the Cluster. **Action: SC**

The Committee received and noted the report.

11/11 **LEARNING DISABILITY PROGRESS REPORT**

Terry Rich said that the reprovision programme was subject to some further unavoidable building delays. However, seven of the twenty five residents still on the Bassetts site would move to their new homes in July. The remaining eighteen residents would transfer to their new providers in July in preparation for moving to their new homes in November. He said that getting the new provider to take on responsibility earlier also provided mitigation of about £200k. Anna Bennett pointed out that it would lead to some increased estates costs. The Committee noted that the business case for the reprovision of 218 Widmore Road as a respite care resource was being prepared.

Angela Bhan said that it now seemed unlikely that the Bassetts site could be cleared for disposal before the end of the year. The BSU would also need a plan for redisposal of the capital receipts to avoid the loss of this resource to Bromley.

The Committee received and noted the report.

12/11 **DEVELOPMENT OF BROMLEY COMMISSIONING CONSORTIUM**

Andrew Parson presented a progress report. The election process for six GP representatives to sit on the Board had started with a well attended meeting on 22 June, when the speakers had included Doug Patterson and Angela Bhan. He described the election process for a Chair, Vice Chair and four clinical leads. The election was being run by the LMC and included a competency test for all candidates.

In order to proceed to full delegated authority the Clinical Commissioning Groups would need to undertake a 360º assessment process. A list of approved providers had now been published and Luke O'Byrne was making arrangements for the development support that would be required. Funding of £75k plus 40p per head of population was available to develop the commissioning group. NHS London wanted the new Group to be shadow running from April 2012, and with full delegation from April 2013.

Angela Bhan said that it was in the best interests of Bromley that the Group had full delegated authority from April 2013, otherwise the National Commissioning Board would take on greater responsibility and might not be so locally responsive.

Jim Gunner said that a summary plan with key milestones would be helpful for the LCCC and the Health and Well Being Board. The Committee agreed to a suggestion from Angela Bhan that the LCCC should allocate some development time to this.

Terry Rich said there were two strands to this; the development of the overall strategic view for which the next meeting of the Health and Well Being Board should be used, and the architecture required to support the Group, including where the commissioning support would lie. Angela Bhan said there was an additional dimension involving the working together of Bexley, Bromley and Greenwich on a "super strategy".

It was agreed that the Committee Chair and BSU Managing Director would discuss and arrange a suitable forum to develop these important strands. **Action: JG, AB**

13/11 **ANY OTHER BUSINESS**

There was none.

14/11 **DATE OF THE NEXT MEETING**

2.00 p.m. on Thursday 25 August 2011 in the Harry Lyne Room at the Beckenham Beacon.

…… CHAIR

NHS

South East London

A meeting of the SEL PCT Boards* and Bexley Care Trust
21 July 2011

NAME OF COMMITTEE: Greenwich Clinical Commissioning Committee

DATE OF COMMITTEE: 20 April 2011

PRINCIPLE FOCUS:

- Greenwich Clinical Commissioning Committee - Terms of Reference
- Operating Plan / QIPP 2011/12
- Performance Report
- UCC & GP Led Health centre QEW site consider future options
- QIPP highlight report
- Policy & Strategy
  a. Greenwich Health and Well Being Strategy
  b. Dementia Strategy
  c. Health Outcome Framework
  d. Information Strategy for Greenwich Health

ISSUES ARISING:

1. Dementia Strategy approved and implemented; to be published
2. Decision made to procure UCC at QE without GP led Health procurement started
3. QIPP gap in plan identified; new schemes agreed
4. Recommendation covering Information Strategy approved and being implemented

RECOMMENDATIONS MADE:

To note minutes from the first Greenwich Clinical Commissioning Committee meeting

COMMITTEE CHAIR:

Name: Dr Hany Wahba
E-Mail: Hany.Wahba@nhs.net
Telephone: 0208 317 6868

LEAD DIRECTOR:

Name: Annabel Burn
E-Mail: Annabel.Burn@greenwichpct.nhs.uk
Telephone: 0208 293 6761

*SEL PCT Boards = Boards of Lambeth Primary Care Trust, Southwark Primary Care Trust, Lewisham Primary Care Trust, Bromley Primary Care Trust and Greenwich Teaching Primary Care Trust.

ENCLOSURE 20

Greenwich NHS
Teaching Primary Care Trust

ENCLOSURE A
Greenwich CCC
22 June 2011
Item: 3.0

GREENWICHTEACHING PRIMARY CARE TRUST

Minutes of the Greenwich Clinical Commissioning Committee
held at 1.30 p.m. Wednesday, 20th April 2011
at Charlton House

PRESENT

Members:

Dr Ram Aggarwal- GP Commissioning Consortium Board Member
Mrs Annabel Burn- GBSU Managing Director
Mr Chris Costa – GBSU Head of Financial Delivery
Dr Hilary Guite – Director of Public Health
Dr Robert Hughes - GP Commissioning Consortium Board Member
(for part of the meeting)
Dr Eugenia Lee - GP Commissioning Consortium Board Member
Dr Niraj Patel - GP Commissioning Consortium Board Member
(for part of the meeting)
Dr HanyWahba- GP Commissioning Consortium Board Member
And Committee Chair
Mr John Nawrockyi – London borough of Greenwich Representative

In Attendance:

Ms Sharon Davidson – Head of Transitional Business Development
Mr Langley Gifford - Head of Non Acute commissioning & Partnership
Ms Alison Goodlad - Head of Service Planning, Redesign & Delivery
Ms Sheila Freeman – LINks Representative
Mr Andrew Thomas - QIPP Business Manager
Mr Colin Nash - Minute Taker

ENCLOSURE 20

Opening Business

001/2011	**WELCOME**	**ACTION**
	Dr Wahba welcomed members and officers to the first meeting of this Committee.	
002/2011	**APOLOGIES FOR ABSENCE**	
	Dr Nayan Patel and Dr Rebecca Rosen.	

Formal Business

003/2011	**DECLARATION OF INTERESTS**	**ACTION**
	The following declarations were made:- Dr Agarwal – a provider of local GP services, including minor surgery through the company Plumstead Clinicians Ltd and a shareholder in GPCC. Dr Hughes – a provider of local GP and community services(declaration made when he joined the meeting) Dr Lee – a provider of local GP services. Dr Niraj Patel – a provider of local GP services (declaration made when he joined the meeting). Dr Wahba – a provider of local GP services and member of Grabadoc (out of hours GP service)	
	TERMS OF REFERENCE	
004/2011	**a) To receive the Terms of Reference of the GCCC**	
	Mrs Burn referred to the Committee terms of reference dated 18 March 2011, which sought to allow the GCCC to function as the successor to the PEC and had been approved by the GTPCT Board. In line with the previous PEC terms of reference provision had been made for a nurse representative to sit on the GCCC. Following discussion it had been decided that it would not be appropriate for a nurse representative from the cluster to sit on the Committee and Mrs Burn would recruit or select a suitable local nurse to serve. It was also considered important that a patient's representative was a member of the GCCC and she thanked Ms Freeman, Greenwich LINk, for agreeing to attend the meeting. The GCCC was formally a committee of the PCT Board. She expected that its terms of reference would evolve as consortium arrangements developed. In answer to a question from Dr Guite, Mrs Burn confirmed that the required attendance of members of at least 75% of meetings (Terms of Reference paragraph 5.3) would be monitored. The GCCC **RECEIVED** the terms of reference.	**AB**
005/2011	**b) To note the terms of reference of the Medicine's management sub committee, which reports to the GCCC and consider nominating 2 GPs to take responsibility for authorising Patient Groups Directions for NHS Greenwich**	
	The GCCC **NOTED** the terms of reference and **AGREED** that the nomination of 2 GPs would be discussed at the next meeting of the Greenwich Health Board. The GCCC further **AGREED** that it was sufficient that the minutes of the Medicine's Management Committee were circulated to the GP nominees, rather than the Committee as a whole.	**HW**

	OPERATING PLAN/QIPP 2011-12	ACTION
006/2011	**a) To receive NHS Greenwich QIPP 2011-12** **b) To receive the outcome framework for 2011-12** **c) to receive the budget for NHSGreewich 2011-12**	
	Mrs Burn referred to the three documents which had been approved by NHS Greenwich. They were brought to the first meeting of the GCCC as they provide the framework within which commissioning decisions for 2011-12 will need to be made. Dr Hughes joined the meeting. With regard to the outcome framework for 2011-12 Dr Guite made a slide presentation (the slides of which are retained with the papers for this meeting) setting out how performance monitoring of PCTs in 2011-12 will differ from the past. She noted that of the current headline and supporting measures, the 8 quality headline measures, 8-9 resource headline measures, percentage of deaths at home and improved access to psychological therapy will not be measured in 2011-12. Whilst it was not yet certain what the new performance regime would be, Dr Guite emphasised the importance of the PCT ensuring that it achieved good performance this year in the areas it believed would be part of next year's performance framework. Dr Niraj Patel joined the meeting. Mr Nawrockyi informed the Committee that the local authority'sfocus with regard to social care would be investing in reablement and improving the personalisation, dignity and safeguarding of the services it provided. With regard to the budget Mrs Burn took the Committee through the 2011/12 Budget Setting & Operating Plan Detailed Assumptions paper prepared by Mr Elvy and dated 18 March 2011. This represented a high level view of the total income and expenditure budget for 2011-12. The GCCC **RECEIVED** the NHS Greenwich QIPP 2011-12, the Outcome Framework for 2011-12 and the NHS Greenwich Budget for 2011-12.	
	PERFORMANCE	
007/2011	**a) To receive the Board Performance Report March 2011**	
	Mrs Burn referred the Committee to the last performance report seen by the GTPCT Board. Areas of performance concern were recorded at the front and tables RAG rating (red/ amber/ green) each performance indicator were included at the back. With regard to correcting areas of underperformance, the GCCC would need to decide how much effort and resource to devote to particular indicators. There was local discretion and she advised that the Committee would want to focus on those areas of greatest importance to the people of Greenwich. Dr Lee added that the GCCC's decisions should also be guided by its judgement on what areas would form part of the performance framework for next year. Dr Guite and Mrs Burn believed an informed judgement could be made. The GCCC **RECEIVED** the report.	

		ACTION
008/2011	**b) <u>To receive the NHS Greenwich Risk Register and hand over of risks to the new organisational structure</u>**	
	Mrs Burn referred to the latest iteration of the Risk Register received by the NHS Greenwich Board. It was important that the GCCC had sight of this and in due course took a view on whether the format for presenting this information should be modified to best suit the Committee's needs. Under the transitional arrangements some of the risks identified would sit at cluster level and the sector were working on a new joint register covering all the component PCTs. In response to a question from Dr Lee, Mrs Burn agreed to ensure the litigation risk with regard to the PMS contract be included. Dr Hughes asked that GCCC members had sight of the written basis the delegation of risks to a Committee of the Board. Mrs Burn explained that delegation of responsibility could be transferred to the Shadow Consortium by the GTPCT Board, as the current legal body and through the Pathfinder process and that the framework would be going to the next Board meeting and would be shared. Mrs Burn drew attention to the letter from Ms Schofield to Mr Robbins, dated 30 March highlighting particular risks that he, as the new Accountable Officer, would need to be aware of. These were Safeguarding, Prison Health and Emergency Planning/response and the Olympics. The GCCC **RECEIVED** the Risk Register and handover letter from Ms Schofield.	**AB** **AB**
	<u>CHANGE PROGRAMME</u>	
009/2011	**1) <u>UCC & GP Led Health Centre: QEW Site to consider future options</u>**	
	Dr Wahba referred to the paper headed APMS Procurement of GP Health Centre and Urgent Care Centre at Queen Elizabeth Woolwich (QEW) Site, dated 4 April 2011. The GCCC had to decide whether to proceed with a GP led health centre as well as an urgent care centre on the QEW site or whether to procure an UCC only. In response to a question from Ms Freeman, Dr Wahba clarified that an UCC alone would provide a walk in service to patients. A GP led health centre would be able to register patients and provide routine GP services to them. The Greenwich Health Board had considered the matter and decided to recommend to the GCCC that an UCC only be procured. The reasons were that there were already GP practices, open seven days a week, within a short distance from the QEW, none of which had closed their lists to new registrations. Secondly few patients currently attending the QEW UCC required on going treatment. Thirdly, given the lack of demand for such a service, the establishment of a GP led health centre would be wasteful of public money which could be better spent meeting more urgent patient needs elsewhere.	

	Dr Hughes added that the needs assessment relied upon by the DoH in suggesting that the area around QEW was under doctored, was flawed. It had only counted GP Partners and not the salaried doctors who also provided GP services to patients. Mrs Burn enquired how the problem of people using the UCC to meet their primary care needs could be met if there was no GP practice on site. Dr Wahba replied that leaflets were available and he had not come across any patient complaining that they had been unable to register. He also stated that the specification for the UCC could include a need to address this proactively. Dr Guite noted that half those attending the UCC were under 25 years old and the numbers between 0 and 4 years was double what was expected. She therefore recommended that the UCC should be staffed with adequate numbers of clinicians with paediatric and young people experience, to meet this demand. The GCCC **APPROVED** the procurement of a UCC only on the QEW site. Mrs Burn will ensure that this project proceeds on this basis.	**ACTION** **AB**
	2) <u>QIPP Highlight Report</u>	
010/2011	**<u>i Staying Healthy</u>**	
	Dr Guite referred the Committee to page 8 of the paper headed South East London Sector QIPP year 1 Implementation Plan Staying Healthy. This set out the priorities at Sector and Borough level. At the Greenwich Borough level there would be a focus on smoking cessation and vascular disease prevention. She took the Committee through actions to be taken in 2011-12 described in the paper. With regard to smoking cessation, the campaign to encourage people to quit would be maintained through successful public engagement and she was pleased to report that in Greenwich the numbers of people quitting continued to increase. Dr Hughes asked for the evidence base that quitting smoking had an impact on the use of health services in the short to medium term. It was agreed that a full exposition of this could not be achieved in this meeting so that a separate briefing could be arranged. A business case to improve the early detection of those at risk from vascular disease had been submitted but implementation had been delayed by 6 to 9 months. She noted that the modelling carried out as a result of the Greenwich health checks programme for cardio-vascular patients would prevent 187 readmissions to hospital and 30 deaths each quarter by the end of full implementation of the programme in 5 years time. The financial benefit from this would be to start showing was expected in the quarter three figures 2011/12. The GCCC **RECEIVED** the report.	**HW**
011/2011	**<u>ii Out of hospital Services</u>**	
	Mrs Burn took the Committee through the table headed Detail of QIPP schemes 2011-12. The RAG rating used had been applied to each scheme following a stock take by the Sector and scored the risks of not achieving the financial benefit identified. Where schemes were rated as	

	green they were expected to deliver 100% of the saving attributed to them, those rated amber 40% and those rate red 20%. Dr Guite was concerned that the "Develop a systematic approach to prevention in primary and secondary care (goal 2) (PRO3)" had been rated red despite adopting a risk averse approach and being supported by detailed work plans. She was also concerned that because of a PCT decision not to roll out the scheme to GP practices unwilling to participate in the new PMS contract; it would not deliver its entire savings in year and may be discontinued, despite being a robust scheme. Dr Hughes noted that RAG ratings necessarily made a judgement about risk and it was difficult to assess their accuracy unless one had information about the assumptions made. Dr Niraj Patel replied that the table RAG rated schemes across the Sector and not all PCT plans were as advanced as those in Greenwich. Mrs Burn added that the best way to secure the scheme's future was to ensure it delivered the savings identified for it. Mrs Burn then drew the Committee's attention to three schemes: • "Reducing emergency admissions and readmissions – medical nursing management of LTCs, UTIs, frail elderly, TV/cellulitis, abdominal disorders & senility (UC04)" (slide 2 item 3), • "Prevention of emergency admissions – management of iron deficiency anaemia (PRO3)" (slide 6 item 3) and • "Prevention of vaccine preventable emergency admissions – flu and pneumonia (PRO1)" (slide 6 item 4). There was an opportunity for all three to be combined into a single project which she colloquially described as **"finding the vulnerable".** This would need to be a joint scheme with the local authority that could lead to substantial financial savings. Ms Goodlad would lead for the PCT. Dr Lee supported the proposal and suggested it may consider expanding the role of community matrons out of hours. Dr Wahba supported the proposal suggesting that a key component should be improving the ability of clinicians to accurately assess risk in these vulnerable groups. Dr Niraj Patel supported the proposal which he felt would link well the Consortium's IT strategy. Mr Nawrockyi offered the local authority's support in developing a joint scheme. The GCCC **RECEIVED** the report and **APPROVED** the proposal to combine the three QIPP schemes as described above. Dr Hughes asked for further clarification concerning the KPI QIPP schemes described in slide 8. Dr Niraj Patel replied that these had been included by the Bexley, Bromley and Greenwich PCTs who wanted to gather information about consultant to consultant referrals, to ensure that GPs were appropriately informed. At this stage the aim was to understand if a problem existed, not to prevent such referrals occurring.	**ACTION** **AB**

		ACTION
012/2011	**iii Acute Hospital Services**	
	Mrs Burn reported that NHS London had decided against the three South East London PCTs in a recent arbitration with South London Healthcare NHS Trust. NHS London had found in favour of the Trust on both the Referral to Treatment time and outpatient first to follow up ratio components. The additional cost pressure to the PCT would be between £1 and £2m. The arbitration had ruled that in 2011-12, PCT contracts with SLHT would be on a cost and volume basis (where last year's had been a block contract). It was therefore particularly important that the PCT achieved its demand management schemes for the year and reduced use of the hospital unnecessarily. Mr Nawrockyi asked how SLHT would be paid in 2011-12. Mrs Burn replied that they would receive a monthly payment equal to one twelfth of the expected activity undertaken. These would then be flexed up or down depending upon the actual activity carried out. The GCCC **RECEIVED** the report.	
013/2011	**3) Contingency Planning**	
	Mrs Burn indicated the need for further QIPP schemes to be brought forward in the light of the arbitration finding and the risk rating. There remained a gap in the plans in place and this will require focused work by all members of GCCC outside this meeting. The GPs on the Committee agreed to be involved in this piece of work. Mrs Burn will work with Dr Wahba to identify a suitable forum to take this forward.	**HW/AB**
	POLICY AND STRATEGY	
014/2011	**a) To receive the Greenwich Health and Well-being Strategy**	
	Dr Wahba commended the document to the GCCC and believed it should form the basis of a clinical strategy for the GP Consortium. Mrs Burn added that it had been approved by the GTPCT Board and would be used as a key driver by the Health and Well-Being Board. They had suggested an awayday with GPs to take forward the initiatives contained within it. Dr Guite thanked Dr Wahba for his comments and informed the Committee that it had been based upon the PCTs Joint Strategic Needs Assessment (JSNA). Once approved it would be published on the PCT website to allow wide access. With regard to the next JSNA, Ms Freeman informed the Committee that the Greenwich LINk had over 800 participants who had given their views on local health services and formed a useful data base to inform future strategic developments. The LINk had recently carried out a survey of discharged patients from hospital, receiving over 200 responses. A report on the results would be available in the next few weeks. Dr Guite confirmed that the PCT would wish to make use of LINk data and involve them in the development of the next JSNA. Dr Guite then drew the Committee's attention to the very high levels of male mortality and morbidity for many areas of ill health in Greenwich.	**HG/SF**

	These were markedly different from other areas of London and nationally. The APHR and JSNA had explored reasons for this and the main drivers were smoking related mortality particularly lung cancer and cardio-vascular disease and this represented an enormous challenge to those responsible for commissioning local health services. The GCCC **AGREED** to receive a presentation on this matter at a future meeting. The GCCC **AGREED** that the Strategy reflected their aspirations and **RECEIVED** the document.	**ACTION** **HW/HG**
015/2011	**b) To approve the Dementia Strategy**	
	Mr Gifford referred to the Strategy which had been developed by the Dementia Implementation Group, comprising NHS Greenwich and Greenwich Council as commissioners and Oxleas NHS Foundation Trust, the Alzheimer's Society and South London Healthcare as local providers. The resulting strategy and action plans focused upon the four priority objectives set out in the DoH National Dementia Strategy. These were described on page 3 of the document. The draft Strategy was circulated to stakeholders and discussed at engagement events and amendments made. The Strategy had also passes a Quality Impact Assessment and been approved by the GTPCT governance arrangements. If approved progress with progresswould be overseen by the Dementia Implementation Group. Mr Nawrockyi commented that improving services for those with dementia was the biggest issue for carers and a priority for the local authority. In response to a question from Mrs Burn, Mr Gifford confirmed that the Strategy aimed to use existing resources to best effect. Dr Wahba enquired about the adequacy of nursing home beds to care for this group. Mr Gifford replied that there were pressures and the adequacy of beds was under review, but the support available to carers had improved and this enabled more dementia patients to be cared for at home for longer. Dr Hughes enquired about Government plans to reduce the amount spent on Disability Living Allowance. Mr Nawrockyi confirmed that the Government wished to reduce expenditure on the allowance nationally by 20%. The Committee then discussed Dr Guite's suggestion that the Strategy should be amended to reflect new evidence of a link between other risk factors, such as hypertension, cholesterol levels and diabetes and dementia.DrWahba commented that the Strategy could also consider the timely use of anti dementia medication. The GCCC **APPROVED** the Strategy as written so that progress could begin, but were content to consider further amendments such as those proposed by Dr Guite and Dr Wahba if recommended by the Dementia Implementation Group.	**HG/LG**
016/2011	**b) Health Outcome Framework**	

	See minute 006/2011 for Dr Guite's presentation on this item.	**ACTION**
017/2011	**c) Towards and Information Strategy for Greenwich Health**	
	Mr Thomas took the Committee through his paper, reminding members that the commissioning process was information intensive. It required an understanding of the needs of the population served and inequalities within that population, coordination of the delivery of existing services, facilitation of the development of new services and the capacity to monitor contract performance and hold providers to account. An information strategy was essential to achieving these objects. A suggested template for a strategy was attached to the paper. It was envisaged that all elements of the Strategy should be implemented by April 2013. However as it was expected that most GP consortia will be managing some delegated budgets from April 2012 the IT systems necessary to support them would need to be developed, tested and rolled out during 2011-12. Wherever possible developments should look to be sustainable beyond April 2013, but it may be appropriate to adopt some quick fix options to ensure progress in the short term whilst also working on a longer term solution. With regard to immediate information needs, discussion with GCCC members identified a gap in Practice/GP level reporting on activity and finance to enable GPs to review provider activity in a timely way. The single development that would take this objective forward most rapidly would be the implementation of Sollis PBC, for which the PCT already held the necessary licences. There was also an immediate need to provide risk stratification information. If participation could be agreed with all practices, it would be possible to roll out risk stratification using tools such as the Combined Predictive Model supplied by the Kings Fund. It would also be necessary to purchase an application such as Apollo, to ensure a feed of practice data. At the same time the longer term information strategy would be developed to meet the target dates set for its completion. With regard to the longer term, the GCCC would need to decide how far the functions of the various systems it required would need to be under the direct control of Greenwich Health, or farmed out to be provided by some external body. As a broad point of principle, Mr Thomas suggested that where resources permit, in house capacity should be developed for the majority of key functions to give Greenwich Health control, flexibility and sustainability. Mrs Burn asked the Committee to note that the Greenwich Health IT team was small and it needed to place some reliance on Sector resources. Dr Wahba noted the likely economies to be achieved if Sector wide solutions were adopted. Mr Thomas replied that these were being considered and its was likely that the Sector as a whole would adopt Sollis PBC. Dr Guite emphasised the importance of good public health data to useful risk stratification, so that audits could be undertaken. She suggested that consideration be given to purchasing the Health Intelligence	

	application or similar. She also expressed concern that developing a joint approach may delay the point at which useful information would be available. Mr Gifford left the meeting. Dr Wahba replied that there was some likelihood that Sector PCTs would require similar IT solutions that included the additional functions proposed by Dr Guite. Dr Niraj Patel added that there was nothing to preclude adding applications like Health Intelligence later even if the short term fix of Sollis PBC was pursued. Dr Hughes stressed that, in addition to IT solutions, an information strategy must ensure that the public were appropriately informed about how to access services. Despite reassurance from other Committee members, Dr Hughes remained concerned that once the PCT had signed a contract with an IT provider, its ability to follow a different path, if circumstances changed, would be circumscribed. Mr Nawrockyi left the meeting. Dr Guite enquired if the proposal set out in Mr Thomas's paper were approved sufficient server capacity would remain to implement the risk stratification applications mentioned above. Mr Thomas replied that this would depend upon the level of risk stratification the PCT decided wished to achieve. Dr Lee was concerned that unless the PCT proceeded with the Sollis PBC and risk stratification options proposed in the paper, there would be an unacceptable six months delay in pushing forward with contact and performance monitoring. With the exception of Dr Hughes who abstained, the GCCC **APPROVED** pursuing the next steps set out in Mr Thomas's paper, provided the capacity to monitor long term conditions and carry out clinical audits was added as an objective in the IT Strategy.	**ACTION** **AT**

Closing Items

	ANY OTHER BUSINESS	**ACTION**
018/2011	**a) Future agenda items**	
	No agenda items were suggested at this time. Mrs Burn informed the Committee that a draft GCCC agenda would be circulated in advance of the next meeting, to give members the opportunity to make additions and amendments if they wished.	
019/2011	**DATE FOR NEXT MEETING**	
	The next meeting will be held on Wednesday 25May 2011, 13.30 – 15.30, Greenwich Park Street.	

South East London

A meeting of the SEL PCT Boards* and Bexley Care Trust
21 July 2011

NAME OF COMMITTEE: Lambeth Clinical Commissioning Collaborative Board (LCCCB) – Meeting Held in Public

DATE OF COMMTTEE: 1st June 2011

PRINCIPLE FOCUS:

- First LCCCB meeting held in public.
- Update on the work of the Diabetes Modernisation Initiative (DMI) with a focus on a user experience.
- Review of the proposed 2011/12 NHS Lambeth Business Plan and its three key areas of business.
- Review of Engagement Stock take and Proposals for 2011/12
- Cancer developments – implementation of cancer service improvement plans for Lambeth.
- Performance – review of Lambeth's performance.
- Finance – review of the draft year-end accounts

ISSUES ARISING (Actions):

- Discussed and agreed the Business Plan 2011/12, subject to any further in-year review.
- Agreement the proposed approach to patient and public engagement and our key areas of focus for 2011/12.
- Noted updated performance and financial risks facing NHS Lambeth in 201112 and considered processes for mitigating and managing risk in year
- Agreed proposed £2 per head development fund use

RECOMMENDATIONS MADE (Decisions):

- To continue to update the Board on the development work on cancer across London

ENCLOSURE 20

COMMITTEE CHAIR: Name: **Adrian McLachlan** E-Mail: **adrian.mclachlan@nhs.net** Telephone: **0203 0494444**
LEAD DIRECTOR: Name: **Andrew Eyres** E-Mail: **andrew.eyres@nhs.net** Telephone: **0203 0494076**

*SEL PCT Boards = Boards of Lambeth Primary Care Trust, Southwark Primary Care Trust, Lewisham Primary Care Trust, Bromley Primary Care Trust and Greenwich Teaching Primary Care Trust.

Lambeth Clinical Commissioning Collaborative Board (LCCCB) Meeting
Wednesday 1st June 2011
1.00pm – 4.00pm
Canteen Area 4th Floor, 1 Lower Marsh, Waterloo, SE1 7NT

Minutes of the Meeting

Present:	**Adrian McLachlan**	**LCCCB Chair**	**AM**
	Patricia Kirkman	**Clinical Member – South East Locality**	**PK**
	Graham Laylee	**Non Executive Director**	**GL**
	Sue Gallagher	**Non Executive Director**	**SG**
	Andrew Eyres	**Managing Director, NHS Lambeth**	**AE**
	Ruth Wallis	**Director of Public Health (joint with LB Lambeth)**	**RW**
	Gillian Ellsbury	**Clinical Member – South East Locality**	**GE**
	Ray Walsh	**Clinical Member – South West Locality**	**RWa**
	Rajive Mitra	**Clinical Member – North Locality**	**RM**
	Ruth Jeffery	**Clinical Member – South West Locality**	**RJ**
In Attendance:	**Tania Barnett**	**Interim Corporate Business Manager**	**TB**
	Jane Burroughes	**Business Support Administrator**	**JBu**
	Christine Caton	**Chief Financial Officer**	**CC**
	Helen Charlesworth-May	**Executive Director of Integrated Commissioning**	**HCM**
	Una Dalton	**Director of HR and Corporate Affairs**	**UD**
	Ash Soni	**Interim Clinical Network Development Lead**	**AS**
	Nicola Kingston	**Chair of Lambeth LINk**	**NK**
	Tyrrell Evans	**LMC Representative**	**TE**
	Mark Chamley (item 6)	**GP, Crowndale Practice**	**MC**
	Sandy Keen (item 6)	**Programme Manager – Diabetes Modernisation Initiative, GSTT**	**SK**
	Trevor Critchley (item 6)	**CCH, Diabetes Modernisation Initiative**	**TC**
	Therese Fletcher (deputising for Moira McGrath)	**Assistant Director of Primary and Community Care Commissioning**	**TF**

	Jayesh Patel	**CEO of the LPC**	
	Nye Patel	**Vice Chair of the Lambeth Pharmaceutical Committee**	
	Sharon Wellington	**SLaM – Behavioural and Developmental CAG**	
	John Moxham	**King's Health Partners**	
	Les Elliot	**Lambeth Walk**	
	John Pryor	**SLaM**	
	Carolyn Emanuel	**Clinical Associate, NHS Lambeth**	
	Michael English	**LINk**	
	Hermia Henry-Esezobor	**Member of the public**	
	Hiten Dodhia	**AD Health Strategy**	
	Marie Vieu	**Public Health Specialist - Health Inequalities**	
	Emma Smith	**Performance and Information Manager**	
	Ruth Sheridan	**NHS Lambeth**	
	Raziye Dowdall	**NHS Lambeth**	
	Navneet Parmer	**NHS Lambeth**	
	Tracy Everard	**NHS Lambeth**	
	Sian Carr	**NHS Lambeth**	
	Niymeti Ramadan	**NHS Lambeth**	
	Jacqueline Sinclair	**NHS Lambeth**	
	Gail Tarburn	**NHS Lambeth**	
	Janie Conlin	**NHS Lambeth**	

NHS Lambeth

1.	**Welcome & Introductions**
	AM welcomed colleagues, staff members, members of the public and partners to the first meeting held in public of the LCCCB and confirmed that here will be an opportunity at the end of the meeting to talk to LCCCB members over refreshments. All members of the LCCCB introduced themselves as well as representatives from the NHS Lambeth Senior Management Team. AM confirmed it had been agreed that going forward the following co-opted members would be invited to join the membership of the LCCCB: • Representative of the Local Authority – Co-opted member • Representative of the LINk – Co-opted member, non-voting • Representative of the LMC - Attendee AM and AE set out a short presentation on the development of the LCCCB to date including: • The LCCCB's role across NHS Lambeth, the three Lambeth localities, 52 practices and the Lambeth population. • The LCCCB's role within the South East London Cluster • The LCCCB's Mission, Vision and Values • Current health issues in Lambeth • The current financial outlook • Arrangements for engagement with partners, patients and communities
2.	**Apologies for Absence**
	Apologies were noted for the following: John Balazs, Clinical Member – North Locality and Moira McGrath, Director of Care Pathway Commissioning.
3.	**Declarations of Interest**
	The LCCCB noted the current register of interests and AM asked Board members to declare any additional interests as they arose during the meeting. AM noted that at the next Board meeting, declarations of interest would also be included for the additional external partner co-opted members and attendees. It was requested by a member of the public that remuneration of Board members should be made available to ensure transparency. AM agreed to consider this request and confirmed that this information is publicly available in the Annual Report published on the website.

4.	**Minutes of LCCCB Meeting: 4th May 2011**
	Agreed as an accurate record.
5.	**Matters Arising (not on the Agenda)**
	Medicines Management GE confirmed that an evaluation was taking place of 22 practices on the use of ScriptSwitch, and the Medicines Management team had submitted a bid to apply for the 2% non-recurrent funding to roll out across the practices. **Vice Chair of the LCCCB** AM confirmed that he was in the process of drafting a proposal regarding the Vice Chair role, including role requirements. **2010/11 Delivery – Month 12 Year End Report** CC confirmed that she was in the process of drafting an item for the Cluster e-bulletin to highlight Lambeth's achievement in this area. **GP Commissioning – Development Support for GPs** UD to provide an update paper on the development process following the emergence from the pause and any available information from NHS London. **Locality Terms of Reference** UD confirmed that a model for Locality appointments was nearing finalisation and would be published shortly. AS confirmed that the LCCCB had signed off the job description for the Clinical Network lead and confirmed that this role would be advertised over the coming weeks. **Public Health and Strategic Issues – Incapacity Benefits** RW confirmed that an initial letter had been circulated to practices evaluating the impact of changes to incapacity benefits.
Presentation	
6.	**Looking Forward** **Diabetes Modernisation Initiative (DMI)** AE introduced Dr Mark Chamley, GP at Crowndale Practice; Trevor Critchley, Service User and Lay Tutor; Sandy Keen, Programme Manager – Diabetes Modernisation Initiative, GSTT and Therese Fletcher, Assistant Director of Primary and Community Care Commissioning. MC and TC provided an overview on the Diabetes Modernisation Initiative. It is a

	Lambeth and Southwark initiative that aims to get the right balance between support and independence for patients, to ensure treatment is reliable and accessible and to use state of the art treatment approaches to deliver the best health outcomes. It is hoped that active dialogue with the LCCCB will ensure joint working to deliver the best diabetes care. TC provided a personal account of self management of Diabetes from his own experience with the condition over a number of years. A number of issues were discussed including: • Work completed to reduce Long Term Conditions (LTCs) e.g. obesity, which will have an impact on reducing the number of cases of diabetes. • Responsibility of health professionals to educate patients on the links between LTCs e.g. obesity and diabetes. • Diabetes user engagement work and links with self management. • Training and sharing of good practice amongst nurses within practices. • Work arising from the Living Well Collaborative, to develop communication champions for direct communication with patients with diabetes. • The role of Public Health professionally. • Pilot being developed by the LPC on managing care for diabetes including signposting to relevant services. • Dealing with variations in care across the Borough. The Board welcomed the work of the DMI in support of one of our key areas of local priority. AM thanked MC, TC and SK for the presentation updating on the work of the Diabetes Modernisation Initiative and noted that going forward it is planned to have an areas of clinical interest presented at each LCCCB meeting held in public.
Items for Decision	
7.	**Governance**
	UD gave an overview of the Lambeth BSU governance arrangements, lead roles for LCCCB members and presented the proposed 2011/2012 NHS Lambeth Business Plan for approval. UD noted that potential for conflicts of members' interests had been taken into account as part of the governance arrangements and the Board would review arrangements further in light of best practice examples. She confirmed that recruitment was underway for the Clinical Network Lead and for members of the three Locality Boards, which is due to be concluded by the end of June. UD highlighted that the Business Plan centres around three key areas of business:

	• Operational Delivery • Organisational Development • Governance and Assurance UD gave an overview on the Board Assurance Framework and the heat map of current residual risks and asked the Board to consider risks identified and action in hand to minimise risk. A number of issues were discussed including: • Accountability of the LCCCB and the governance interface between the BSU and the SEL Cluster, particularly in relation to primary care and acute contracting. • How important issues of concern or areas of significant risk for Lambeth will be raised for discussion at LCCCB meetings and also on the SEL Cluster Board agenda. The LCCCB: ▪ Received feedback from the Cluster Board concerning delegation of responsibility. ▪ Received an update on Lambeth BSU management arrangements ▪ Agreed the Lambeth Business Plan 2011/12, subject to any further in-year review. ▪ Agreed the Lambeth BAF as presented.
8.	**Engagement Stocktake and Proposals for 2011/2012**
	UD tabled a draft of a document outlining NHS Lambeth teams, and their contact details. The document will be finalised next week and circulated to all GP Practices. UD confirmed that as a priority piece of work engagement activity has been reviewed and provided the headlines of the engagement stocktake and proposals for 2011/12, confirming that engagement was in the early stages to reflect the recent development of the business plan. This work will provide clinical leads with clear guidelines and will focus on strengthening relationships with external partners. The LCCCB will be kept updated on work as it develops. A number of issues were discussed including: ▪ Positive engagement already taking place with external partners such as the Lambeth LINk and through the Health and Wellbeing Board. ▪ Work underway by LCCCB leads to engage with practices ▪ Improving innovative ways of working to engage with the public. ▪ The level of engagement with King's Health Partners and the Integrated Care Pilot.

	▪ Further work to be carried out to ensure robust engagement with communities and patients. UD agreed to provide an update at the December LCCCB meeting. **Action: UD** The LCCCB: ▪ Agreed the approach to engagement outlined in this paper, and the key areas of focus for 2011-2012.
Items For Discussion	
9.	**Integrated Plan and Risk Assessment 2011/12**
	CC gave an overview on the Integrated Plan and Risk Assessment including an update on the financial framework, financial risks, 2% non-recurrent investment programme and agreement of contracts. CC reported that key contracts have now been agreed. CC confirmed that the Cluster and NHS London are both responsible for signing off bids against the 2% non recurrent investment fund and that a Cluster wide package will be presented to NHS London for approval. Borough MDs are due to meet to peer review latest bids as part of this process. CC confirmed arrangements if the PCT did not receive funding for the 1% as initially forecast, stating that it would be likely that further contingencies would be required in order to break even. CC confirmed that the month 2 forecast will be submitted to the LCCCB meeting in July. This would include an update on the position in relation to the use of the 2% non recurrent investment fund. A number of issues were discussed including the concerns over reviewing the process for managing risk. The LCCCB: Noted the updated performance and financial risks facing NHS Lambeth in 2011/12 and the processes for mitigating and managing them in year.
10.	**Improving Cancer Outcomes**
	AE gave an overview on the work to improve cancer outcomes in line with the strategy 'Improving Outcomes: A Strategy for Cancer' published by the Department of Health in January 2011 to improve cancer outcomes across England. This was presented at the SEL cluster Board meeting on 19th May 2011. Work to take forward the development of cancer services across South East London is coordinated by the South East London Cancer Network.

ENCLOSURE 20

	AE outlined the range of actions to improve cancer outcomes that underpins the strategy: ▪ diagnosing cancer earlier (area of primary focus) ▪ helping people to live healthier lives to reduce preventable cancers ▪ screening more people ▪ introducing new screening programmes and ▪ making sure that all patients have access to the best possible treatment, care and support. AE reported that a Local Awareness and Early Detection Initiative (LAEDI) Plan is being developed and a South East London-wide event involving commissioning teams, public health, GPs and secondary care is scheduled for 29th June 2011. Further work across London is also being developed. AE confirmed that he will continue to update the LCCCB of the integrated development work on cancer taking place across London over the coming months. **Action: AE** A number of issues were discussed including: ▪ Level of correlation between financial investment within area of cancer in Lambeth and improvement in cancer outcomes. ▪ Reducing prevalence vs early diagnosis/treatment, e.g. focusing on smoking cessation to reduce cases of lung cancer. AM thanked AE for the update on work to improve cancer outcomes in line with 'Improving Outcomes: A Strategy for Cancer'.
11.	**GP Consortia: Pathfinder Development**
	UD gave an update on the support available for Consortia development and introduced Janie Conlin - Assistant Director, Organisational Development who leads on this work. UD confirmed that the paper highlights early thoughts on development, including confirmed prioritisation areas and how the £2 per head development fund is to be spent. This work will be developed more fully throughout June and updates will be provided at future LCCCB meetings. **Action: UD**
Regular Reports	
12.	**Chair's Report**
	AM presented the LCCCB Chair's report for the period 1st April 2011 – 31st May 2011.

	AM reported that the end of the pause in the passage of legislation was nearing with the outcome awaited of the listening exercise. The formation and professional diversity within the LCCCB was also highlighted. AM also acknowledged the retirement of Dr Frances Dudley, formerly a partner at the Hurley Clinic and on behalf of the Board thanked her for her contribution to Lambeth and wished her well for the future. AM confirmed that he was happy to discuss any further items in the report following the end of the meeting at the informal session. The LCCCB received and noted the Chair's report.
13.	**Managing Director's Report**
	AE presented the Lambeth BSU Managing Director's report for the period 1st April 2011 – 31st May 2011. AE highlighted that the Health and Wellbeing Board is making good progress, with the second of a series of workshops having taken place on 11th May 2011. LCCCB members were also encouraged to attend Lambeth's Wellbeing and Happiness Network meeting taking place on 22nd June 2011. The LCCCB received and noted the Managing Director's report.
14.	**Director of Public Health Report**
	RW gave the headlines of the Director of Public Health's report. RW highlighted that the Lambeth Healthy School's partnership is currently targeting schools, to drive forward Healthy Schools and the advanced healthy schools agenda. RW also updated on organisational change within Public Health. The LCCCB will continue to receive updates. AM confirmed that hard copies of the Annual Public Health Report were now available. The LCCCB received and noted the report of the Director of Public Health.
15.	**2010/11 Performance Framework – Outturn Performance Report**
	AE presented the Performance Report, noting that formerly this was submitted to the NHS Lambeth Board.

	AE reported that last year presented a number of challenges for the PCT and NHS Lambeth had performed very well in a very difficult climate of organisational change, demonstrating sustained improvement in a number of key national standards, with certain programmes making significant progress. AE confirmed that data is available from NHS London's website to compare improvements in performance standards between PCTs. AE reported that financial targets had been delivered and this had resulted in part from the successful delivery of contingency plans led by the Clinical Board. The LCCCB agreed that achievement of the financial targets should be externally communicated as a good news story. CC agreed to draft key highlights for publication. **Action: CC** The LCCCB asked that thanks are passed on to all staff for achieving this successful position in 2010/11. The LCCCB noted: 1. NHS Lambeth's 2010/11 outturn Performance Report, highlighting: • Delivery against 2010/11 Business Plan objectives • Delivery against 2010/11 targets using outturn data where currently available. 2. That 24 out of 34 targets on forecast to be achieved, 7 underachieved and 4 not met.
16.	**Report from the Chief Financial Officer**
	Finance Report CC confirmed that the final Annual Accounts are due to be signed off by the Cluster PCT Audit and Risk Committee on 6th June 2011. CC reported that NHS Lambeth: ▪ As at March 2011 is underspent by £6.251m against a planned surplus of £6.22m ▪ reported a capital surplus of £0.150m ▪ drew down its allocated cash limit during this year and utilised this cash in settling creditors to achieve its national target of keeping its closing cash balance under £50k. AM thanked CC and the wider PCT for this strong financial position. The LCCCB: ▪ Noted the 2010/11 financial position at month 12 as reported in the draft Annual Accounts.

ITEMS FOR INFORMATION	
17.	**To receive for information the following minutes:**
	The LCCCB received for information minutes from the following meetings/committees: ▪ Lambeth First Meeting – 20th January 2011 ▪ Children & Young People's Strategic Partnership – 19th January 2011 and 16th March 2011 ▪ Communications and Stakeholder Engagement Meeting – 2nd March 2011 ▪ Adult's Safeguarding Board – 7th February 2011 ▪ Children's Safeguarding Board – 1st March 2011 and 29th March 2011 ▪ Research Management Group – 25th January 2011 ▪ Infection Control Committee - 14th January 2011 ▪ Quality and Governance Committee – 11th April 2011
18.	**Business Programme**
	LCCCB noted the business programme to date and UD asked all LCCCB members to advise UD and AM of any future agenda items.
CLOSING ITEMS	
19.	**Any Other Business**
	LCCCB Meetings Held in Public Going Forward AM confirmed that alternative venues were being considered for future LCCCB meetings held in public. Any suggestions gratefully received. AM thanked TB and JBu for their work in organising today's meeting and noted that dates for future LCCCB meetings held in public are published in the meeting papers.

ENCLOSURE 20

NHS

South East London

A meeting of the SEL PCT Boards* and Bexley Care Trust
21 July 2011

NAME OF COMMITTEE: Lewisham Clinical Commissioning Committee

DATE OF COMMITTEE: 30 June 2011

PRINCIPLE FOCUS:
The LCCC principle focus was on reconfirming commitment to existing partnership arrangements for adult mental health and other adult clients groups through a section 75 agreement and agreed intentions for HIV support and care services, integrated equipment service and CAMHS, as well as regular performance reports.

ISSUES ARISING:
Pathfinder Delegation and Development Update – The Lewisham Pathfinder planned to submit plans for delegated responsibility for prescribing in July 2011 and all main areas by April 2012.

CASCAID – the Committee noted the intention to redesign the HIV support and care services which would follow a public health led needs assessment and service review to be carried out across LSL during Q1 & Q2.

Section 75 Report – Formalising Joint Commissioning – arrangements for Adult Mental Health and Social Care – The Committee approved the continued participation by the PCT in the revised S31 agreement for the commissioning and provision of Adult Mental Health Services as part of the overarching S75 agreement between the council and the PCT. It was also agreed that authority would continue to be delegated to the Executive Director for Community Services to oversee and progress the work ensuring that contracting arrangements were fit for purpose and in line with joint intentions.

Healthcare for People with Learning Disabilities – The main priorities for an improvement in services for people with LD in Lewisham were agreed. These would be validated by NHS London before confirmation and finalisation.

Children and Adolescent Mental Health (CAMHS) Savings Update – The Committee requested that their concerns regarding any further reductions in CAMHS being taken back to Lewisham Council and for it to be flagged as a potential future high risk to the delivery of clinical priorities.

ENCLOSURE 20

Finance Report for Month 2 – The Committee discussed the financial position for NHS Lewisham at the end of month 2, and the year end forecast in the context of limited secondary care data.

QIPP Status June 2011 – The Committee discussed the reporting pack. There was work being undertaken with the GP Executives on outpatient referrals which would be reported back in next month's report along with milestones and an action plan.

NHS Safeguarding Group – The Terms of Reference for the Group were agreed with a caveat that further adult clinical expertise would be included. A revised Safeguarding Framework for all Providers of Healthcare Services in Lewisham would come back to the July meeting with further work being undertaken regarding adult services and the inclusion of the reviews of domestic violence.

Lewisham Work Plans – The BSU and Lewisham Public Health Directorate's 2011/12 work plans were presented. Following further discussion with the GP Executive they would come back to the LCCC on a quarterly basis to track progress.

RECOMMENDATIONS MADE:
There were no recommendations made to the Joint Board. The Joint Board is asked to note the reconfirmation of existing partnership arrangements for adult mental health and adult client groups with Lewisham Council through S75 agreement.

COMMITTEE CHAIR:
Name: Dr Helen Tattersfield
E-Mail: Helen.tattersfield@nhs.net
Telephone: 020 8695 6677

LEAD DIRECTOR:
Name: Martin Wilkinson
E-Mail: martinwilkinson@nhs.net
Telephone: 020 7206 3371

*SEL PCT Boards = Boards of Lambeth Primary Care Trust, Southwark Primary Care Trust, Lewisham Primary Care Trust, Bromley Primary Care Trust and Greenwich Teaching Primary Care Trust.

South East London
Lewisham Business Support Unit

CLINICAL COMMISSIONERS EXECUTIVE COMMITTEE

Minutes of the meeting of the Clinical Commissioners Executive Committee held on Thursday 30 June 2011 at 1:00 pm at
St. John's Medical Centre, Loampit Hill, London SE13 7SX

Present

Dr David Abraham	GP (Chair) Deputy Chair, Lewisham Federation
Ms Aileen Buckton **(AB)**	Executive Director, Community Services, LBL
Dr Judy Chen **(JD)**	GP, Clinical Executive Lewisham Federation
Ms Jane Cook **(JC)**	Lay member
Dr Hilary Entwistle **(HE)**	GP Clinical Executive Lewisham Federation
Dr Arun Gupta **(AG)**	GP, Clinical Executive Lewisham Federation
Ms Miriam Long **(ML)**	Lewisham LINk Development Manager
Dr Faruk Majid (**FM)**	GP, Deputy Chair Lewisham Federation
Ms Rona Nicholson **(RN)**	Non-Executive Director, NHS SE London
Dr Marc Rowland	GP, Clinical Executive Lewisham Federation
Mr Geoff Price **(GP)**	Head of Finance
Dr Danny Ruta **(DR)**	Joint Director of Public Health
Dr Alan Thompson	GP, Chair of LMC
Mr David Whiting **(DW)**	Vice Chair (Lewisham) NHS SE London
Mr Martin Wilkinson **(MW)**	Managing Director, Lewisham BSU

In Attendance

Ms Lesley Aitken **(LA)**	Head of Business Support and Integrated Governance
Mr Mark Cheung **(MC)**	Head of Financial Management, NHS SE London
Ms Eleanor Davies **(ED)**	Assoc Director Joint Mental Health Commissioning
Ms Yvonne Davis **(YD)**	Project Manager for Service Redesign
Dr Brian Fisher **(BF)**	GP
Mr Mike Hellier (**MH)**	Head of System Management
Ms Ruth Hutt (**RH)**	Consultant in Public Health
Ms Corinne Moocarme (**(CM)**	Assoc Director, Physical Disability, Joint Commissioning
Ms Marie Searle **(MS)**	Project Manager
Ms Rachael Turner **(RT)**	Joint Commissioner, Children & Young People, LBL

Apologies

Dr Helen Tattersfield	GP, Chair LCCC, Chair of Lewisham Federation
Ms Rosie Fooks	LINks Representative
Dr Steve Smith	Clinical Advisor

LCCC 11/60- <u>Apologies for absence</u>

Apologies for absence were received and noted.

ENCLOSURE 20

LCCC 11/61 Introductions and welcome

Introductions were made and DA welcomed all to the meeting.

LCCC 11/62 Declarations of Interest

The Standards of Business Conduct letter from Mr Simon Robbins, Chief Executive, NHS SE London and the Code of Conduct and Accountability in the NHS was taken for information and noted. The Declaration of Personal and Financial Interests form for LCCC members would be emailed for completion and returned to LA for the register. This would be standing item on the agenda.

ACTION: LA

LCCC 11/63 - Minutes of last meeting

The minutes of the Committee meeting of the 26 May 2011 were agreed to be an accurate record of that meeting.

LCCC 11/63- Action Log and Matters Arising

Min 11/50.3 refers - NCA (Non Contracted Activity) – GP referred to the paper, Analysis of 2010/11 expenditure at BMI Healthcare by GP Practice, and explained that the highest expenditure by provider, which had doubled since last year, was BMI Healthcare (formerly BUPA). A paper giving a breakdown by HRG description was tabled. The budget for NCAs for this year had been increased.

GP agreed to find out how much of this activity was due to Choose and Book.

ACTION: GP

This area would be covered by the GP Executives as part of their discussions regarding peer review and issues around referrals.

Min 11/42.5 – Prescribing Implementation Plan – There would be a detailed report on prescribing to be included bi-monthly in the QIPP update. Mr Salter would be requested to report back on the investigation of prescribing of anti-malarials with a view across the LSL boroughs.

ACTION: MS/MH

63.1 Urgent Care Centre (UCC)

YD presented the report which provided an update on the progress of the project.

It was acknowledged that the financial aspects to the project were complex but that slack had been built into the project plan. It was being funded through shift of activity from A&E to the UCC and through the new A&E tariffs whereby a saving would be made, which was factored into the QIPP Plan. The UCC tariff was less than for A&E. The capital costs were being managed by LHNT and had been covered by approval of a full Business Case by NHS London last year.

Lewisham Business Support Unit (LBSU) would commission the provision of the UCC to a number of providers including LHNT, an out of hours primary care provider (SELDOC) and local GP practices for in hours primary care provision. All providers had been engaged in the commissioning process. LBSU were entering the formal application process for GP practices for which confirmed providers would be identified by early August. All providers once identified would form a Joint Management Board to oversee deliver of the UCC.

The UCC shall use EDIS as the electronic system in place. SELDOC would continue to provide an out of hours contract in addition to the UCC contract for which they shall continue to use Adastra.

The PCT were working closely with LHNT on the Communications and Engagement Plan building on the messages from the Choose Well campaign. RN asked for greater clarity in the report of the project status. MW confirmed the project was on time against the agreed project plan. A more focussed paper which provided assurance of the project against given milestones with a RAG rated project plan and summary communications plan, was requested for the next meeting.

ACTION: SS/YD

The Committee formally ACKNOWLEDGED and gave comments on UCC progress for June 2011; ACKNOWLEDGED the key timescales and decision points for progress; and AGREED that the Committee would make agreed amendments of key decisions outside of the meeting in order to keep on track with the project plan therefore minimising risk to delivery. The Chair and Deputy Chair would provide comments and decisions by email with report back to the full LCCC.

It was agreed that a template would be produced which detailed what was required from reports presented to the LCCC. Discussions would be held with the GP Executives and Non Executive Directors (NEDs) to discuss length of reports and future agenda planning.

ACTION: MW/LA

63.2 Pathfinder Delegation and Development Update

MW presented the paper which outlined the content and processes for the delegation of commissioning responsibilities to commission pathfinders and for development support. The development would be for the whole pathfinder with wider clinical involvement which included younger doctors.

The Lewisham pathfinder planned to submit plans for delegated responsibility for prescribing in July 2011 and all main areas by April 2012 with support from BSU, other commissioners and central Cluster teams.

The Committee NOTED the report

LCCC 11/64 CASCAID

RH introduced the item. She reported that HIV nature had changed over the past 10 years, it was now recognised as a manageable illness hence the client group needs had changed, some had complex medical and social needs which could impact on health outcomes and onward HIV transmission. The number of people who lived with HIV had increased in the UK. CASCAID – the specialist HIV Mental Health Service was managed by South London and Maudsley NHS Foundation Trust (SLaM) with a budget of £1.2m.

A stakeholder mapping event was to be held on 19 July. RH would liaise with ML regarding a mention of the event in the LINk bulletin. Focus groups would be held in liaison with PPE leads and main client groups would be targeted. A service user consultation event would follow the publication of recommendations. Contract variations would need to be issued to Care and Support contracts which included CASCAID within the SLaM contract.

It was pointed out that there was some children's provision. The implications of the service change would be looked into.

ACTION: RT/RH

The Committee AGREED the intention to redesign HIV support and care services which followed a public health led needs assessment and service review to be carried out across LSL during Quarter 1 and Quarter 2, 2011/12.

LCCC 11/65 Integrated Community Equipment (ICE) Service

CM introduced the report. She explained that the contract for the ICE service had been tendered in 2008 with Medequip achieving the contract. This would come to an end in October 2011. 17 PCTs had already joined the pan London Consortium. Joining the consortium would result in sharing a depot with less expensive rates for larger pieces of equipment. The aim of transforming community equipment services would be to move provision of Simple Aids to Daily Living (SADLs) of less than £100 to local pharmacies.

The Committee AGREED a six month extension to the current contract with Medequip. AGREED to the implementation of the Retail Model for Simple Aids to Daily Living (SADLs) and AGREED to an expression of interest to be submitted regarding joining the pan London Consortium.

LCCC 11/66 Section 75 Report – Formalising Joint Commissioning – arrangements for Adult Mental Health and Social Care

ED introduced the report which made recommendations to update the current Mental Health Section 31 agreement during 2011/12 in line with the 2006 changes to the 1999 Health Act. The S31 agreement would be revised to form a schedule within the overarching S75 Agreement which was currently in place between Lewisham Council and Lewisham PCT which aligned health and social care budgets managed by the council, approved by Mayor and Cabinet on 10th June 2010 and signed on 23rd December 2010.

This would reconfirm existing integrated joint commissioning arrangements for adult social care and health between Lewisham Council and Lewisham Primary Care Trust, under the strategic leadership of the Council, in order to enhance opportunities to achieve a wide range of benefits for local adult service users and their carers.

The proposal to update the Mental Health S31 agreement to a S75 has been signed off by Mayor and Cabinet in July 2011.

ED highlighted the main benefits to the Section 75 agreement as:

- The purpose of the agreement was to benefit service users. SLaM is commissioned to provide an integrated health and social care service to holistically assess and meet the needs of service users. The result was efficient delivery of services with resources being applied according to need rather than theoretical responsibility. As such, response to pressure can be quicker and more effective.

- A "joined up" approach, which enables financial decisions to be based on overall needs, rather than sub sections of particular budgets. This allows savings made in one area to be reinvested across the system, bringing immediate benefits to current service users, by improved provision of individual placements, as well as longer-term benefits through the development of new services, which better meet needs.

- All overspend has been managed within the Pooled Budget since its inception

- Commissioning in this way will give greater strength to commissioning as commissioners will be responsible for a larger sum of money and will prevent the provider playing off different income streams against each other. This was particularly important in the current financial climate where decommissioning elements of services may become necessary.

- The Pooled Budget is responsible for the delivery of £4.5m and £600k savings target required by the PCT and Council respectively by 2013/14. This was done as a partnership piece of work. Clear savings plans have been drawn up for 2011/12 and 2012/13 to realise the PCT and Council savings required.

Learning Disabilities was already included in the overarching S75 which was managed by the local authority, this was separate from Mental Health.

The Committee; APPROVED the continued participation by the PCT in the updated S75 to cover existing S31 arrangements for the commissioning and provision of Adult Mental Health Services as part of the overarching S75 agreement between the Council and the PCT recognising it reconfirmed existing joint arrangements

NOTED that the Council would enter into a management agreement with SLaM to support the clinical delivery of services as a result of extracting SLaM from the existing S31 agreement when updating to a S75 agreement.

AGREED the delegation of authority to the Executive Director for Community Services to oversee and progress the work. Ensuring that contracting arrangements were fit for purpose and took account of joint health and social care commissioning intentions.

NOTED that a separate report would be brought to the LCCC to cover Children and Young People Commissioning at a later date which would cover the same legal format as the overarching S75 agreement.

LCCC 11/67 Healthcare for People with Learning Disabilities (LD)

MH introduced the Assessment Framework 10/11 and Priorities for Improvement which set out the process, including the involvement of people with learning disabilities, that had led to the assessment and priorities for improvement for their healthcare.

As a result of concerns of level of care the DoH had developed a self assessment framework to be completed by all health commissioners which had been completed last year for the first time. The 10/11 framework had been informed by 'A Big Health Check Up Day' which involved people with learning disabilities rating the services and a review by the LD commissioner.

The validation date for the Lewisham framework by NHS London was 25 July.

The indentified proposed priorities for 2011/12 were:

- Improved communications
- Improved access for people with a learning disability to treatment pathways
- Ensuring that consent to treatment worked better for people with LD
- The development of an easy read guide on how to influence services

Further work would be undertaken on the PALS and Complaints process which was not transparent for people with LD.

It was suggested that the outcome of the NHS Health Check could be used with the inclusion of additional symbols as the easy read guide.

The Self Assessment Framework and action plan would come to the July or September meeting for information along with comparison to last year as an improvement had been made in some areas and a comparison with neighbouring boroughs.

ACTION: MH

The Committee AGREED the main priorities for improvement of services for people with LD in Lewisham. These would be reviewed by NHS London before confirmation and finalisation.

LCCC 11/68 Children and Adolescent Mental Health (CAMHS) Savings Update

RT presented the report which gave a summary of the savings made to CAMHS, the process of decision making which led to the changes and the implications for service delivery.

Funding for the CAMHS service was provided by both the Council and PCT. Funding has been reduced for 2011/12 due to reductions in central government funding and grants.

Service priorities have been set in line with those of the Children's and Young People's Plan, to target available resources on those in most need.

6.1 full time equivalent clinical posts and 1 admin post had been deleted from the CAMHS service. 5 members of staff had been redeployed; one member of staff retired and one had taken redundancy.

RT said that the savings to date would have little impact on frontline delivery of service. All further proposals for savings would be considered in consultation with CAMHS management and partners including the LCCC.

Information on the service configuration, and breakdown by workforce by FTE would be circulated to the LCCC. It was asked whether there was a way of tracking the impact of the changes and outcomes for children and young people, such as monitoring waiting times either tier 3 or 2.

ACTION: RT

RT said that clinical priorities would still be covered by the CAMHS service. Further support was available through the Borough's family support services, and the development of early intervention services, which will include a targeted offer for those children and young people at a Tier 2 level of need.

AB raised issues around;

- There was a need to look at the development of tier 2 services,
- Who was not receiving a service? – this should be reported
- Was the social and educational impact of the outcomes collected?

RT was asked to take back to the Joint Commissioning Group the concerns of the LCCC regarding further reductions in CAMHS and to flag it as a high risk to the delivery of clinical priorities in the future. The LCCC however agreed to the 2010/11 savings plan and impact assessment provided.

A report would come to LCCC in six months.

ACTION: LA to agenda

The Committee NOTED the review of the CAMHS service reconfiguration and CONSIDERED the limited potential for further savings for 2012/13 and beyond

LCCC 11/69 <u>Finance Report for Month 2</u>

GP introduced the report which set out the financial position for Lewisham PCT at Month 2, the two months ended 31 May and the year end forecast.

Though it was acknowledged that the information for some areas for month 2 was not robust a break even position at month end was reported. The PCT was forecast to achieve its planned surplus in 2011/12 but there were significant risks because of potential service over performance and the delivery of the QIPP savings. A table on risks and contingency on revenue and the management accounts for two months to the end of May 2011 were taken for information.

MC presented the report which set out the 2011/12 financial position for each of the PCTs in the cluster. He said that it had been a challenge to bring the six financial plans together and acknowledged that that the BSU and Cluster finance teams had worked well together.

A key risk for Lewisham Healthcare NHS Trust (LHNT) contract was outpatient procedures charged as a day case. Work was being undertaken on the change management and contract challenge system.

RN said it was a good report, especially for comparison purposes.

In future there would be a Cluster wide quarterly report to the LCCC with the detailed monthly report to the GP Executives. A Lewisham PCT report would be prepared monthly of LCCC to show performance of the total Lewisham budget.

ACTION: MC/GP

The Committee NOTED the report

LCCC 11/70 QIPP Status – June 2011

MH presented the QIPP Reporting Pack which showed progress and continued work to deliver the QIPP.

He reported that the QIPP report in May showed that there was a total QIPP plan of £14.6m with a risk adjusted total of £10.7m and with a further risk of £0.3m on mental health savings due to reviews this would leave a gap of £4.2m. Plan B schemes were being worked up.

There was work being undertaken on out patient referrals with the GP Executives, this would be reflected in next months report along with milestones and an action plan. A discussion on learning from the North Lewisham Plan and outcomes would be useful to share.

ACTION: DR

There was a reminder that Lewisham People's Day was being held on Saturday 9 July.

The Committee NOTED the QIPP Reporting Pack

LCCC 11/71 Proactive Primary Care

BF introduced the report which explained the proposed Community Nurse led pilot. This had previously been discussed in the Business Case and Tenders Approval Committee.

The feasibility study was **agreed** in the short term with the aim of the preferred model longer term being to initially progress with community nurse led pilot whilst in parallel developing a voluntary sector led pilot. This would read across to the Telehealth Long Term Conditions in Lewisham project

A template for re-admissions funds would be completed.

The Committee AGREED that the project could proceed.

LCCC 11/72 Telehealth for Long Term Conditions in Lewisham

AG introduced the paper.

It was proposed that a scoping exercise would be undertaken, to then proceed to a pilot at a cost of £16k.

Safeguarding implications were raised because of the requirement to collect outcome data in patient's homes.

If required for information, LA had a copy of the working document produced by PA Consulting Group on delivering a comprehensive Telehealth solution in Lewisham and the Project Brief Template by Bexley Care Trust on file.

It was agreed that a business case would be required for the pilot.

There would be further discussion required on the process on determining which reports should come to the LCCC as, for example, there could be a conflict of interest with some items and LCCC previously had a business case and approval group which needs to scrutinise these proposals before coming to LCCC if needed.

ACTION: GP Execs/MW/LA

It was AGREED that the scoping exercise could proceed

LCCC 11/73 Proposed Priority Outcomes for the Lewisham Health and Well Being Strategy

DR presented the report which requested comments of the proposed priority outcomes for the Lewisham Health and Wellbeing Strategy.

Comments should on the paper be sent to DR but it was acknowledged that further discussion would be required following the Health and Wellbeing Board meeting on 1 July 2011.

ACTION: MW/DA/HT/DR/AB to take stock after 1 July discussion and agree next steps

LCCC 11/74 NHS Safeguarding Group

DR introduced the Safeguarding Framework for all Providers of Healthcare Services in Lewisham (including Child Protection) and the Terms of Reference for South East London NHS Lewisham Children and Adults Safeguarding Committee.

Comments given were:

- There were concerns over levels of CRB checks at LHNT
- There needed to be more emphasis on adults with more adult clinical input.
- The framework was for children, therefore requires to be changed to include adults
- The Safeguarding Committee meeting could be split into two parts, adults and children
- Reviews of domestic violence (homicides) to be built into the framework

To date there was no designated nurse for Adult Safeguarding though a resource had been identified. This would be a priority. Discussion would be held to ascertain what was already in place.

ACTION: DR/CM

A revised Framework would come to the July meeting.
The Terms of Reference were AGREED with the caveat that further adult clinical expertise would be included.

LCCC 11/75 Lewisham 2011/12 Work Plans

MW outlined the Lewisham Business Support Unit's and the Lewisham Public Health Directorate's 2011/12 work plans. Tracking and monitoring arrangements would be put in place. These would be further discussed with the GP Executive and come back to the LCCC on a quarterly basis.

ACTION: LA to agenda

The Committee NOTED the work plans

LCCC 11/76 Items for information

The following items were taken for information only:

NHS London Commissioning Support Strategy
Palliative Care Respite Scheme

LCCC 11/77– Date and time of Next Meeting

The next meeting was scheduled for Thursday 28 July at 1.00 at Cantilever House, Eltham Road, London SE12 8RN

Future meetings to be held at 1pm on:

29 September to include the AGM , 27 October, 24 November, 29 December.

ACTION LOG FOR CLINICAL COMMISSIONING COMMITTEE –

Minute Reference	Action	Responsible Person	Timescale	Status/ Comments
June 2011				
11/62	Declaration of Interest – The Declaration of Personal and Financial Interest form to LCCC members for return	Lesley Aitken	To be received by 28 July	
11/63	NCA – to ascertain how much of this activity was due to Choose and Book	Geoff Price	July/Sept meeting	
11/42.5	Prescribing Implementation Plan – to report back on the prescribing of anti-malarials with a view across the LSL boroughs	Mike Salter	July meeting	
63.1	Urgent Care Centre – A more detailed paper showing the project against milestones would come to the next meeting	Steve Smith/Yvonne Davies	July meeting	
11/64	CASCAID – The implications of any service change to children's services would be investigated.	Rachael Turner/Ruth Hutt	September meeting	
11/67	Healthcare for People with Learning Disabilities – The Self Assessment Framework and action plan would come back for information	Mike Hellier	September meeting	

ENCLOSURE 20

11/68	CAMHS Savings Update – Information on the number of people involved in the process and the affect on the waiting times for tier 2 and 3 would be circulated	Rachael Turner		
11/70	QIPP Savings – To share the learning from the North Lewisham Plan and outcomes with the LCCC	Danny Ruta		
11/72	LCCC reports – to discuss the process and format of which reports should come to LCCC	GP Executives/Lesley Aitken/Martin Wilkinson	Before July meeting	
11/73	Proposed priority outcomes for the Lewisham Health and Well Being Strategy – To take stock after 1 July HWB Board and agree next steps	Martin Wilkinson/David Abraham/Helen Tattersfield/Danny Ruta/Aileen Buckton	After 1 July meeting	
11/74	NHS Safeguarding Group - Discussion to be held to ascertain what was in place regarding a designated nurse for Safeguarding	Danny Ruta/Corinne Moocarme		
May 2011				
11/50.2	Vascular Project update LNHT to be asked to provide comments on the proposed service's local effectiveness for patients and providers with a focus on a specific patient concern.	Martin Wilkinson	July	**This has been raised with LHNT and a local meeting is to be arranged to discuss.**

11/50.3	Analysis of NCA Expenditure – to look at which practices referred patients to BMI Healthcare and for what procedures.	Geoff Price	June meeting	**A verbal update to be given at June meting**
11/51	HIV Testing Results – a profile of the extra spend and where to take these monies out of the system to be produced. Public Health to do financial modelling and the normalisation of the service with involvement of LHNT Sexual Health Services.	Dr Danny Ruta/Ruth Hutt	October To go to the October LMC meeting	
11/54	Lewisham Cluster 1 Dietetics Service – A decision template for the Business Case Panel to be developed. A progress report to come to a LCCC meeting.	Martin Wilkinson Dr Ashok Jain/Ashley O'Shaughnessy	To go to Business Case and Tender meeting	
11/57	Lewisham Primary Care Federation Executive Team – the OD Programme would include the development of younger doctors.	Charles Malcolm-Smith		
11/58	London Review of Cancer Services - a full report to come to the July meeting	Dr Danny Ruta	29 September	
April 2011				

ENCLOSURE 20

11/37	Inpatient Care of Arterial Vascular Surgery Ms Grothier would propose the mutual safeguard standards which could be agreed to help mitigate committee concerns.	Lucy Grothier	Date to be agreed for report back	**Report to be taken under matters arising**
11/41.1	Terms of Reference Nurse member recruitment to be progressed.	Charles Malcolm-Smith	Report back to meeting - September	
11/41.2	Subcommittee outline Terms of Reference and overview of meetings for the year to be produced.	Mike Hellier/Lesley Aitken	May meeting	**The Strategy Group would have their first meeting in Sept and the Quality and Safety Group would meet in August**
11/42.2	Finance Update The spend on NCAs and high cost drugs was being analysed.	Geoff Price	May meeting	**On agenda for May**
	To look at the potential of GPs directing/advising referrals to LHNT rather than GSTT and King's.	GP Executives	Report to go to future Fed. Meeting	This would be part of the peer review
	Stocktake of quality at LHNT, King's and GSTT would be undertaken with public health involvement for areas of dermatology, MSK, COPD and diabetes.	Mike Hellier/Danny Ruta	TBA	This would be discussed at the Q&S Group

11/42.5	<u>Prescribing Implementation Plan</u> 1)To work with community pharmacists to develop a system which would allow them, to raise with prescribers, other options when a special was prescribed. 2)To investigate the issues around the Nurse Prescriber who left JA's practice four years ago. 3)Dr Platman (on behalf of PMM) to be requested to investigate the prescribing of anti-malarials. To have a view across the LSL boroughs.	Mike Salter Mike Salter Mike Salter	TBA	1)Work with community pharmacists – this was raised at a meeting of 45 community pharmacists on the 6/6/11. There was acceptance that pharmacists would be able to do this and I understand some have started to do this in an ad hoc (non funded) way. We are developing a fax-back form and defining a few rules (about whether to do with only new pts or also existing patients). The form based system will need a simple LES agreed with the LPC. 2)Investigation is under way – the issues will be resolved and we will look to recover dispensing cost from the new host PCT 3)Dr Platman is awaiting a date for the meeting. Have chased Southwark who are leading the work to get a date for the meeting with HPA to agree a new position.

ENCLOSURE 20

11/43	Urgent Care Centre – Expressions of interest to be sought for Practice 1 & 2. To check the business case for issues around non-required investigations/diagnostics as part of the financial modelling work	Martin Wilkinson	Progress report to May meeting	**UCC to be a standing item**
24/03/11 11/35	PBMA End of Year Reports Haematology would be a potential target – scoping work to be undertaken on how this could be managed.	Martin Wilkinson		Scoping work is ongoing to identify potential speciality areas of focus for future redesign work which includes Clinical Haematology.
24/03/11 11/33	Outline of the management structure of LHT to be sent to Aileen.	Lesley Aitken		LA has requested the structure and will forward when received.
24/03/11 11/31	CCEC Arrangements – Summary of workshop to be circulated to absent members. Clarification on conflict of interest	Lesley Aitken Aileen Buckton		Circulated – 27 April To be circulated before the meeting.
24/03/11 11/30	LHT 2011/12 Contract – an update to be given at the April meeting.	Sarah Cottingham	April meeting	
24/03/11 11/29	Bariatric surgery – to provide clarification on bariatric surgery. Briefing note to be sent to members.	Danny Ruta	April	Briefing emailed on 13 April.
24/03/11 11/29	Mental Health CQUIN – Sam to provide further info – refer to mins.	Sam Madden	For April meeting	To be taken under matters arising

24/02/11	Public Health White Paper - Updated version of Joint response to be circulated to CCEC	DR/AB	March 2011	24.3.11 – second draft to be circulated and signed off by Chair's action - DR
24/02/11	Mental Health CQUIN – MW to follow up with Eleanor Davies and update the Committee.	MW	March 2011	Sam Madden attended meeting
24/02/11	Lewisham Healthcare Foundation Trust Application – Agreed that AO will chase up on progress on this.	AO		Update on LHNT Contract mediation on agenda – 28 April
24/02/11	Bariatric Surgery policy - to be put on GP website and intranet.	CB	By end February	This is still to be actioned.
24/02/11	SEL IFR - Magda would arrange • circulation of the Policies to the Federation, via Ashley, • patient leaflets would be explored, via LINK, • Policies would be placed on the GP website.	Magda/Ashley Una/Brian Ashley/Colin Paget	Feb 11 Feb 11	Magda reported that Carol Byrne was following up on this and still working on the policies. Agreed that when these are complete, they would be circulated to HT and the Federation.
270510/18	Third Sector Action plan to be developed to come back to CCEC	CB		Now deferred to April 2011 meeting. MW reported that Carol Byrne is leading on this. **AB to bring a report from LBL to the October meeting**

ENCLOSURE 20

South East London

A meeting of the SEL PCT Boards* and Bexley Care Trust
21 July 2011

NAME OF COMMITTEE: Southwark Clinical Commissioning Committee

DATE OF COMMITTEE: 2 June 2011

PRINCIPLE FOCUS:
Borough based commissioning – The Southwark Clinical Commissioning Committee considered commissioning of those areas for which it holds with delegated responsibility as a Board committee.

ISSUES ARISING:

Local Clinical Commissioning Committee sub groups - The committee received feedback on the emerging arrangements for Cluster directorate input on all local sub groups reporting to the committee. The interaction between the local Integrated Governance Group (IGG) and the cluster Quality and Safety Committee was confirmed.

Local Authority update - Joint commissioning arrangements and Health and well being Boards being discussed with LA Chief Executive.

Economic and clinical review of non-GMS areas of the GP led Walk-in centre - the terms of reference for this review, as part of the wider commissioning of urgent care services was considered and approved.

Budget report and risks 2011/12 - The Committee reviewed and considered the current position and the associated and anticipated risks for the coming year. The committee received a full and detailed report on all risk areas.

Financial outturn 2010/11 - The committee noted that the audit of the final accounts was almost complete and the achievement of all financial targets was expected.

QIPP Delivery Group - The committee received and considered an update on all areas of QIPP implementation and those areas currently rated as 'red' or at risk of delivery. The template for business case approval was approved.

The committee noted - the NHS South East London delegation process and the progress and direction of travel for the Integrated Care Pilot led by Kings Health Partners (KHP).

ENCLOSURE 20

RECOMMENDATIONS MADE:

No formal recommendations are made to the Board. The Board is asked to note:

The approval of the economic and clinical review of non-GMS areas of the GP led Walk-in centre and of the local business case approval process to be used within the Business Support Unit.

COMMITTEE CHAIR:

Name: Dr Amr Zeineldine
E-Mail: amr.zeineldine@nhs.net
Telephone: 0844 3756375

LEAD DIRECTOR:

Name: Andrew Bland
E-Mail: andrew.bland@southwarkpct.nhs.uk
Telephone: 020 7525 0401

*SEL PCT Boards = Boards of Lambeth Primary Care Trust, Southwark Primary Care Trust, Lewisham Primary Care Trust, Bromley Primary Care Trust and Greenwich Teaching Primary Care Trust.

South East London

Southwark Clinical Commissioning Board

2 June 2011

Aylesbury Medical Centre

MINUTES

PRESENT:	Dr. Amr Zeineldine (AZ)	GP Commissioning Lead & Chair
	Dr. Mark Ashworth (MA)	GP Commissioning Lead (Excl item 1-3)
	Andrew Bland (AB)	Managing Director SBSU
	Dr. Adam Bradford (ABr)	GP Commissioning Lead
	Dr Jane Cliffe (JC)	GP Commissioning Lead
	Dr. Ann-Marie Connolly (AC)	Director of Public Health
	Dr. Roger Durston (RD)	GP Commissioning Lead
	Dr Simon Fradd (SF)	GP Commissioning Lead
	Dr. Stewart Kay (SK)	Southwark LMC Chair
	Richard Gibbs (RG)	Non-Executive Director, SEL
	Dr Jonty Heaversedge(JH)	GP Commissioning Lead
	Malcolm Hines (MH)	Chief Financial officer
	Dr. Patrick Holden (PH)	GP Commissioning Lead
	Martin Saunders (MS)	LINK [Local Involvement Network]
In attendance:		
	Amitee Parashar (AP)	Senior Acute Commissioning Redesign Manager
	Kieran Swann (KS)	Commissioning Manager
	Peter Underwood (PU)	Senior Finance Manager
	Rosemary Watts	Head of Communications and Engagement
	Ben Pert (BP)	GP registrar Albion Street - Observer
	Christian Search (CS)	Risk Manager - Observer
	Jim Lusby (JL)	Director Integrated Care Pilot
	Maggie Kemmner (MK)	Deputy Director Integrated Care Pilot
	Femi Osonuga (FO)	Chair Integrated Care Pilot Board
Apologies:	Tamsin Hooton (TH)	Director of Acute Commissioning
	Gwen Kennedy (GK)	Acting Director of Client Group Commissioning and Partnerships

1.	**MINUTES OF LAST MEETING** The minutes of the meeting held on 5 May 2011 were agreed to be an accurate record with the following amendment:

ENCLOSURE 20

	3.3 Terms of reference for the Engagement and patient experience Sub group – (first para)……..that under the new arrangements **UIPEC [User Involvement and Patient Experience Committee] and PPAG [Patient and Public Advisory Group – part of the Transforming Southwark NHS programme] would be replaced.**
2	**Matters Arising** **3. Clinical Commissioning Board Sub Groups** **3.1 Terms of reference for the QIPP Delivery Sub Group** - Feedback is awaited from the Sector on arrangements for their input to the group **ACTION MH to follow up** **3.2 Terms of Reference for the Integrated Governance Sub Group** – Serious incidents will be reported through the Sector Quality and Safety Committee. SBSU's representative is Maggie Aiken Arrangements for Caldecott Guardianship – AMC is the BSU lead and Donna Kinnair is the Cluster lead. **5. Acute SLA Round 2011/12 outcomes** – Financial envelopes have been agreed this week. Local Work is on going on the re-investment of local monies on the 30 day readmissions. **6. QIPP Update** – main agenda item. **8. Local Authority Update** – AB reported that he would be discussing joint commissioning arrangements and Health and Wellbeing Boards with Annie Shepherd, LA Chief Executive.
	ITEMS FOR DECISION
3	**GP Led walk In Centre Terms of reference for the Service Review** **NB Mark Ashworth had declared an interest in this item and was not present or part of the discussion** AB outlined the decision making process that will follow the review of the Walk In Service at the Lister GP led health centre. He highlighted that the review will be carried out in parallel to the review of the core GMS requirements of the contract being carried out by NHS South East London Primary Care team. A recommendation will be made by AB and RG to the SCCC, who will in turn make a recommendation to be considered by the NHS South East London Primary Care Decision Making [PCDM] Committee alongside their review of the wider requirements of the contract. The BSU led review is of the walk-in element of the service only.

PH outlined the principles of the review and the scope of consultation. He highlighted that there is no division between the walk in patients and general primary care patients attending their GP. He referred to the recent review on walk in centres carried out in Nottingham and stated that there proposed economic indicators will comprise a significant part of this review. Key performance Indicators have been requested and a full clinical review will be carried out focussing on quality of service provided and value for money. There will be in-depth reviews of clinical operating procedures, any serious incidents and also to confirm that requirements of "Good medical practice" are in place.

ABr requested that there should be a fourth possible service implication to recommission a walk in service within current primary care provision and emphasised that any decommissioning must be in line with the wider urgent care strategy. AB stated that the Committee must be mindful of commissioning intentions and it is not possible to have a fourth course of action to recommission the service within urgent care provision. However, when the final outcome of the review is decided, recommissioning the service could be considered. SF highlighted that a risk analysis must be carried out if it is decided not to recommission the service.

SK highlighted that any future tendering process may be curtailed because of the governance implications as other members of the CCC may express an interest. AB reassured the CCC that the governance arrangements are robust in that RG and he will make the recommendation which will then be presented to the cluster PCDM committee who will make the final decision.

JH suggested that there may be opportunities to consult through local groups before decisions are made. AB stated that at present it is not possible to resource this. Information on patients views re access to GPs is already available and he suggested that there could be further discussion at local patient participation groups. **ACTION AB/JH/RW**

AP outlined the proposed economic review indicators. SF stated that benchmarking must be based on expected and actual volumes and that infrastructure costs must also be included.

AB highlighted the risk to the timescale if it is recommended to recommission the service under significantly different terms as there will need to be patient consultation.

Recommendations following the review will be reported to the SCCC in August with a final recommendation to the SE London Cluster PCDM in September.

The SCCC approved the terms of reference for the Economic and Clinical review of the Walk In Service at the Lister GP-Led health

	Centre. AZ reminded members that conflicts of Interest must be updated at each meeting. A current register of interests is attached for information.
4	**Budget Report and Risks 2011/12** MH reported that all main contracts have been agreed. He highlighted the key financial risks and the current position in relation. SK enquired about the robustness of the population growth estimates. MH stated that 1.5% list growth has been used as an estimate and funding has been adjusted at this level. However, the PCT is now 1.6% below target on Southwark capitation target. In previous years funding had been increased for PCTs below target but because there has been such a small increase in NHS budgets overall for 2011/12, everyone's increase has been at a similar level of approximately 2-2.5%. In answer to a question from SF, MH stated that premises costs have not been ring fenced in primary care budgets for some years. MH will check with the local authority the arrangements with GPs for issue of blue badges **ACTION MH** MH also outlined the current position re securing use of 2% non recurrent funds. Bids had to be prepared within a short timescale and are currently being considered by NHS SE London. It is vital that appropriate approval is given as this will allow projects to proceed to ensure delivery of the full QIPP plan for this year. SF highlighted the risk of dependency on this money for the necessary initiatives. AB agreed the difficulties of using the 2% non recurrent funds to address the risks and stated that a number of BSUs have also highlighted this. **The CCC noted:** **The 2011/12 opening budget position** **The key financial risks** **The current position in relation to securing the 2% non recurrent funds.** **Financial Outturn 2010/11** MH reported that the audit of the accounts was almost complete and Southwark will deliver our full £1.3m surplus and meet all targets for

	2010/11. Members expressed their thanks and acknowledged that this gives the Consortium a strong start position.
5	**QIPP Delivery Group feedback** KS outlined the QIPP programme update following agreement of the acute and non acute contract positions. All information has been closely reviewed at the QIPP sub group. He drew the committee's attention to the RAG-rated red initiatives which have yet to be delivered in full and the mitigations to be put in place. SF highlighted the potential political risk that under the health reforms, all aspects of price competition would be excluded. AB reassured him that it is very unlikely there will be any changes in 2011/12. Discussion ensued on the risks of the following unsecured QIPP red rated initiatives and the mitigations. **First outpatient appointments** –Update on the position of referral management was requested and MA requested that interim processes are confirmed as soon as possible. A single point of referral is required as in diabetes and dermatology and these arrangements could be extended for other conditions. In answer to a question from JH, KS stated that a full review on impact on acute activity would be undertaken in ENT, Dermatology and headache and MSU after a full six months of extended operation. Where services are successful in the community AB stated that other services should follow. Redesign work is important and must proceed quickly. Immediate benefit may not be obtained but there is great potential for the future. **Reduce A&E attendances** – AB stated that extended hours have been re-commissioned in the majority of GP practices. SK emphasised that the good will of GPs should not be over relied upon. **Admissions Avoidance Programme** - KS circulated an admissions avoidance update. TH and Angela Dawe, Director of Operations Southwark Provider Services are in discussion on the Virtual Ward model and progress will be fed back through the QIPP group. MS emphasised the importance of patient discharge to a named GP and the SCCC agreed that good patient focussed communication between GPs and hospitals is vital. KS reported that the decommissioning of support for delivery of the Gold Standard Framework in primary care and care homes has now been delivered by reversing previously earmarked investments. This means that no additional money is being invested in End of Life care this year at this stage.

	SF highlighted the number of Southern Cross Nursing Homes in Southwark. AB stated that contingency plans are being co-ordinated by Jane Schofield at NHS SE London Cluster. The issues are national and the situation is being closely monitored. **The CCC agreed the current risk rated position and noted the key risks for QIPP initiatives and the mitigations in place** **Feedback on Business case review Template** The Business case appraisal template had been reviewed from a Quality, Outcomes and cost efficiency perspective. TH is developing guidance to bidders on completing business cases and criteria for their assessment. KS highlighted that the process will be applied to any AWP procurement and not where invitations to tender have been placed. PH enquired whether GPs can assume that legal cover for GPs is provided by the PCT. MH stated that the current protection arrangements remain in place until 2013. **The CCC approved the appraisal template and the process for managing AWP business.**
6	**NHS South East London Delegation Process** AB stated that all detail is contained within the reports presented. Work is ongoing to adhere to the submission deadline of 17th June. **The CC noted the report and the recommendations agreed at the NHS SE London PCT/Care Trust Boards on 19th May**
7	**Use of Development Funds/ Development Support** AB stated that use of £220K development funds had been discussed at the GP Away day. A Statement of Works would be produced for GP Lead consideration in late June 2011 before submitted to the Cluster.
8	**Kings Health Partners** AZ welcomed Jim Lusby, Maggie Kemmner and Femi Osonuga from the King's Health Partners Integrated Care Pilot to the meeting. JL outlined the developments in the pilot across Lambeth and Southwark PCTs.

	In answer to a question from SF MK outlined the structure of the Clinical Design Group [CDG]. She stated that the Frail Older People CDG has a good mix of Lambeth and Southwark representatives and professions and will review the ideal pathway, the current pathway, the major differences and the priorities for change, workforce, governance and IT and performance information. The first meeting was very positive and there were suggestions around rapid response, fast access to diagnostics, co-ordinated packages of care and types of interventions to support patients "tipping" into frailty. Measurable indicators must align with the key performance indicators and there is a need for strong clinical engagement. AB referred to the earlier discussion at SCCC regarding Virtual Wards and enquired about the timetable for these. MK stated that there is general support for the model and work is ongoing with the team. SK highlighted that the pilot will only be successful if the new pathway is commissioned. Any savings must be quickly realised and must tie into reality. The model for proactive health checks must be sold to each GP. IT information sharing is unattainable in governance terms and there is also incompatibility between GP and hospital systems. FO stated that were lots of good ideas at the first meting of the CDG but these must be coupled with reality checks. There is also commissioning membership of the group providing commissioning input. Feedback will be provided to GPs and a report on progress will be made back to the SCCC in late summer. JL agreed that information governance is an issue and a structured process is required. There are a number of products available but these can be quite pricey. SK stated that GPs entering information onto other systems is very labour intensive and JL stated that he is mindful of other people's time. However, it is important that the plan for long term conditions is in place by the next financial year and this must align with the QIPP and the strategic objectives. **The SCCC noted the update on the Integrated care Pilot across Lambeth and Southwark. A further report will be presented to the CCC in August**.
9	**QIPP Delivery group** **The CCC noted the minutes of the meeting on 19th May 2011.**
10	**Any other Business** AB requested feedback to himself and RW on arrangements and level of detail that should be provided in the supporting reports for the next meeting.

ENCLOSURE 20

	ACTION ALL The CCC complimented BSU members on the quality and structure of reports presented to the meeting. In response to a question from SF, AB stated that CQUINs are monitored by NHS SE London cluster and suggested that there should be full reports at the QIPP delivery group. Community contracts should also be included and AZ suggested that there is further discussion at the Operational meeting **ACTION AZ/AB** MA stated that the CCC should have more input into the QOF. AB replied that Jean Young, BSU Senior Primary Care and Community Commissioner is carrying out some work and suggested that MA/AZ meet with JY to ensure the deadline is met. **ACTION AB/AZ/MA** SK emphasised that it is important to avoid developing second tier pathways and the opportunity should be used to reinforce the work already in place. He also highlighted the need to reduce the size of the commissioning groups. AZ stated that a pan Southwark approach as one commissioning group. Further details to be reported for CCC **ACTION TH/JY** JC reported her attendance at the Safeguarding Board
11	**Date of next meeting 7 July 2011, Tooley Street Room GO2C**

NHS

South East London

A meeting of the SEL PCT Boards* and Bexley Care Trust 21 July 2011

ENCLOSURE 21, 22 & 23

NHS SEL COMMITTEES HIGHLIGHT REPORT AND DRAFT MINUTES

DIRECTOR RESPONSIBLE: Gill Galliano, Director of Development

AUTHOR: Ben Vinter, Integrated Governance Manager,

TO BE CONSIDERED BY: All

SUMMARY:
The Joint Boards are asked to consider:

a) The highlight reports of each of the first meetings of the Joint Boards' Committees
b) The draft and unapproved minutes of each of the Joint Committees

The first meeting of Joint Committees of the Boards took place as follows;

- The Joint Audit Committees met on 6th June 2011
- The Joint Performance, Finance and QIPP Committees met on 30th June 2011
- The Joint Quality and Safety Committees met on 30th June 2011

KEY ISSUES:
The key issues as considered by each of the Boards' Joint Committees are set out within the enclosed highlight report prepared on behalf of each Chair.

INVOLVEMENT: As stated

RECOMMENDATIONS:
The Boards are asked to:-
1. NOTE the highlight reports
2. NOTE receipt of the unconfirmed minutes of each

DIRECTORS CONTACT:
Name: Gill Galliano
E-Mail: g.galliano@nhs.net
Telephone: 020 7206 3332

AUTHOR CONTACT:
Name: Ben Vinter
E-Mail: ben.vinter@nhs.net
Telephone: 0203 049 4421

NHS

South East London

A meeting of the SEL PCT Boards* and Bexley Care Trust
21 July 2011

NAME OF COMMITTEE: Joint Audit Committees

DATE OF COMMITTEE: 6 June 2011

PRINCIPLE FOCUS: Approval of Annual Accounts, Statements on Internal Control, and Annual Reports for each of the NHS SEL PCTs and Care Trust.

ISSUES ARISING:

The Joint Audit Committees considered the following information for each of the NHS SEL PCTs and Care Trusts:

1. Minutes of last PCT Audit Committee;
2. Internal Audit Briefing / Head of Internal Audit Opinion;
3. Board Assurance Framework / Self Assessment of Assurance Arrangements;
4. Top risks identified and carried forward;
5. Statement on Internal Control;
6. Annual Accounts;
7. Annual Report; and
8. External Auditor's Report.

RECOMMENDATIONS MADE:

Subject to a number of requested clarifications, amendments and / or wording changes the Committees:

- Noted receipt of draft Statements on Internal Control and recommended their signing to the NHS SEL CEO;
- Noted and recommended adoption of the draft Annual Accounts of each PCT / Care Trust and signing by the CEO; and
- Considered each Annual Report and whether they were consistent with our understanding of each PCT's and Care Trust's activities and financial situation and recommended they be adopted by each PCT and Care Trust.

ENCLOSURE 21

The Committees further recommended that its future meeting's consider:

- A process for review of Internal Audit arrangements resulting in alignment of skills for best benefit to NHS SEL during the transition;
- Transitional Internal Audit Plan;
- Briefing on the implications of the Bribery Act ;
- Clarification of arrangements for how the Local Authorities will monitor Learning Disability contracts;
- Conclusions from outstanding Internal Audit Reviews / Reports;
- NHS SEL revised governance arrangements; and
- Approach to management of charitable funds within NHS SEL.

COMMITTEE CHAIR:
Name: Steven Corbishley

LEAD DIRECTOR:
Name: Gill Galliano
E-Mail: g.galliano@nhs.net
Telephone: 020 3049 3209

*SEL PCT Boards = Boards of Lambeth Primary Care Trust, Southwark Primary Care Trust, Lewisham Primary Care Trust, Bromley Primary Care Trust and Greenwich Teaching Primary Care Trust.

NHS
South East London

Joint Audit Committees
Draft Action Notes
6 June 2011, held at 1 Lower Marsh, London SE1

PRESENT:

Name	Job Title	Organisation
Steven Corbishley	Chairman	NHS SEL
Keith Wood	Non Executive Director	Bexley PCT
Harvey Guntrip	Non Executive Director	Bromley PCT
Graham Laylee	Non Executive Director	Lambeth PCT
Rona Nicholson	Non Executive Director	Lewisham PCT
Susan Free	Non Executive Director	Greenwich PCT
Robert Park	Non Executive Director	Southwark PCT

IN ATTENDANCE:

Name	Job Title	Organisation
Marie Farrell	Director of Finance	NHS SEL
Terry Blackman	Audit Manager (External Audit) Representing: Greenwich, Bexley, Lewisham	Audit Commission
Derek Corbett	Director of Audit (internal audit) Representing: Lambeth, Southwark, Greenwich	London Audit Consortium
Susan Exton	District Auditor (External Audit) Representing: Greenwich, Lewisham, Bexley	Audit Commission
Liz Flanders	Minutes (am)	NHS SEL
Wendy Gilfrin	Minutes (pm)	NHS SEL
Ben Vinter	Integrated Governance Manager	NHS SEL
BROMLEY PCT		
Janet Dawson	External Auditor	Price Waterhouse Cooper
Kathy Nelson	External Auditor	Price Waterhouse Cooper
Neil Thomas	Internal Auditor	KPMG
Jacqui Scott	Head of Finance	Bromley PCT
LAMBETH PCT		
Andrew Eyres	Managing Director	Lambeth PCT
Christine Caton	Chief Financial Officer	Lambeth PCT
Dilawar Mahboob	Assistant Director, Finance	Lambeth PCT
Nigel Johnson	Partner (External Audit)	Deloitte
Angus Fish	Audit Lead	Deloitte
SOUTHWARK PCT		
Malcolm Hines	Director of Resources	Southwark PCT
Bill Bryant	Financial Controller	Southwark PCT
Jayne Rhodes	External auditor	Audit Commission
Shahida Nasim	Engagement Lead	Audit Commission
GREENWICH PCT		
Mark Hughes	Assistant Director	London Audit Consortium
Graham Elvy	Director of Finance	Greenwich PCT
LEWISHAM PCT		
Gill Galliano	Chief Executive	Lewisham PCT
Geoff Price	Head of Finance	Lewisham PCT

Stephen Smith	Bromley / Lewisham Financial Controller	Lewisham PCT
BEXLEY PCT		
Theresa Osborne	Chief Financial Officer	Bexley CT
Julie Witherall	AD Finance Performance and Information	Bexley CT
Mark Kinsella	Audit lead	Chantry Vellacott
Jayne Rhodes	External Auditor	Audit Commission

MINUTES

Item no:	Topic / outcome	Action by
1	**INTRODUCTION** Steven Corbishley, Chairman, welcomed all to the meeting and explained the format of meeting as follows. This meeting will consider each of NHS SEL's PCT / Care Trust's Annual Accounts and Annual Reports and supporting assurance and evidence in the form of the following information: 1. Minutes of last PCT Audit Committee 2. Internal Audit Briefing / Head of Internal Audit Opinion 3. Board Assurance Framework / Self Assessment of Assurance Arrangements 4. Top risks identified (carried forward) 5. Statement on Internal Control (SIC) 6. Annual Accounts 7. Annual Report 8. External Auditor's Report The Committee will then make recommendations to Simon Robbins, Chief Executive of NHS South East London in his role as Accountable officer for each of the six PCTs, on the suitability of the SIC and accounts for 'sign off'.	
2	**APOLOGIES FOR ABSENCE** Apologies received from: • Jeremy Fraser, Non Executive Director – Greenwich • Sarah Gardner, Deputy Director Integrated Governance – NHS SEL	Committee secretary

3	**INFORMAL MEETING HELD ON 19 APRIL 2011** The committee noted that it had met informally, at a briefing session, notes of the briefing session were shared amongst members who noted: • Jeremy Fraser was present representing Greenwich; • Toyin Akinyemi attended representing Greenwich PCT; • The committee noted that Marie Farrell (MF) had commented that there were some differences in accounting policies of each of the PCTs but there would be a process towards aligning these and the audit process to simplify arrangements in future years. **MATTERS ARISING NOT LISTED ELSEWHERE ON THE AGENDA** The committee heard that Internal Audit contracts remained in place across 4 Trusts within NHS SEL with contracts having expired and therefore subject to review in 2 other areas. The committee proposed that its preferred way forward, recognising current contractual commitments, would be for MF to devise a process for review of existing arrangements and skills and their alignment for best benefit to NHS SEL during the transition. This would include appointing a Head of Internal Audit to co-ordinate all audit effort across NHS SEL. The committee requested that MF develop a transitional internal audit arrangement making best use of the skills and relationships with existing providers, but give notice to existing providers to secure best arrangements for the future. The Committee would wish to see a draft Internal Audit Plan at its next formal meeting.	Committee Secretary Marie Farrell Marie Farrell Marie Farrell Gill Galliano
4	**AUDIT COMMITTEE TERMS OF REFERENCE** The committee noted the terms of reference adopted by the Board and recognised they would be kept under regular review.	
	BROMLEY PCT **<u>Review the Minutes of Audit Committee 8 February 2011</u>** <u>Patient Referral Centre</u> Completed to timescale and revised protocols have been put in place. <u>Bribery Act</u> The implementation date had been postponed by the Government to allow further consultation with interested parties. The implementation of this Act within NHS SEL will be reviewed at the next formal meeting of this Committee.	Marie Farrell

	Assurance Framework Budgets for provision of Learning Difficulties services had transferred to the Local Authority as of 1 April 2011. Clarification of monitoring arrangements in respect of quality of the re-provided services was raised with a potential risk exposure for all 6 organisations. The Committee suggested this issue should be discussed at a future Committee meeting. Internal Audit Progress Report The Committee heard that the information governance self assessment had now been completed however the PCT's performance was likely to be considered "unsatisfactory" at the year end, with the only other level of achievement being "satisfactory". The committee heard that the 'unsatisfactory' status had arisen because the parameters by which the IG toolkit had to be completed had changed and required documentary evidence. Whilst PCT may be conforming documented evidence was not available at this point The committee was reminded that information sharing arrangements had now been put in place across NHS SEL **Internal Audit Briefing / Head of Internal Audit Opinion** A 'Significant' assurance judgement was provided. The committee heard that there are no outstanding Internal recommendations to take forward. The Committee NOTED the briefing and opinion provided to it. **Top risks** 1. Potential acute over performance; in particular at SLHT which currently has a block contract in place owing to quality of performance data 2. Transfer of non-cash 11/12 funding for ophthalmic services 3. Learning Disabilities Service arrangements and LA contingency arrangements 4. Quality of services at SLHT Emerging risks for 2011/12 related to the transition and QIPP. The committee received assurances relating to contracts held by SEL Trusts through, for example, regular review of SLHT performance and data quality outputs. Harvey Guntrip noted the need for and existence of GP ownership in delivery of QIPP. Susan Free observed that the issues detailed relating to SLHT would be common for Bexley and Greenwich as well as Bromley. The committee NOTED receipt of the PCT's self assessment of its assurance framework.	Committee Secretary

	Statement on Internal Control Based on the evidence above, and the Committee's review of information submitted to support the SIC and its discussion, there were no key areas to highlight. The Committee NOTED the submitted statement. **Based on the evidence presented to it, the Committee recommends sign-off by Simon Robbins, NHS SEL CEO, of the SIC.** **Annual Accounts** Further to the review of earlier version, the committee heard that Public Health figures had been adjusted to provide consistency and some minor changes to disclosure notes had been made. No further changes were made to the accounts. **The Committee NOTED the submitted information and RECOMMENDED their adoption by the AO.** **Annual Report** The committee heard that the disclosure to summary financials was to be updated. **Based on the evidence presented the Committee recommends sign-off by Simon Robbins.** The Chair thanked Bromley PCT, and in particular Jacqui, for their work in completing the accounts. **External Auditor's Report** The committee heard that the document was felt to provide a useful conclusion to the work of the PCT. A number of areas were highlighted to the committee which included comments on claims audit, valuation of assets, and further work required on how the PCT indexed its values. It is anticipated that a clean, unqualified audit and use of resources opinion will be provided. The transfer of community services took place on 1 April. Some adjustments in terms of disclosure are expected to demonstrate a post balance sheet event. The committee considered and satisfied itself with how redundancy payments had been declared. The letter of representation covered estates valuation, leasing arrangements and impairments. No adjusted or unadjusted errors were found to be above the agreed reporting threshold. The committee NOTED receipt of the report.	

6	**LAMBETH PCT ACCOUNTS & AUDIT REPORT** **Review the Minutes of Audit committee 25 March 2011** Report on Smart Card usage A report on smart card usage was to be presented to the committee. This is not yet available for circulation. Counter Fraud All outstanding counter fraud cases relating to Lambeth community services transferred to GSTT on 1st April 2011. The GSTT Counter Fraud Team have been briefed accordingly. Internal Audit of QOF payments This activity remains ongoing. SEL Sector Prescription Compliance The committee noted this as a generic issue across the sector. MF was requested to compile a status report on this issue. Charitable Funds Update The committee identified this issue as one requiring a common cluster approach. The committee requested MF collate information and present to the next meeting of the committee with a view as to the governance arrangements over these funds. **Internal Audit Briefing / Head of Internal Audit Opinion** A 'Significant' assurance rating was provided. The Board Assurance Framework met Department of Health requirements and was given 'A' Status. A review on Podiatry equipment undertaken highlighted that there was no documented procedures in place resulting in the introduction of an action plan. The committee determined that it should be possible, going forward, to secure third party assurance relating to the transfer of community services to GSTT. The outcomes from the Electronic Staff Records review have not yet been finalised and documented and will be reported to a future meeting. The pension scheme arrangements met requirements. The provided list of outstanding audits recommendations was noted as draft meaning an assurance rating could not be assigned at that time. The committee sought to understand why reviews and their recommendations remained outstanding and were advised that the internal audit year extends into May in some PCTs – the issues will be revisited. The committee heard from Graham Laylee that Lambeth had a strong history of seeing through and actioning IA recommendations. The Committee NOTED the briefing and opinion provided to it. **Key Risks** 1. Acute overspend – decommissioning, system sustainability	Christine Caton David Sturgeon Marie Farrell Christine Caton / Derek Corbett Christine Caton / Derek Corbett

	and prescribing contingency plans developed and agreed 2. Impact of organisational change 3. Key QIPP delivery risks include breast feeding, immunisations, smoking cessation, challenging Primary care efficiency targets. 4. Embedding clinical leadership	
	The committee NOTED receipt of the PCTs self assessment of its assurance framework.	Marie Farrell
	<u>Statement on Internal Control</u> The Chair commended Lambeth for the approach, structure and style of its SIC and recommended its use as the standard framework for all six organisations going forward.	Christine Caton
	The committee requested that a common amendment be made to the SIC statement of all six organisations statement's which related to the last paragraph of each statement being removed; "*with the exception of the internal control issues outlined in this agreement*…"	
	The Committee NOTED the submitted statement.	
	Based on the evidence presented, the Committee recommends sign-off of the SIC by Simon Robbins.	
	<u>Annual Accounts</u> The committee received an updated version of the accounts and heard that since the informal briefing in April the stated surplus had increased to £6.251m. No other changes to overall position had been made.	
	A number of areas were highlighted which included disclosure of the provider arm's transfer and approach to provider cost recovery duty. The assets of community services are retained by the PCT. The transaction was detailed through a post balance sheet event on pages 37 and 43. The committee heard how the handling of payments, including invoices, across the Cluster is hosted by Lambeth meaning the transition had an impact upon the ability to process invoices according to target which is being taken forward through training and publication of standards.	Christine Caton
	Page 65 of the accounts (PEC members) will be checked for accuracy.	
	The committee heard that the PCT / BSU plans to make an application for use of the 2% non recurrent funding / reserves in order to facilitate achievement of QIPP. MF advised those present that strict NHSL criteria existed in this area and that funds had been top sliced. Any bids not meeting the criteria were unlikely to be approved by NHSL.	
	The Committee NOTED the submitted information and RECOMMENDED their adoption. .	

	Annual Report It was highlighted that the report was written with statutory requirements in mind only. The public engagement that would usually accompany such publication would be taken forward separately. **Based on the evidence presented the Committee recommends sign-off by Simon Robbins** **External Audit Report** Upon consideration of a number of outstanding external audit recommendations the committee was informed that many had already been addressed and included within the accounts before the committee. Minor corrections to be made. It is anticipated that a clean audit opinion will be provided. Following questioning from the Chair the committee heard how the recorded unadjusted errors had fallen below the threshold for reporting. In considering the Letter of Representation the committee were advised that no non standard representations had been included. The committee requested that a statement (page 12) – point 16 *'no claims in connection with litigation have been or are expected to be received'* be amended to reflect the greater level of certainty regarding claims and potential litigation not being expected. The committee NOTED receipt of the report The Chair thanked Lambeth.	Nigel Johnson / Angus Fish Nigel Johnson / Christine Caton
7	**SOUTHWARK PCT ACCOUNTS & AUDIT REPORT** **Review the Minutes of Audit committee 19 January 2011** Governance in Partnership Review The committee stated its expectation that it consider the findings of this review when available. The committee heard that all audit action plans detailed have been taken forward. **Internal Audit Briefing / Head of Internal Audit Opinion** A 'Significant' assurance rating has been provided. The IA work plan runs to the end May Board Assurance Framework has been measured against NHS best practice guidelines and was judged to be sufficient. IA had determined that third party assurance existed for (SBS) payments with the committee being satisfied that this was the case.	Malcolm Hines

	Assurance has not yet been received in respect of Electronic Staff Records and will be reported to a future meeting A review of the NHS pension scheme arrangements had provided satisfactory assurance. In respect of outstanding internal audit recommendations the Committee heard that Southwark undertakes a quarterly review to ensure all issues are actioned and closed off. At the committee's request a stocktake of all outstanding internal audit issues across NHS SEL will be presented to this committee in order to ensure that all recommendations are completed and closed. The committee heard from Robert Park that the presented position represented progress. **Key Risks** 1. Delivering QIPP programme. Need to deliver circa £20m of efficiencies. 2. Overall financial position. Began the year with an agreed but low level of reserves of £1.3m 3. Transitional changes/partnership arrangements New risks were identified as; the transfer of Learning Difficulty funding to the Local Authority; transitional changes and changes in the Health Bill resulting in uncertain end point, as well as new service demands and reduced resources. The committee explored Southwark's budgetary situation, reserves and contingencies in more depth and understood that £5/6m of general contingencies and £2m of acute reserves were in place. The PCT expects to see a return of previously transferred health funding return from the local authority. The committee were informed that Southwark found itself with a particularly challenging financial situation as a result of below target funding allocations. Following the committee's reflection on the relative arguments in respect of funding allocations and scaling of QIPP challenges they heard from MF that a clear and unambiguous process for application of use of reserves and 2% contingencies were in place and would be commonly applied across NHS SEL. The committee NOTED receipt of the PCTs self assessment of its assurance framework. **Statement on Internal Control** The committee noted strong governance procedures with monthly local finance, risk and board assurance reporting. Rona Nicholson (RN) sought and received assurance from the Audit Commission that the identified issue of response to recommendations represented a reporting timing issue only.	Malcolm Hines / Una Dalton Malcolm Hines Marie Farrell

	The committee requested that a common amendment be made to the SIC statement of all six organisations statement's which related to the last paragraph of each statement being removed; "*with the exception of the internal control issues outlined in this agreement*…"	Malcolm Hines
	RN noted the need to cross reference information, positions and statements made in the SIC with those in other PCT documents	Malcolm Hines
	The Committee NOTED the submitted statement **Based on the evidence presented the Committee recommends sign-off by Simon Robbins**	
	<u>Annual Accounts</u> The committee heard how changes had been made to the draft accounts following the April meeting these including a summary of the changes was provided. The target surplus for the year was achieved. Capital budgets have not been allocated in common with all of NHS SEL. The committee heard that any identified capital programmes require presentation of a business case to NHSL and their support following withdrawal of delegated capital limits. Community Services were confirmed as having been transferred to GSTT with budgets however efficiency savings obtained from operating budgets in year were retained by the PCT. The committee were advised that draft accounts clearly highlight where adjustments have been made. The committee sought and received assurances as to the process undertaken with respect of the valuation of the vacant Dulwich site. Revaluation of the site had been requested prior to the establishment of NHS SEL. The future of the site is currently under discussion. A decision should be reached within the next 2/3 months and is being actively considered by the Southwark LCCC. There is potential for part of the site to be used for provision of GP services with the remainder potentially of value for provision of other health associated services. The stated accounts error (Dulwich site) related to difficulty in the accurate interpretation of the valuation (provided by a 3rd party) resulting in revised valuation of £1m (£17m) less arising from different valuations being applied to different parts of the site owing to its varied classifications and current use. The committee were advised that a reversed impairment disclosure had been applied as detailed in notes 12 and 14. The external auditors confirmed that they were content with the disclosure and use of notes as advised. **The Committee NOTED the submitted information and RECOMMENDED their adoption.**	

	Annual Report The report was considered as set out. **Based on the evidence presented the Committee recommends sign-off by Simon Robbins** **Annual Governance Report from External Audit** No significant internal control assurances weaknesses were brought to the attention of the committee. With relation to redundancies the circulated submission had not been completed, aim to finish on the day of the meeting (6 June 2011). The auditors confirmed that they do not anticipate encountering any major issue. There are a number of changes to the accounts required as stated in the Addendum. One error relates to an unadjusted error in the financial statements; a miss-posting of an accrual between NHS/Non-NHS. The committee sought and received assurance that there was no fraud risk. The committee AGREED that the word 'accrual' must be included in the wording of the stated corrections in order to avoid any misunderstanding. Further details of the incident that resulted in the unadjusted error would be supplied to MF. In respect of the letter of representation no significant issues were identified however an error was detailed which appeared based upon an extrapolation from a small sample. MF requested a classification be added to the stated error which related to manual adjustments of non NHS journal codes. The committee was advised that receipt of an unqualified audit opinion and Use of Resources judgment could be expected shortly The committee NOTED receipt of the report. The Chair thanked Southwark.	Malcolm Hines / Jayne Rhodes Malcolm Hines Malcolm Hines / Jayne Rhodes
8	**GREENWICH PCT ACCOUNTS & AUDIT REPORT** **Review the Minutes of Audit committee 31 March 2011** Internal Audit – Limited assurance with Payroll The committee reviewed one area of limited assurance impacting upon payroll. The PCT outsources its payroll to a shared service which also provides services to Lambeth, Southwark and Lewisham PCTs. The audit had identified some concerns around access controls as there were found to be two Members of staff who had wide access to a number of other PCT payrolls. The committee was advised that management had agreed to changes recommended by audit.	

	The Director of Finance proposed, and the Committee agreed, that internal audit should undertake a further short review of payroll to check that management have since taken the steps agreed to resolve the issues raised by internal audit and whether the same issue impacted on other PCTs.	Derek Corbett
	Internal Audit Briefing / Head of Internal Audit Opinion The committee heard that the PCT was to be provided with a significant assurance status. The Board Assurance Framework has been judged to be fit for purpose and compliant while a number of areas of the report were noted as due to be updated. No third party assurance had been obtained for payments and data on Electronic Staff Records management were not yet available. The committee was informed of no other significant disclosure items had been identified.	
	In response to enquiries by the committee it was confirmed Greenwich payments service is provided by Oxleas and payroll services via Lambeth. Different versions of the PCTs reports states that payroll has differing levels of assurance. The committee noted that this needs to be cross reference and rectified.	Derek Corbett / Graham Elvy
	Following questioning the committee understood that not all 6 organisations within the Cluster are using the same financial ledger system. Four are using Shared Business Services (SBS), system with 2 using Oxleas but that progress was being made toward moving all to this single operating system. The committee noted its expectation that an update report to come back to this committee based upon the understanding that the introduction of such a system will resolve any payment issues identified by IA and as a result felt it had received assurance that appropriate management action is being taken forward in this area to resolve the identified issues (limited separation of responsibilities and absence of authorised signatory lists).	Marie Farrell
	Keith Wood (KW) noted, in respect of Oxleas payment service, that Bexley had received third party assurance on the services provided. The committee proposed that Greenwich's auditors be in touch with Bexley's to develop a common position.	Derek Corbett / Graham Elvey
	The Chair stated his appreciation of the form of presentation used for presentation of internal audit recommendations and proposed its adoption going forward.	Marie Farrell
	In respect of charitable funds the Chair requested MF establish what funds exist, how they are managed and used across NHS SEL. The committee heard that Greenwich had arrangements in place to undertake audit on the funds it managed which included Bromley and Bexley.	Marie Farrell / Graham Elvy

	Key Risks The committee noted the Board Assurance Framework and heard that the top identified risks in Greenwich included; 1 Safeguarding children; no designated doctor is in place but contingency plans have been developed which include plans to utilise GPs with special interest and proposals developed with SLHT to cross appoint a clinical lead. 2 Organisational Change 3 QIPP; Block Contract with South London Healthcare Trust No Greenwich specific risks have been identified for 2011/12. The committee NOTED receipt of the PCT's self assessment of its assurance framework. **Statement on Internal Control** This has been fully commented on by External Audit. The committee requested that paragraph 2 be moved to the end for consistency and therefore that the final paragraph be deleted and replaced with paragraph 2. In common with the review of each SIC the committee requested a common amendment be made to removing; "*with the exception of the internal control issues outlined in this agreement*…" The Committee NOTED the submitted statement. **Based on the evidence presented the Committee recommends sign-off by Simon Robbins** **Annual Accounts** The committee were informed of a number of changes from earlier drafts including; a post balance sheet note relating to the transfer of community services has been included. In addition a change in miscellaneous income related to GP Practice had resulted in a £3m uplift relating to overpayment of rent. Following discussions with external audit it was felt that anticipated income from the GP Practice should be accounted for as income and provided for as this would ensure that the issue was actively managed and revisited and was in line with the expectations arising from investigations to date. The committee was informed that a matching entry had therefore been made in the bad debt disclosure. The Chair stated the committee's desire to receive a status report on this issue at the next Audit Committee meeting. Following the meeting the committee heard that the stated salary figures for 2010/11 would be updated and the list of Associate Board Members will be checked for accuracy.	Graham Elvy Graham Elvy Marie Farrell/ Graham Elvy

	The Committee NOTED the submitted information and RECOMMENDED their adoption. **<u>Annual Report</u>** The report was considered as set out. **Based on the evidence presented the Committee recommends sign-off by Simon Robbins** **<u>Annual Governance Report from External Audit</u>** There committee heard that a number of issues remain to be resolved however all are in hand to be completed within the specified timescales. Following questions it was explained that delays in the production of the accounts were in the main judged to have resulted from technical difficulties which had now been identified and resolved rather than being related capacity issues. Balance sheet movements had resulted in the errors detailed within the report. In respect of comments made relating to resilience, savings plans and PbR assurance at SLHT the committee requested amendments to the working in page 9 (financial statements, recommendation 9) to include *'to continue to…'* after 'The PCT should ……'. In recognition of the previous and on-going work explained to the committee being taken forward to provide improved PbR data assurance in respect of SLHT and therefore to allow for cost and volume rather than block contracting in addition to the focus on improved data quality overall. Appendix 2 detailed amendments to the draft financial statements. Two action points remain outstanding and require follow thorough and resolution with management. The committee will be advised when these have been resolved. The committee NOTED receipt of the report The committee thanked Greenwich and extended a special thanks to Graham Elvy.	Graham Elvy / Susan Exton Graham Elvy / Susan Exton
9	**LEWISHAM PCT ACCOUNTS & AUDIT REPORT** The committee were advised that all outstanding actions from the last Audit Committee meeting were completed. Lewisham appealed to NHS CFSMS on their 2 rating but this was declined. The committee were referred to an area of limited assurance; Payroll relating to separation of duties. The Chair advised the Lewisham delegation that this issue had been raised at an earlier part of the meeting and was to be addressed.	Marie Farrell

	Internal Audit briefing / Head of Internal Audit Opinion Areas highlighted for the committee included an issue of concern re the IG toolkit BAF was given reasonable assurance in implementing a local approach going forward at LCCC level the auditors would like to see the controls strengthened. The Chair sought assurance on the arrangements in place to manage a NHS SEL approach to information governance and was advised by MF that her directorate had responsibility for management of the issue. A common information sharing protocol was in place and works in progress on standardising policies and procedures. MF is the SIRO for NHS SEL & has commissioned a review of the Information Governance arrangements The committee NOTED the update and reiterated its desire that a comprehensive update of the outstanding IA recommendations be brought to a future meeting. **Key Risks** Gill Galliano (GG) briefed the committee and advised that the majority of issues contained on the BAF had been closed, brought forward to the NHS SEL JBAF or were being managed locally. Key outstanding issues related to management of the year end process and managing the transition. On-going risks related to the requirement to achieve financial balance while realising efficiency and improvement programmes. Retaining staff and capacity during the transition and not losing staff in key positions with specialist knowledge. PMS contracting represented an area of significant potential conflicts of interests with the development of GP Commissioning Going forward key areas of consideration included: levels of acute spend particularly when coupled with the requirement to deliver stretching QIPP targets. Delivery of a prescribing savings plan remains imperative and has been based upon GP engagement Risks emerging in year to date include; Significant QIPP savings in other areas i.e. Mental Health provision and Community Services. Such challenges arise at a time when no additional general reserves exist except the required contingency of 0.5% which gives Lewisham less flexibility The committee NOTED receipt of the PCT's self assessment of its assurance framework. **Statement on Internal Control** The committee was briefed upon the significant activities from the previous year which included the transfer of community services and supporting GP development.	Marie Farrell

	The committee were referred to the entry related to the IG toolkit and action plan and the fact that only 26% of staff have completed their mandatory Governance training at Lewisham despite efforts to ensure more staff completed the training.	Gill Galliano
	The committee's attention was further drawn to successes arising from work on Equality & Diversity lessons from which should be brought forward to the developing NHS SEL approach.	Gill Galliano / Geoff Price
	In common with the review of each SIC the committee requested a common amendment be made to removing; "*with the exception of the internal control issues outlined in this agreement*…" The Committee NOTED the submitted statement. **Based on the evidence presented the Committee recommends sign-off by Simon Robbins**	
	<u>Annual Accounts</u> The key changes since the briefing in April were highlighted to the committee as; • Restatement of comparatives regarding Community Health services transfer to Lewisham Hospital. – left both sets of figures in • Grossing up of prescription charges income which happened late in 10/11as requested by the SHA. This does not effect the bottom line	Geoff Price
	There was a query on p31 regarding the Auditor's fees which looked too high in comparison to the previous year. Geoff Price to recheck figures & report on the difference. *(Figures have subsequently been amended prior to submission)* **The Committee NOTED the submitted information and RECOMMENDED their adoption**	
	<u>Annual Report</u> GG confirmed that the information before the committee represented a fair representation of business and successes of Lewisham PCT. The Chair queried why Director of Public Health remuneration was lower than the previous year which was explained to be due to moving and relocations costs being included in the previous year's remuneration costs.	
	MF queried the CETV (Cash Equivalent Transfer Values) contained in the Pensions Table which were lower than the previous year. The reason was due to uprating changes (from RPI to CPI) made in a previous budget. The Chair requested that disclosures about the membership and	Geoff Price

	tenure of the remuneration committee be re-considered given changes in chair during the year. **Based on the evidence presented the Committee recommends sign-off by Simon Robbins** **<u>Annual Governance Report</u>** The auditors confirmed that the audit is complete subject to the final review and they will expect to issue an unqualified opinion and conclusion subject to the Audit Committee signing off. The committee heard that points of note related to; the sale of Wardalls Grove – where it would have been preferential to have undertaken an up to date valuation before sale. However the committee heard that given the economic climate the property was sold for Market Value. All the DH requirements were met but attention was drawn to this for future disposals. The draft letter of representation was reviewed and the Committee agreed they would recommend to the NHS SEL CEO. The committee NOTED receipt of the report	
10	**BEXLEY PCT ACCOUNTS & AUDIT REPORT** The Committee heard that all outstanding minutes from the last PCT Audit Committee meeting were completed **<u>Internal Audit briefing / Head of Internal Audit Opinion</u>** The committee heard that t the HOIA provided significant assurance and was based upon a work programme which, in its last year, had focussed upon targeted areas that may not have received close scrutiny recently. 64 recommendations were made in the year and these were challenged if not felt appropriate. The committee heard that there had always been good 'buy in' and completion rates for IA recommendations within Bexley In respect of the work undertaken on the IG toolkit submission; a process has been put in place since the review's completion in March and the auditors were satisfied that the evidence requested had been submitted by the due date. MF sought clarification of the areas given 'high' rated recommendations; Adult's and Children's Safeguarding and was advised that a high rating had been recommend as they had tight timescales for turnaround and implementation given the potential severity of the subject matter. **Ensure outstanding recommendations are tracked and notification of completion brought back to the audit committee.**	Theresa Osborne/ Marie Farrell

	Top Risk and BAF The committee was informed that the BAF had been regularly reviewed by the Audit Committee. The top risk facing Bexley Care Trust at this time were felt to mirror those issues raised in the HIAO. The committee NOTED receipt of the PCT's self assessment of its assurance framework. **Statement on Internal Control** No major changes made had been made since prior informal discussions. Clarifications and points of accuracy have been taken forward In common with the review of each SIC the committee requested a common amendment be made to removing; "*with the exception of the internal control issues outlined in this agreement*…" **Based on the evidence presented the Committee recommends sign-off by Simon Robbins.** **Annual Accounts** The Committee considered the accounts and were advised; • The surplus has changed from draft set presented at the meeting in April as have presentation of running costs • Restatement of comparative expenditure regarding Community Health services transfer • Public Health costs for block contract as requested by SHA have had to be estimated as the provider were unable to provide a breakdown when requested. • Prescription charges (gross) have been included as requested by SHA Bexley was noted to have 2 outstanding validation errors. Bexley have not restated every note but have agreed with their auditors to restate Notes 4, 5.1,5.2 7.1 and community services operating segments. The Committee requested a letter is sent to the provider (Oxleas) to request the costs for services as required for the annual accounts be provided in line with statutory purposes. The Committee extended their thanks to Theresa Osborne and Julie Witherall for their contribution. The Committee NOTED the submitted information and RECOMMENDED their adoption **Annual Report** Following development of the annual report it was recommended that acronyms were reverted to their full versions,	Theresa Osborne Theresa Osborne / Marie Farrell

	some grammar was to be amended and dates to be changed as some were showing 09/10 not 10/11. The stated total expenditure on page 31 also needs to be updated. The committee further noted that the stated pensions details contained within the report needed to be reviewed and updated. KW wished to echo the committees thanks to Bexley Finance team and the Auditors **Based on the evidence presented the Committee recommends sign-off by Simon Robbins** **<u>Annual Governance Report</u>** The auditors confirmed that the audit work programme has been completed subject to a final review and they expect to issue an unqualified opinion and Use of resources conclusion subject to the Audit Committee signing off. The key points of the AGR were explained as including no significant validation errors, the introduction of the new arrangements were initially considered to represent a risk but this had proved not to be the case, the transfer of the provider arm had been completed. Page 13 of the report should say should "*continue* to work…." And will be amended The draft letter of representation was also reviewed. The committee NOTED receipt of the report	Theresa Osborne Theresa Osborne
11	**ANY OTHER BUSINESS** **<u>Generic issues related to all 6 organisations.</u>** <u>Annual General Meetings</u> The committee noted that it is a legal requirement for the Annual Reports and Accounts to be presented to an AGM of each PCT and asked for clarification as to what AGM arrangements will be made for NHSSEL. **Governance team to clarify plans for AGMs across the NHS SEL.**	Oliver Lake
12	**DATE OF NEXT MEETING** Next meeting to be in September. **Governance to review Corporate Calendar and provide dates of future Committees.**	Clerk

NHS

South East London

A meeting of the SEL PCT Boards* and Bexley Care Trust
21 July 2011

NAME OF COMMITTEE: Performance, Finance and QIPP

DATE OF COMMITTEE: 30th June 2011

PRINCIPLE FOCUS:

1. Establishment of this new committee and the forward plan and approach to be adopted.
2. Consideration of interface with work of quality and safety committee and how major providers could be considered 'as a whole' when necessary.
3. Review of month one performance and month two finance data and identification of initial areas of concern.

ISSUES ARISING:

1. Need to plan forward meetings to enable the output of the Executive quarterly 'stock takes' for each borough to be received by committee members in order for them to both receive assurance and to identify any cross cutting themes of concern. Need to ensure we get best possible fit of meeting dates with the financial reporting cycle. Need to build in time for an in depth exploration of issue of major concern if required and to ensure we are pro-actively sharing learning across boroughs where possible.
2. Caroline Hewett to review approach to be taken when major providers needed to be considered 'as a whole' bringing together issues around quality, performance and finance.
3. Concern expressed at poor performance on A and E [SLHT] and 18 weeks [SLHT and GSTT]. Current Cluster approach to mitigating this performance risk discussed.

RECOMMENDATIONS MADE:

No specific recommendations for the Board were made at this first meeting of the committee.

COMMITTEE CHAIR:

Name: Graham Laylee
E-Mail: graham@glaylee.com
Telephone: 07956 355284

LEAD DIRECTOR:

Name: Jane Schofield
E-Mail: JaneSchofield1@nhs.net
Telephone: 07951 123561

*SEL PCT Boards = Boards of Lambeth Primary Care Trust, Southwark Primary Care Trust, Lewisham Primary Care Trust, Bromley Primary Care Trust and Greenwich Teaching Primary Care Trust.

NHS
South East London

JOINT PERFORMANCE, FINANCE & QIPP COMMITTEE

A meeting of the Joint Performance, Finance & QIPP Committee was held on 30 June 2011, 1.30-3.30pm at 1 Lower Marsh, London SE1 7NT

DRAFT MINUTES

PRESENT:

Name	Job Title
Graham Laylee	Chair & Non-Executive Director
John Davey	Non-Executive Director
Marie Farrell	Director of Finance & Information
Jeremy Fraser	Non-Executive Director
Richard Gibbs	Non-Executive Director
Jim Gunner	Non-Executive Director
Caroline Hewitt	Chair
Tony Read	Director of Strategy & QIPP
Jane Schofield	Director of Operations

IN ATTENDANCE:

Name	Job Title	Organisation
Sean Morgan	Director of Performance	NHS SEL
Jane Walker	Head of Corporate Office/Board Secretary	NHS SEL

Item no:	Topic / outcome	Action by
1.	**Welcome & Introductions** Graham Laylee welcomed members to the first meeting of the Joint Performance, Finance & QIPP Committee and stated that there was a wide range of expertise and experience represented at the meeting that benefited having one meeting across the 6 boroughs.	
2.	**Apologies for Absence** Apologies had been received from Keith Wood and Rona Nicholson, Non-Executive Directors.	
3.	**Terms of Reference** Jane Schofield introduced the Terms of Reference for the Joint Performance Finance and QIPP Committee. Jane Schofield confirmed these had previously been agreed at the May meeting of the NHS SEL Joint PCT/Care Trust Boards. Jane Schofield asked the Committee to formally adopt the Terms of Reference in taking forward the Joint Performance, Finance and QIPP Committee. **<u>Recommendation</u>** **The Committee formally adopted the Terms of Reference noting that future meetings may be held via conference call rather than meeting in person.**	

Item no:	Topic / outcome	Action by
	<u>Capital Investment and Estates Compliance Group (CIECG) – Terms of Reference</u> Marie Farrell, tabled draft Terms of Reference for a CIECG asking the Joint Performance Finance and QIPP committee to consider and agree. Marie Farrell stated that the role of the CIECG would be to oversee the development, co-ordination and implementation of all PCT estates and ICT matters. This would include estates and ICT strategy development, information governance, approval of all capital business cases and the prioritisation of the use of available capital funds. The CIECG would be accountable to the Joint Performance, Finance and QIPP Committee, which is itself a sub-committee of the PCT Boards. The Committee discussed the proposed membership and felt that due to the potentially difficult issues and decisions to be made especially around capital funds, it would be important to have Non-Executive Director (NED) representation from across the 6 boroughs. Jim Gunner agreed to Chair the CIECG with Jeremy Fraser agreeing to deputise. **<u>Recommendation</u>** **It was agreed to revise the Terms of Reference taking into account the areas discussed and to review the membership to include NED Borough representatives as well as a NED Chair.** **The Committee agreed that Jim Gunner act as Chair, with Jeremy Fraser deputising.**	Marie Farrell
3.	**<u>Establishing the Committee</u>** Jane Schofield introduce a paper which described the framework and proposed that members of the Joint Performance, Finance and QIPP committee received regular assurances that the framework was being actively implemented, that key risks were being identified and that corrective and recovery action was being taken when indicated. It was also proposed that each committee meeting received and considered an overview report of the latest Finance and Performance position enabling members to be kept appraised of the most up to date position across these key items. Jane Schofield also stated that the committee would review any issues that arose from the Quarterly Borough Stocktake meetings. Graham Laylee felt it was important to see monthly finance	

Item no:	Topic / outcome	Action by
	reports via the Finance, Performance and QIPP committee and the NHS SEL Joint PCT/Care Trust Boards meeting linked to the Quarterly Borough Stocktake meetings. Marie Farrell raised concern with regards to the timetable of meetings ensuring that the most up-to-date finance information was available. It was therefore agreed to review the dates of the Joint Performance, Finance and QIPP committee, taking into account the finance timetable. Graham Laylee also confirmed that as Chair he would be meeting Marie Farrell on a monthly basis and would inform members of any areas of concern. It was agreed that there was benefit in working across the 6 boroughs, learning from each other. Jane Schofield agreed to circulate details of the agreed governance structures cross the 6 boroughs detailing who was responsible for what. It was agreed that discussions at the LCCC meetings relating to finance and performance must be consistent with the cluster/BSUs. **Recommendation** **The Joint Performance, Finance and QIPP Committee noted and endorsed the SE London Cluster's Performance Framework noting the comments raised.** **It was agreed to share good practice across the 6 boroughs, take forward workplans and review the timetable.**	Jane Schofield/ Marie Farrell via Graham Laylee
4.	**To receive and consider the latest Cluster wide Performance report** Sean Morgan introduced the first performance report for 2011/12. The performance report and performance dashboards cover the Headline and Supporting measures (as set out in the national 2011/12 Operating Framework), as well as he previous set of public health indicators which are retained for 2011/12. This suite of metrics replaces and builds on the Vital Signs indicators in use for the previous three years. The following areas where discussed: Acute performance – it was agreed there was a need to think about how this information was reported. Dashboard – need to agree which committees needed to receive this information. BSU reporting – it was agreed to try produce tailored reports for each of the 6 BSUs and include, where required, information	

Item no:	Topic / outcome	Action by
	relating to Darenth Valley and St Georges. It was agreed that there was a need to ensure that the information that both the Joint Performance, Finance and QIPP committee and the Quality and Safety committee was shared across the two in some way to ensure members had sight of all the information. Caroline Hewitt agreed to discuss this with Jane Schofield outside of the meeting including issues raised around SLHT. **<u>Recommendation</u>** **The Joint Performance, Finance and QIPP committee noted the report taking into account the comments and agreed actions above.** **Members agreed to feedback direct to Sean Morgan on the format of the report.**	Caroline Hewitt/ Jane Schofield All
5.	**<u>To receive and consider the latest Cluster wide Finance report</u>** Marie Farrell introduced the month 2 finance report based on month 1 acute data, which showed a breakeven position against plan. Marie Farrell asked members to note the limitations of forecasting year end positions at this early stage of the financial year and that the robustness of forecasts would improve as the year progressed. Marie Farrell asked member to comment, outside the meeting, on the format of the report and stated that a one page summary for each BSU with key issues would be produced in future. Marie Farrell also confirmed that the Cluster would be migrating to one ledger and a business case would be brought back to a future meeting. Members also noted the expenditure risks set out in the report, particularly in relation to QIPP delivery and activity growth and progress in delivering PCT cash management targets for 2011/12. It was agreed that Marie Farrell would provide an analysis for the next meeting showing the estimated running costs of the GP Consortia, National Commissioning Board and the Public Health Function (i.e. how we get from the current £60-65 per head to a proposed £15-25 per head. **<u>Recommendation</u>** **The committee noted the month 2 financial position.**	All Marie Farrell
6.	**<u>To receive and consider a report on the ongoing development of the Cluster QIPP plans</u>** Tony Read provided the committee with a verbal update on the	

Item no:	Topic / outcome	Action by
	development of the Cluster QIPP plans. Tony Read informed the committee that external planning guidance for refresh of QIPP plans had not yet been received. Stakeholder engagement would be picked up through the Stakeholder Reference Group. Tony Read stated there was room for improvement on some Cluster wider elements which pay provide more strength within the plans including: - London wide Mental Health care plans - Dementia - Cancer Services - Emergency Admissions/Consultant cover - Directory of Services/111 - London wide pathfinder modernisation workstream Tony Read informed the committee that the Clinical Strategy Group would be starting discussions with the 6 borough LCCC. Discussions would continue with BSU MDs regarding individual plans. **Recommendation** The committee noted the update on the development of the Clusters QIPP plans.	
7.	**Any Other Business** There was no other business to discuss.	
8.	**Dates of Future Meetings** To be discussed by Marie Farrell and Jane Schofield in liaison with Graham Laylee.	Jane Schofield/ Marie Farrell via Graham Laylee

NHS

South East London

A meeting of the SEL PCT Boards* and Bexley Care Trust
21 July 2011

ENCLOSURE 23

NAME OF COMMITTEE: Joint Quality and Safety Committees

DATE OF COMMTTEE: 30th June 2011

PRINCIPLE FOCUS:

- Establishment of Committee, agreement of Terms of Reference
- Quality Assurance Framework across main providers
- Quality Assurance and Performance Framework for General Practice
- Agreement of Serious Incident Reporting and Assurance process across SEL Cluster
- Business Continuity Planning – Assurance of arrangements across SEL Cluster

ISSUES ARISING:

The Joint Quality and Safety Committees considered the following:

1. Establishment of Committee, agreement of Terms of Reference
   Terms of Reference were discussed and agreed. Subject to the agreement by the Joint Boards to create a Corporate Equalities Sub Committee as this will mean that the work to implement the Equality Delivery System will report to the Board and should therefore be removed from this Committees remit.

2. Quality Assurance Framework across main providers
   Acute Provider framework was agreed. Further development of the Quality metrics will need to completed and be reported to subsequent committees. Further development of the quality assurance process for Community and Mental Health providers and non local providers is also required.

3. Quality Assurance and Performance Framework for General Practice
   An informative paper detailing current General Practice Quality Assurance and Performance Management position. Further links to Public Health and the tackling of inequalities, long term conditions and QOF achievement is required.

4. Serious Incident Reporting and Assurance process across SEL Cluster
   The process by which Serious Incidents are reported to the Cluster was agreed by the Committee. The assurance process with providers will require a further clarification through a time limited working group.

5. Business Continuity Planning
The action plan was discussed by the Committee with assurance given that the Cluster was in a fit state of readiness for any Major Incidence. Further work on the Action plan was required and would be reported back to the Committee.

RECOMMENDATIONS MADE:

- Noted and recommended adoption of the Terms of Reference for Committees
- Noted and recommended adoption of the Quality Assurance Framework for Acute Providers
- Recommended that further detailed work on the Quality indicators be reported to the next committee.
- Recommended that the Quality Assurance Framework for Community and Mental Health providers be included in the Quality Report for the Joint Boards in July 2011.
- Noted and recommended adoption of the reporting process for Serious Incidents across the Cluster, subject to the assurance process with providers being further clarified through short term working group. This agreed process will be reported to the next Committee together with a thematic over view of year to date Serious Incident reporting levels.
- Endorse recommendations made in GP Performance Report :
  a) Further Investigation of key areas of performance
  b) Primary Care Business Intelligence Unit creates a SEL Cluster performance tool
  c) Business case developed to improve timely and efficient reporting across all independent contractors
  d) Dissemination of quality and performance information with Local Clinical Commissioning Committees
- Noted and recommended adoption of the SEL Cluster Business Continuity Action Plan subject to final amendments.

COMMITTEE CHAIR:

Name: Susan Free
E-Mail: c/o jane.fryer@nhs.net

LEAD DIRECTOR:

Name: Jane Fryer
E-Mail: jane.fryer@nhs.net
Telephone: 020 7206 3355

*SEL PCT Boards = Boards of Lambeth Primary Care Trust, Southwark Primary Care Trust, Lewisham Primary Care Trust, Bromley Primary Care Trust and Greenwich Teaching Primary Care Trust.

NHS

South East London

NHS SOUTH EAST LONDON PCT/CARE TRUST BOARDS

JOINT QUALITY & SAFETY SUB COMMITTEE MEETING

Held on Thursday, 30th June 2011 at 11.00 am – Room 407,
1, Lower Marsh
London SE1 7NT

ENCLOSURE 23

Present:

Non-Executive Members Susan Free, Non-Executive Director (**Chair)** Robert Park, Non-Exec Director (**Deputy Chair)** Caroline Hewitt, Chair, NHS SEL Paul Cutler, Non-Executive Director **Executive Members** Dr Jane Fryer, Medical Director, NHS SEL Ms Donna Kinnair, Chief Nurse, NHS SEL Dr Ann-Marie Connolly, Director of Public Health, NHS SEL Dr Adrian Mclachlan, Clinical Lead, Lambeth BSU Dr Hany Wahba, Clinical Lead, Greenwich BSU Dr Amr Zeineldine, Clinical Lead, Southwark BSU Dr Faruk Majid, Clinical Governance Lead, Lewisham BSU Dr David Parkins, Clinical Governance Lead, Bexley BSU Ms Sarah Gardner, Deputy Director of Integrated Governance, NHS SEL Ms Yvette London, Deputy Director of Engagement, NHS SEL Ms Sonia Colwill, Pharmacy Representation – on behalf of NHS SEL Cluster and Governance Lead, Bromley BSU
In Attendance Ms Cleo Gurbuz, **(Minutes)** Mr Michael Fairbairn, Governance Lead, Bexley BSU Ms Maggie Aiken, Governance Lead, Southwark BSU Mr Mike Hellier, Governance Lead, Lewisham BSU Ms Pravitha Rajendraprasadh-Ortolani, Governance Lead, Greenwich BSU Ms Marion Shipman, Governance Lead, Lambeth BSU Ms Sarah Cottingham, Joint Director of Contracting, NHS SEL Ms Rylla Baker, Deputy Director of Primary Care, NHS SEL Mr Ben Homer, Primary Care Intelligence Manager, NHS SEL
Apologies Sue Gallagher, Non-Executive Director Harvey Guntrip, Non-Executive Director Cllr Eileen Pallen, Non-Executive Director

David Whiting, Non-Executive Director			
Board Membership	**Quorate**	**Board Membership**	**Quorate**
All Boards/South East London	YES	Lambeth PCT	YES
Bexley Care Trust	YES	Lewisham PCT	YES
Bromley PCT	YES	Southwark PCT	YES
Greenwich Teaching PCT	YES		

QS/001/11	**Welcome & Introductions** Ms Free welcomed members to the first meeting of the Joint Boards of NHS South East London Quality & Safety Sub Committee and asked members to introduce themselves.	
QS/002/11	**Apologies of Absence** Apologies were received from Non-Executive Directors as above.	
QS/003/11	**Terms of Reference** The committee went through the terms of reference, they were discussed and agreed. Any further comments to be sent to Dr Fryer	**All** **Dr Fryer**
QS/004/11	**Update on Quality Assurance Process – Acute Contracts** Ms Cottingham briefed the committee on the acute contracts quality assurance process and reported on the work being undertaken by the Cluster with the acute Trusts in taking this process forward. Ms Cottingham stated that the Cluster is trying to establish a standardised framework on quality assurance for all acute contracts with the Trusts, by having a set of core quality indicators that would be monitored by the Cluster Acute Contracting team. Agreed that Cluster Contracting Team will monitor and report acute contract performance to the Quality & Safety Committee Further development of a dashboard of Quality metrics to be included in report Contract leads to be provided and circulated with minutes Ms Free asked that the Cluster should ensure that there is a resource where local people could obtain the information that they may need in terms of acute performance and quality. A particular concern was highlighted by the committee in that it was not	**Ms Cottingham** **Ms Cottingham** **Ms Cottingham**

	clear where local BSU quality alerts would feed into the quality framework with providers. Ms Cottingham agreed that these will form part of the clinical quality meetings with providers. Agreed that the contracting team would review quality assurance processes within non local contracts eg. observer at Darrent Valley and St Georges quality reviews Mr Park asked if the work being undertaken by the quality committee is being supported by the acute Trust, and Ms Cottingham stated that the quality framework being produced involves working closely with the four acute providers, that they are all signed up to the framework and that the framework contains a lot of contractual must-do's that the acute providers must adhere to. Mr Cutler asked if there was a mechanism for clinical governance leads to feed into this framework process. Ms Kinnair reported that clinical commissioners were part of the process and that the structure was still being worked out so that it works across all organisations. Dr Fryer stated that we are trying to design a consistent process across the cluster. Ms Shipman made enquiry as to the source of data that was being uploaded and utilised by the contracting teams . It was noted that Ms Cottingham would look into the concerns raised by Ms Shipman and report to the next committee in September. **<u>RECOMMENDATION</u>** **Subject to the above issues and concerns being resolved by the Contracting Team, the Committee agreed the recommendation for the proposed acute quality framework for the monitoring and management of quality standards across the acute contracting for South East London.**	**Ms Cottingham** **Ms Cottingham**
QS/005/11	**<u>Serious Incident (SI) Reporting & Management</u>** Ms Gardner informed the Committee that this report was to ask the Committee to agree the recommendation for all serious incidents to be reported centrally to the Cluster from all the BSU's. SG then went on to brief the Committee on the two reporting systems that are currently being used for serious incident reporting, one via STEIS for non-Foundation Trusts and one via BSU's via Foundation Trusts. The focus	

	Ms Kinnair informed the Committee that the current state of practice is that SI's are being sent to each BSU's and the proposed system would mean that the alerts are sent once to the Cluster, who will then disseminate the alerts to the six BSU's. The committee had a discussion about the current practice and highlighted the advantages of the SI's going to the BSU's. The committee also discussed the good governance practice that would be assured if the SI's were sent centrally to the Cluster and that the BSU's could then get involve in the details of any investigations that may be needed after the Cluster had received these. The discussions highlighted the need for the BSU's to be involve in the process, and on this basis, it was decided that a sub group should be urgently set up to agree the detailed process. Mr Fairbairn expressed concern in relation to those SI's reported by GPs and community health providers, such as Care Homes, as these are currently reported locally BSU's which enables local investigations and monitoring to be provided. Dr Fryer stated that the Joint Boards are responsible for the wellbeing of all residents in South East London and need to ensure good governance in relation to any serious incidents by recording and reporting these centrally but that processes for these group of SI's and subsequent investigations would be maintained locally. Ms Hewitt added that it should be made clear that the Cluster has one management board for the six PCT's, supported by the six BSU's, and that the BSU's are not separate entities to the Cluster. **RECOMMENDATION** **The Quality & Safety Committee agreed the recommendation that all SI's currently going into the BSU's should now be sent on to the Cluster as the central receiving body and that an urgent Task & Finish sub-group be set up to work through the new arrangements.**	**Ms Gardner** **Ms Gardner & BSU Governance Leads**
QS006/11	**Update on Quality Assurance Processes – Community Providers** Dr Fryer informed the Committee that a new approach is being proposed for the reporting format to the Quality & Safety Committee from all providers in future. Dr Fryer proposes that a common framework would be developed for all providers, may they be community health services, mental health or acute Trusts.	

	Mr Park asked that a simple map of where all the commissioning services across South East London are managed and governed should be produced, perhaps in the form of a template It was suggested that the majority of quality assurance should remain reported fully at each Local Clinical Commissioning Committee level, and that only exception reports would be prepared and sent to the Quality & Safety Committee and the Joint Boards. It was then agreed that the BSU's would supply the committee with a named person from each BSU, who will be responsible for collating the quality assurance reports from community and mental health providers. It was also agreed that the map of commissioned services would be drawn up by Ms Gardner, with assistance from all the BSU Governance leads, particularly Ms Aitken from Southwark BSU and Mr Fairbairn from Bexley BSU. In addition, it was agreed that Ms Colwill will take the request to the mental health group for a similar map on mental health services. The committee then had further discussions around the quality reports from each BSU. Ms Hewitt asked the BSU governance leads to highlight any issues of concerns to the committee. <u>Bromley</u> Ms Colwill reported that in relation to Bromley, concerns were around maternity. <u>Bexley</u> Dr Parkins stated that in relation to Bexley, concerns were around the increase in A & E attendances, which the committee noted was a London wide problem, and not just Bexley, and that the issue was also being raised at the Finance & Performance Board Sub Committee. Mr Fairbairn also reported that Bexley was concerned about safeguarding issues and infection control <u>Greenwich</u> Dr Wabha reported that the concern for Greenwich was in mental health and people in Nursing Homes. <u>Lewisham</u> Mr Hellier reported that Lewisham's concerns were discharge summaries and the quality alerts, A & E transfers to mental health and the 12-hour trolley waits. <u>Southwark</u>	**Ms Aiken** **Ms Gardner** **Each Governance Lead BSU's**

	Nothing to add to report <u>Lambeth</u> Nothing to add to the report Ms Hewitt stated that she would take all of these concerns to the Finance & Performance Committee meeting that she would be attending later that day.	**Ms Hewitt**
QS/007/11	**<u>GP Performance Report</u>** Mr Homer and Ms Baker introduced themselves to the Committee and went on to give a briefing on the GP Performance report, stating that they had focused on the easily available data which do not highlight the Public Health issues in relation to hard to reach groups etc. Mr Homer went through the data on QOF, access, and smoking highlighting the differences between boroughs. It should also be noted that different boroughs have taken different approaches to ensuring the quality of this data Mr Homer informed the committee that it is proposed to develop a Cluster indicator framework and would like the Committee to indicate how often they would want primary care reporting to be submitted. Mr Park stated that the report had highlighted some good indicators, especially in relation to each borough and if it would be helpful to have a practice by practice comparison . Mr Homer informed that he would need to come back on this, as he would need to check the data more thoroughly. Mr Park raised a concern in relation to bad GP performers and asked how these performers were being dealt with. Ms Baker went on to brief the committee on how this issue was managed and handled with decisions being made at the decision making panel. Mr Parkins asked that the data should include other contractors and it was agreed this is an area for development Dr Fryer informed the committee that she had asked the Community Pharmacy Advisor to work with Mr Homer on some of these quality issues in community pharmacy. The committee then discussed the report in more detail, particularly those concerns around complaints that are being handled by the practices.	

	Ms Hewitt asked that the concerns highlighted by the report which have now been brought to the attention of the Quality & Safety Committee should be taken back to the BSU's for investigation, as one of the main objectives of the Cluster is to improve primary care quality for the people of South East London and have most impact to better patient lives. The Committee asked that Mr Homer should try to do a borough by borough comparison on most of the indicators for the next reporting round. The committee went on to discuss how patients and the public should have access to the relevant primary care performance information so that they could make the right decision with regards to their primary care choices. It was acknowledged that the London wide quality framework will be published in the Autumn. Ms Hewitt informed the committee that she was concerned that NHS London's framework was not as comprehensive as local frameworks and would not give patients enough information to make the right choices. **RECOMMENDATION** **The Committee then agreed the recommendation in the Primary Care Quality report – section 6.**	**Mr Homer**
QS/008/11	**SLAM Quality Assurance Processes** Dame Donna Kinnair informed the Committee that she had concerns about SLAM regarding medicines safety management and Adult Safeguarding. Ms Hewitt stated that in terms of adults not feeling safe, work need to be undertaken on this and hoped that SLAM has this issue high on up their agenda. Ms Hewitt also stated that it would have been good to have a quality report from Oxleas to the committee. Noted that this would be included in the papers for the next Committee in September. It was also suggested that an Adult Safeguarding report should be produced for this committee. Ms Kinnair informed the committee that a workshop is being planned on Adult Safeguarding and a report to the Joint Boards is planned for July 2011.	**Dr Fryer & Ms Gardner**
QS/009/11	**Business Continuity / Emergency Planning** Dr Connolly presented the Business Continuity and Emergency Planning	

	report and updated the Committee on the template and agreed Action Plan submitted to NHS London. Ms Hewitt asked if the action for the Major Incidence Plan due on the 1st July had been completed, and Dr Connolly reported that this has been done. Ms Hewitt asked if the state of readiness of the NHS South East London for major incidence and whether the Cluster was fit and prepared to undertake what needs to be done in the event of a any major incidence. Dr Connolly reported that each BSU is fully prepared for their role and that South East London was fit and ready for any major incidence. A table top exercise had been undertaken in the last few days and the following day a real incident occurred in Southwark that tested the system **RECOMMENDATION** **The Quality & Safety Committee then approved the Major Incidence Plan Action Plan for Dr Connolly.**	
QS/010/11	**Quality Accounts Reports** Dr Fryer briefed the committee on the quality accounts and stated that not all of these had been received but that the rest would be sent out with the minutes of the Committee meeting. Dr Fryer recommended committee members read the quality accounts as they were important and the information that would be very useful to the committee. Ms Hewitt raised concerns with regards to the acute quality account report in terms of their reporting on vulnerable adults, such as people with dementia. She stated that the Committee would like the Trusts to do incorporate these areas into future quality accounts and that a Cluster process for agreeing Quality Accounts be agreed. In this regard. Ms Free asked if it was possible to obtain the comments made last year to see if these have been reflected in the reporting of this year. Ms Kinnair reported that SLAM, Guys and Kings are currently doing a lot of work on this and that we could establish where they are at the moment with the work around vulnerable groups. Dr Zeinendine asked that the Committee should ensure that the acute Trusts really do deliver on this and should not just be a tick box exercise.	**Dr Fryer** **Dr Fryer** **Ms Kinnair** **Dr Fryer** **Ms Kinnair**

	Mr Cutler reported that there is no where in the quality accounts where patient input is highlighted and asked if it was possible to ensue that this happens next year, so that patients have some input into the exercise. Dr Fryer reported that Kings and Guys & St Thomas had undertaken patient input exercise last year and Ms Free stated that it is about timetabling and that Ms Free will discuss this with Ms Gardner at another time. Ms Hewitt reported on the London Ambulance Service system and how the system had broken down on the day of its launch, but due to good governance and contingency planning, no significant loss of service had occurred.	
QS/011/11	**Any other business** Dr Majid asked how the committee wanted to work in future, as it would be useful for the Committee to use this meeting to discuss good practice and highlight some positives that are sometimes missed at these discussions. The Committee agreed that this was a good idea and that time should be set aside at each meeting for discussion on good practice to take place at the meeting, as this would lead to good learning across the boroughs and BSU's. Ms Free asked that an item should be put on future agendas for this purpose and that time should be allowed for this sort of discussion to take place in the future. Mr Cutler raised the issue of the time of the committee and Ms Free stated that the plan was to try to do the whole committee in a two hour time period and that this will be tested at the next committee. Ms Free also said it all depends on how soon papers could be received by committee members, so that if they had enough time to read all the papers, then the meeting could be conducted much quicker and hopefully finish within two hours. **Meeting ended.**	**Ms Gardner**
QS/0012/11	**Date of Next Meeting** **Monday, 5th September 2011 at 1.30 pm – Room 407, Fourth Floor Lower Marsh.**	