South East London

A meeting of the SEL PCT Boards* and Bexley Care Trust 22nd September 2011

ENCLOSURE 13

PATHFINDER DELEGATION

DIRECTOR RESPONSIBLE: Gill Galliano, Executive Director of Development

AUTHORS: Simon Hall, Interim Director of Transition, NHS SEL
Ben Vinter, Integrated Governance Manager, NHS SEL

TO BE CONSIDERED BY:

- Bromley Primary Care Trust Board
- Greenwich Primary Care Trust Board
- Lewisham Primary Care Trust Board

- Update on progress to be considered by all Boards for information.

SUMMARY:
This report notifies the PCT Boards of three decisions taken following receipt of advice by the Chair through Chair's Action as requested and authorised by the Joint Boards at their meeting on 21 July 2011. The report also updates the Joint Boards on progress made with respect to delegation, and most specifically on the outcome of the NHS London assurance process.

KEY ISSUES:
The Boards requested the Chair take action before the end of August to approve delegation of commissioning responsibilities to GP Pathfinders subject to receipt of an appropriate Delegation Application and its assessment by a Delegation Application Panel.

The enclosed information provides the Boards with:

- An update on the process of delegation within NHS SEL to date and, where appropriate, next steps
- The Delegation Application for each GP Pathfinder (appendices have been published on

our website)
- The Delegation Application Panel meeting notes
- The Chair's Action documentation.

The key issues were considered by the Chair and lead NEDs within each borough with advice sought where appropriate.

COMMITTEE INVOLVEMENT:
The Chair took these decisions at the request of the Joint Boards, upon the advice of the cluster management team and in consultation with the lead NEDs in each borough as denoted on each Chair's Action form and subject to the conclusion of a rigorous internal assessment process – the Delegation Application Panel.

PUBLIC AND USER INVOLVEMENT: N/A

IMPACT ASSEESMENT: N/A

RECOMMENDATIONS:

The Joint Boards are asked to:-

- RECEIVE the update on delegation progress and next steps
- NOTE the positive result of the NHS London assurance exercise (appended to the update paper)

Individual Boards are asked to:

- **(BROMLEY PCT):** To NOTE Chair's Action approving the phased delegation of commissioning responsibilities from the Chief Executive to the Bromley Pathfinder as outlined in the Bromley Delivery Plan.
- **(GREENWICH PCT):** To NOTE Chair's Action approving the phased delegation of commissioning responsibilities from the Chief Executive to the Greenwich Pathfinder as outlined in the Greenwich Delivery Plan.
- **(LEWISHAM PCT):** To NOTE Chair's Action approving the phased delegation of commissioning responsibilities from the Chief Executive to the Lewisham Pathfinder as outlined in the Lewisham Delivery Plan.

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*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.

DELEGATION OF COMMISSIONING RESPONSIBILITES TO PATHFINDER CLINICAL COMMISSIONING GROUPS SEPTEMBER 2011 UPDATE

1. Introduction

1.1 Our approach to PCT / Care Trust governance and the operation of a single management team has informed how we have developed our proposals for delegation to Clinical Commissioning Groups. The prime locus of the internal performance management effort within the south east London Cluster has been explicitly overlaid on the six Pathfinder borough-based geographies, and clinical commissioning leads have been fully and activity involved from the outset in shaping the model.

1.2 The over-riding assumption behind our approach to delegation is that for delegated areas the Pathfinders will lead on the totality of decisions and specific change proposals. The existing system of quarterly Stocktake Meetings has been enhanced to provide the forum for both monitoring performance with respect to delegation, and enabling Pathfinders to move from one phase of delegation to the next in a planned manner.

1.3 At the July meeting of the Joint Boards agreement was given to the proposals for delegation from the first three Pathfinders: Lambeth, Bexley and Southwark. Agreement was also given, in principle, for Chair's action (following advice) to be used to enable delegation to the second three Pathfinders: Bromley, Lewisham and Greenwich. Specific details, including the Delegation Delivery Plans and notes from the Delegation Meetings, are included in the background papers for the Joint Boards' meeting for this second wave of delegation.

1.4 At the end of August NHS London undertook detailed assurance of the process we have used to develop, approve and monitor delegation to our local Pathfinders. This process was reviewed very positively and the documentation outlining this assurance is also attached for your information.

2. Providing Assurance to the Joint Boards

2.1 A performance framework, based on the operational deliverables set out in the integrated operating plan, has been constructed identifying the 'prime owner' and key milestones and deliverables for each initiative/issue relating to each Pathfinder area. A Programme management approach has been adopted to co-ordinate Cluster delivery.

2.2 A process of quarterly Stocktakes is the Executive function that has been set up to bring together all the 'prime owners' for each of the six borough based Pathfinders. These Stocktakes are attended by:

- Director of Operations [Chair]
- BSU MD for Borough concerned [plus any key BSU players they wish to invite]
- Chair of GP consortia for Borough concerned [or nominated Rep]
- DPH for Borough concerned [whilst Public Health a Cluster responsibility]
- Director of Primary Care [whilst Primary Care a Cluster responsibility]
- Director of Acute Commissioning
- Director of Performance

- Director of Strategy and QIPP
- Director of Finance

Each quarterly Stocktake meeting formally reviews, for that borough:

- QIPP delivery
- Performance against key metrics [key national plus key local]
- Contract activity and performance
- Financial position
- Key risks and agreement of mitigating/recovery actions and named owner of these

The output of the quarterly stocktake meetings is a key plank in the assurance process within the Cluster (the Executive functions of the PCT/Care Trusts) and will therefore routinely be summarised and available for the use of a variety of forums.

2.3 The output from the relevant borough stocktake will be reported to each of the borough Clinical Commissioning Committees in order for them to review and take forward the local leadership and action required to support local progress. Each of the Clinical Commissioning Committees will report on the progress made with respect to delegation against the Delegation Delivery Plan to the Joint Boards.

2.4 The output from all six borough stocktakes will be routinely reported to the Finance, Performance and QIPP committee as part of the assurances they will need to confirm that delivery is being systematically managed against plan and as a means of supporting the identification of major risks to Cluster for more in depth consideration by the Committee and onward reporting to the Joint Boards.

2.5 In the event of significant failure of delivery either across a function, or within an area, the matter is escalated to the CEO and a 'Recovery Board' convened chaired by the Director of Operations or Director of Performance and involving relevant Clinical leads, Directors and senior managers from the Cluster. This course of action is / will be triggered where the failure is of a scale sufficient to jeopardise the overall stability of the PCT/Cluster in terms of:

- Management of Patient safety issues or significant deterioration of quality
- Delivering the statutory financial duties
- Failure to deliver multiple national headline measures.

2.6 A more detailed Delegation, Performance Management, Assurance and Escalation Procedures document has been agreed by the Cluster Management Board and will form an intrinsic part of the Compact between the Pathfinder/LCCC and the Cluster.

3. Next Steps

3.1 The stocktake meeting process, and the assurance provided to the Joint Boards by each of the LCCCs, will be the two mechanisms through which progress on commissioning through delegated responsibilites will be monitored. This will also be underpinned by the development process that each Pathfinder is now engaged in, working with a consortium of providers as part of the NHS London Development Support initiative.

3.2 Delegation is an important step on the journey from clinical engagement to full authorisation of Clinical Commissioning Groups (CCGs). The NHS Operating Framework for 2011/12 identifies “GP consortia (now CCG) progress” as a key focus being measured by “% of PCT commissioning spend delegated”. Our delegation process has been developed with this in mind, and this indicator will be reported via NHS London as part of the Operating Framework monitoring.

3.3 The Department of Heatlh has now published its initial guidance on how the authorisation of CCGs will take place. Subject to parliamentary approval, a prospective CCG will be able to apply to the NHS Commissioning Borad to be established as a non-departmental public body (likely to be between July and October 2012). Once the Board has granted an application the CCG will be established as a statutory body. It is proposed that the CCG will then take on its statutory commissioning functions from April 2013.

3.4 In the intervening period, and subject to the parliamentary processes, the role of the existing PCT/Care Trusts will continue to be to ensure that the new CCGs are as prepared as possible. In south east London our approach remains on track to enable a full year of “shadow CCG” status from April 2012.

Simon Hall
September 2011

ENCLOSURE 13

NHS London

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Jane Schofield
Acting Chief Executive
NHS South East London

9 September 2011

Dear Jane

I am writing to confirm the outcome of the NHS London panel meeting to assure the South East London (SEL) PCT cluster process for delegating commissioning responsibilities to pathfinders. This is an important step in enabling pathfinders to:

- improve clinical and financial outcomes before authorisation,
- take responsibility for commissioning decisions,
- develop their organisations to deliver practical outcomes, and
- build a track record in preparation for authorisation.

The panel meeting was informed by a desk-based review by the NHS London Commissioning Development, Performance and Finance teams of the documents that the SEL PCT cluster has developed to support delegation, within a framework that ensures that a grip will be maintained on clinical and financial performance. Input was also sought from Mark Spencer, Medical Director North West London and Tom Easterling, Office of London PCT Chief Executives. A list of the attendees at the meeting is provided at Appendix A.

At the meeting, Simon Robbins, and your team described the SEL PCT cluster approach, including:

- a phased approach depending on local ambition and risk to build confidence and learning by doing, which is co-creative between the PCT cluster and pathfinder, collaborative, and linked to development support,
- an ambition that all pathfinders will have assumed delegation for all services by 1 April 2012, and
- an initial assessment of proposals and delivery plan by desk-based exercise against a number of headings and NHS London Key Lines of Enquiry (KLOE). Feedback is then provided to the pathfinder prior to a face-to-face meeting covering those areas that the PCT cluster team would require further detail on, or

clarification at the meeting. The delivery (Compact) agreement is then redrafted and resubmitted prior to being recommended to the Board / Joint Boards.

Following the NHS London assurance panel meeting, the following steps are planned:

- discussion and approval of the additional three pathfinder proposals from Bromley, Lewisham, and Greenwich, for some delegated responsibilities by Chair's Action and reviewed at the SEL Joint Boards meeting, and,
- by the 27 September Joint Boards meeting finalisation of the delivery (Compact) agreements with each pathfinder for those services that have been delegated. The delivery agreement, establishment agreement, constitution and pathfinder development plan will continue to be reviewed and updated as part of the NHS SEL's delegation process as the pathfinders take on further delegated responsibilities and prepare for authorisation.

In discussion, the following issues were explored:

- The SEL PCT cluster is encouraged to streamline its process, building on the work done to develop core documents for the first phase of delegation. This need not result in a less robust approach to delegation.

Governance

- It is helpful that all the pathfinders are coterminous with PCT and local authority boundaries.
- The local clinical commissioning committee (LCCC) will become the CCG Board. The structure will include committees for QIPP, Quality and Safety, and Audit. The six LCCCs are chaired by lead GPs, who are also full Board members, and include borough directors and others. The governance arrangement ensures the Non Executive Directors (NEDs), borough director, and GPs are acting together during transition.
- Local clinical commissioning committees will take on responsibility for the staff and budget of the Business Services Unit.

Performance

- GPs acknowledge and are interested in continuing performance improvement of primary care and this is included in discussions at the 'stock take' meetings. All practices will be engaged to tackle variation in the quality and performance of primary care.
- The SEL PCT cluster has introduced 'stock take' meetings with borough based commissioning board committees to discuss operational and financial

performance. Intervention will take place where performance is off-track. GP leads have been involved in these 'stock take' meetings for a number of months.

- The SEL PCT cluster will support pathfinders to tackle the challenge of managing operational and financial performance through provision of practice level information.
- The escalation policy describes the process for what will happen should performance deteriorate. Stock take meetings will be used to review, and the SEL PCT cluster reserves the right to chair a recovery board as necessary as a last resort.
- The SEL PCT cluster will maintain a view of pathways of care by ensuring that targets and standards, and QIPP plans are aligned, using stock take meetings to form an overview of the whole, and clearly labelling the reporting structures with who has responsibility for each standard or target.

Finance

- The SEL PCT cluster has not delegated the 2% strategic reserve and any surplus generated, and is developing risk share agreements, in particular for specialised commissioning. The PCT Cluster will investigate a "reinsurance model".

Other

- The time between 'waves' of delegation is limited, and pathfinders will need to learn by doing at quite a significant pace. The dates for subsequent delegation may be extended and an update will be available following the September Board.
- SEL PCT cluster recognises that managing risk moving forward will be a key indicator of operational maturity and as such risk management will be used as a performance measure in future phases of delegation.
- The pathfinders and SEL PCT cluster are working on the development of local plans for an operating model covering what will be delivered locally and what will be out sourced. This will depend on the resources available based on the size of the pathfinder. This will include the possible provision of commissioning support from local authorities.
- The SEL PCT cluster will allow the pathfinders to lead the design of the Locally Enhanced Services (LES). Examples include the early diagnosis of cancer and screening. There is local evidence that peer review and contract management by pathfinders will tackle this variation.
- Where the design of LES contracts is delegated to pathfinders, the contracting and management of these will be retained by the SEL PCT cluster, and governed

by the Conflict of Interest Policy with oversight by non-executive directors. It is important that the SEL PCT cluster retain oversight of this to ensure no conflict of interest develops.

- GP practices have a history of working together across SEL to manage at scale and an example of this is Guy's and St. Thomas'. After 1 April 2012, once there is 100 percent delegation the six pathfinders will link to manage contracts and issues with large providers.

Learning from delegation

During the meeting a number of areas of learning were evident from the work to delegate commissioning responsibilities to pathfinders. These include:

- the need for pathfinders to work together to develop joint working arrangements to tackle some of the challenges that cover the whole of South East London, including managing contracts with large acute trusts, such as Guy's and St Thomas',
- the importance of good engagement with pathfinders, their leadership and membership,
- the pathfinder becoming a 'client' of commissioning support, and
- the need to be mindful of the diversity within pathfinders and geographical areas, and therefore building in the wider equality and diversity agenda.

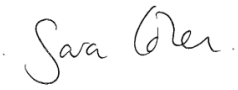
NHS London is identifying examples of difference as a result of clinical leadership in commissioning. This will include trying to capture and share the learning from the examples that pathfinders and PCT clusters have. We would be keen to capture keen to capture examples from South East London within this work.

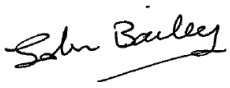
NHS London is assured that NHS SEL has in place a robust framework that will both support pathfinders in taking on delegated responsibilities, enable them to provide clinical leadership in commissioning and enable the PCT cluster to hold them to account for the responsibilities they have taken on.

Many thanks to you and your team for the high quality work you have done to support the delegation of commissioning responsibilities to pathfinders in South East London.

Where initial phased delegation has been assured and delegated, NHS London expects to receive written progress reports in advance of further delegation. A panel meeting may not be needed if assurance can be provided through other routes, including regular meetings between the PCT cluster and NHS London Finance and Performance teams.

Best wishes





Sara Coles,
Director of Performance

Rachel Bartlett,
Assistant Director of and Commissioning Development

John Bailey,
Head of Financial Performance

Cc Paul Baumann, Director of Financial Performance
Hannah Farrar, Director of Strategy and Commissioning Development

Appendix A: NHS London Delegation Assurance Panel Meeting Participants

NHS London:
Sara Coles, Director of Performance
Rachel Bartlett, Assistant Director GP Commissioning, standing in for Hannah Farrar, Director of Strategy and Commissioning Development
John Bailey, Head of Financial Performance, standing in for Paul Baumann, Director of Finance and Investment
Dean Askew, GP Commissioning Project Manager, Note Taker

SE London Cluster:
Simon Robbins, Chief Executive
Marie Farrell, Director of Finance
Jane Schofield, Executive Director of Operations
Gill Galliano, Executive Director of Transition and Development

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.

Pathfinder Development and Delegation

Context;

At the Joint Boards meeting on 19 May 2011, six Local Clinical Commissioning Committees (LCCCs) were established as the vehicles through which Pathfinders would take on delegated responsibilities for commissioning in SE London. The Boards also approved the process for approving delegation to Pathfinders, through a Pathfinder Delivery Plan.

Working with each of the clinical consortia, through the borough-based Business Support Units, a more detailed local assurance process has been agreed and followed as was reported to a meeting of the Joint Boards in July.

The Joint Boards have previously noted that delegated budgets exclude those which relate to the London Ambulance Service, specialised commissioning, primary care contracting, prison health, costs related to non-commissioned services, and nationally required contingencies and reserves.

The July meeting of Joint Boards agreed for the Chair to take Chair's Action to AGREE Bromley's Pathfinder Delegation Application.

Supporting Documentation;

This report makes recommendations on delegation for the Bromley Pathfinder (below).

In considering such recommendations Bromley PCT will be aware of the process and framework outlined to the Joint Boards at their meeting on 21st July.

The detailed assurance process undertaken in respect of this and all applications for Pathfinder Delegation has provided the following supporting information;

- Revised Delegation Application (Delegation Delivery Plan)
- Delegation Application Panel Meeting Action Notes

(Bromley PCT via Chair's Action):
Approve the phased delegation of commissioning responsibilities from the Chief Executive to the Bromley Pathfinder as outlined in the Bromley Delivery Plan

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:

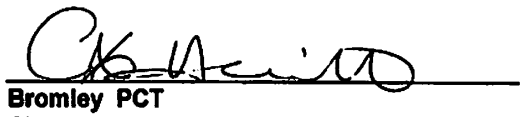
Bromley PCT will wish to report the outcome of this Chair's Action to the next appropriate meeting of its LCCC

Reporting

A notice of this decision will be provided to the next meeting of the PCT Board on 22 September 2011.

Supporting NED / ED input;

Confirmed with James Gunner and Harvey Guntrip (lead non executive directors) – 12/8/2011.



Bromley PCT
Chair

15 August 2011
Date

NHS South East London

Action Points: Bromley Pathfinder Delegation Meeting

12.30 pm, 25 July 2011

Present: Dr Andrew Parson (Chair, Bromley Clinical Commissioning Collaborative / Bromley Clinical Commissioning); Meredith Collins (Finance, Bromley BSU), Luke O'Byrne (Commissioning Support, Bromley BSU), Simon Robbins (CE, SE London Cluster); Gill Galliano (Director of Transition, SE London Cluster); Marie Farrell (Director of Finance, SE London Cluster), James Gunner (Vice Chair, Bromley) Simon Hall (SE London Cluster – taking notes).

Apologies: Jane Schofield (Director of Operations, SE London Cluster) (but input via email), Dr Angela Bhan (MD, Bromley BSU).

The application for delegation was received, and it was noted that the application was based on good documentation underpinned by a strong history of GP and clinician involvement in commissioning in Bromley. The following areas were explored in more depth in the discussion, with the actions outlined below agreed:

1. Engagement of constituent practices of the Pathfinder

It was agreed that this section of the documentation was strong, and AP outlined the strong history of engagement in Bromley. It was noted that the process of election for the GP representatives on the Pathfinder was now underway, and going well following a well-attended meeting in June. This engagement is to be augmented by affiliated clinical leads, and one leadership role is being reserved for a salaried/newly qualified GP.

2. Primary care challenges

AP outlined the linkages across to primary care commissioned services, as delegation is intended to enable a growing maturity and understanding of how all the different commissioned services link – and there may well be decisions to be taken during this transitional process by the cluster that affect primary care. It was noted that the Pathfinder is giving additional opportunities for practices to come together to discuss referral patterns and demand management, and this is being assisted by the implementation of the risk stratification tool. GP education is also a priority, and this is being highlighted in the Pathfinder's Development Plans. Clinicians are also leading work on redesign with respect to cancer services, cardiac, diabetes and sexual health.

3. Acute Outpatients

In response to questioning from SR, AP outlined how delegation will assist in the clinical pathway redesign of outpatients – and detailed that gynaecology, dermatology, MSK, ophthalmology, ENT, neurology and urology are the priorities that will being worked on (in chronological order). This is being undertaken through a Performance Group, which visits practices and feeds back on specific areas (noting activity and cost) and links to an incentive scheme. A QIPP Performance and Delivery Group is also being set up, which will be the way to get the practices to own and understand the data more.

4. Commissioning Support

It was agreed to strengthen the alignment of Public Health, BSU team and cluster central team commissioning support aligned to the Bromley Pathfinder to ensure it is effectively supported in transition to achieve 100% delegation by 1 April 2012. The role of the Stocktake Meetings in support delegation was also outlined, and it was agreed that the cluster team would circulate the documentation supporting this (Delegation Assurance & Escalation Policy/Procedures) following the meeting. In turn it was agreed that the Pathfinder would look more at "what success will look like" and make revisions to the documentation accordingly (as the Stocktake Meeting will monitor against these success criteria). The cluster agreed to ensure alignment of support for delegated services once success criteria agreed on.

5. Delegation Timetable

It was agreed that Bromley's three-phase approach to delegation was mature, and aligned with the particular challenges being faced in the local health economy (particularly with SLHT). However, it was noted that the documentation needed to spell out the rationale for phased delegation more clearly. It was agreed to strengthen the piece on collaboration across Pathfinders in BBG area in the documentation in order to enable large-scale delivery of service change. AP outlined that Bromley was committed to finding a way of working in closer partnership with the Bexley and Greenwich Pathfinders.

Additionally it was agreed that the documentation should include more details of which targets, performance issues and quality initiatives the Pathfinder or Cluster was leading on and from when. Additionally, QIPP delegation and budgets needed to be more clearly linked in the paperwork. It was proposed to tabulate area/budget/quality issue/performance target for each delegated area proposed. It was also agreed to tease out the finance support risk more, with mitigating actions. With respect to support structures, it was agreed that there was a need for a changed structure formally in light of developments, and the Cluster agreed to provide help as necessary to enable the Pathfinder to get the support it required.

6. Phase 1: delegation from 1 October 2011 agreed as:

- Prescribing
- Acute Out-Patients and Community Services (relating to redesigned Care Pathways)
- Bromley Healthcare Community Services Contract
- BSU operational budget: need to draw out issue on BSU more – "continuous reshaping to support Pathfinder" – linked to CSO development
- All other budget lines to remain central and released on agreement e.g. 2% non-recurrent and 1% surplus requirements
- Pathfinder to add in delegation of Orpington Hospital and review of services in the Orpington area as lead role for Pathfinder, with what support required from Cluster.
- Pathfinder to add in detail on patient referral centre, and opportunity for establishing across BBG (increased confidence amongst GPs following review, etc.).
- It was agreed to include greater clarity on what not delegated (2%/surplus/contingencies) in the final documentation.

- It was agreed to map LESs out linked to delegated areas, and make proposal for delegation of design (cluster to keep procurement).

7. Phase 2: delegation from 1 January 2012 agreed as:

- Mental Health
- Joint Commissioning
- Continuing Care
- Remaining Community Services

8. Phase 3: remaining areas

It was agreed that acute commissioning and individual funding requests would be fully delegated from 1 April 2012. However the Pathfinder agreed to lead work on the strategic planning underpinning these areas for the 2012/13 commissioning cycle.

9. Other points

It was noted that BCCC was the first Pathfinder in London to have signed off its MoA with the local Borough, and that this should be mentioned in the documentation. Additionally it was noted that relationship management with Oxleas needed to be added.

10. Next steps

It was agreed that the Pathfinder redraft the report for submission to the Chair in order that Chair's Action can be taken to give approval in principle for delegation as outlined above prior to the cluster's assurance meeting with NHS London in August 2011. It was noted that this would be with the cluster team by Friday 5 August at the latest.

Simon Hall
27 July 2011

ENCLOSURE 13

NHS

South East London

Pathfinder Delivery Plan

Bromley Clinical Commissioning

2011/12

Consortium Name	Bromley Clinical Commissioning
Cluster	NHS South East London
Primary PCT for consortium	NHS Bromley

Lead contact for application	Dr Andrew Parson
Designation	Chair, Bromley Clinical Commissioning
Email address	Andrew.parson@nhs.net
Telephone Number	07877 499983

Consortium membership	49 Practices
Consortium registered population	300,855

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PURPOSE

The purpose of this document is to outline the Bromley Clinical Commissioning (BCC) Pathfinder Delivery Plan. The plan outlines the arrangements the consortium have established to allow for the planned delegation of all commissioning responsibilities between now and April 2012, prior to mobilisation to full authorisation in the year 2012/13.

Vision:
The vision of BCC is to rapidly and systematically improve the health of the population of Bromley and reduce health inequalities within our resources. In order to do this we have developed three priorities:

Identify and lead pathway redesign initiatives that not only improve ease of access, address health inequalities and achieve the best outcome for patients but also build the foundations for a new integrated and collaborative way of working that breaks down the boundaries between primary, community and secondary care

Focus on the earlier identification and more proactive management of long term conditions in community settings. There are opportunities through the new partnerships that will be created between stakeholders to develop integrated systems of care that deliver improvements along all aspects of the pathway, from health prevention to end of life care.

Develop integrated care at home, to avoid unnecessary admissions: Bromley has a high elderly population (16% of the population are older than 65yrs) and consequently an increasingly vulnerable population in term of disease prevalence and long term conditions. These factors give rise to the potential for high emergency admission at times of crisis. We believe an integrated approach to ensure care is received in the most appropriate setting is crucial. We work with all stakeholders to develop the necessary systems in Bromley to intervene earlier and so prevent avoidable admissions and facilitate discharge into community settings.

Achievements so far:

We are pleased with progress prior to and since becoming a Pathfinder. Prior to this there was a great deal of clinical involvement in redesigning pathways, strengthening referral processes, designing the QIPP programme and setting the service level agreements with providers. Since we gained approval we have strengthened our governance processes, (most notable through the establishment of BCCC and our Quality Group), began a development programme for our Clinical Leads and BSU management team and strengthened our pathway work to ensure more systematic coverage of the population.

The plan describes current and future arrangements in following areas:

- Leadership and consortium structure (Section One)
- Delivery through engagement with the wider system (Section Two)
- Governance and performance monitoring arrangements (Section Three)
- Delegated responsibilities, trajectories and process (Section Four)
- Support requirements (Section Five)

The plan should be read in conjunction with the following documents:

- The Establishment Agreement for Board Committees
- The Delivery Agreement between the BCC and NHS South East London

BACKGROUND

Fourth wave Pathfinder

BCC is a consortium of all general practices serving the residents of the London Borough of Bromley. The combined registered population of Bromley's 49 general practices is circa 300,855 and the consortium is coterminous with the London Borough of Bromley and the former NHS Bromley boundaries.

BCC was awarded pathfinder status in April 2011. Our Pathfinder application is attached:

Bromley Clinical Commissioning Pathfi

Building on a strong track record of local clinical commissioning BCC were able to demonstrate compliance with the three tests set by the Secretary of State (relating to local GP leadership and support, local authority engagement and an ability to contribute to the delivery of the local QIPP agenda) and have worked with the NHS South East London Cluster to develop the capacity and capability to assume delegated responsibility against an agreed trajectory for the remainder of 2011/12.

Planned delegation

The PDP outlines the steps taken by BCC and Bromley BSU to prepare for and undertake delegated responsibility in line with the approach to delegation adopted by the NHS South East London joint Boards in May 2011. Bromley Clinical Commissioning Committee (BCCC) has been established as a formal committee of the PCT Board and BCC are represented on this by six GP Clinical Leads. The BCCC is chaired by a Non-Executive Director and membership includes the six BCC Clinical Leads.

BCC developed our 2011/12 QIPP plan as part of the NHS South East London Integrated Plan and lead the implementation of all areas of that QIPP plan working in conjunction with the local Business Support Unit (BSU) and SEL Cluster Directorates. BCC Clinical Leads will continue to play a lead commissioning role across the full portfolio of BSU responsibilities prior to delegation.

As outlined below BCC welcome the opportunity to engage in all areas of commissioning as members of the BCCC whilst taking delegated responsibility for specific areas of commissioning across the year. BCC regard the role of the BCCC as pivotal in securing the timely, appropriate and supported delegation of commissioning to local Clinical Commissioners over time.

SECTION ONE: Leadership and consortium structure

BCC has established a robust leadership and engagement structure to allow for the delegation of commissioning responsibilities over time. The delegation timetable is aligned to the planned development of the leadership group and of the consortium as a whole. The structures established for BCC leadership have been designed for the eventual delegation of all commissioning areas. The leadership and consortium cluster structures are supported by the Bromley Business Support Unit (BSU) and the SEL Cluster Directorates. The Bromley BSU was designed and approved by GP Commissioner Leads in 2010/11 to ensure an alignment to the future needs of the consortium over the transition period.

BCC and the BSU are fully engaged in the NHS London project looking at the future of commissioning support to determine what support is provided locally and what is brought in from other organisations. Depending on decisions that are taken as part of this BCC will adapt BSU structures to ensure that support remains fit for purpose and affordable.

Consortium leadership structure and roles

The consortium is managed through three clusters of constituent members (Bromley, Orpington and Unity) and the BCC team is led by six mandated GP Clinical Leads drawn from these clusters.

In South East London Local Clinical Commissioning Committees (LCCCs) have been established as formal Board committees and the vehicles through which Pathfinders would take on delegated responsibilities for commissioning over time. LCCCs allow GP commissioners to be engaged in and lead all areas of commissioning whilst taking responsibility for them over time.

Membership of the Bromley Clinical Commissioning Committee (BCCC) includes the six mandated GP Clinical leads. The six GPs have voting rights on the BCCC and represent a majority of the voting membership. There are two Non-Executive Directors on the BCCC one of whom chairs the Committee.

As members of the BCCC the GPs that make up the Consortium leadership team each hold portfolios for specific commissioning and corporate functions relating to the leadership and management of the local health system. These portfolio areas are outlined in the Job Description and Person Specifications against which GP leads were recruited via a 'Selection/ Election' process (outlined in the sections that follow).

When taken together the portfolios cover the entirety of the commissioning responsibilities across the Borough. Each Clinical Lead is supported by members of the BSU's Senior Management Team and have objectives aligned to the NHS South East London Business Plan and the local QIPP Plan.

Members of the GP Leadership team have three key responsibilities that will allow them to operate with increasing delegated authority over time:

- A leadership, management and engagement role for a set number of consortium member practices in each locality
- A commissioning portfolio across the borough with responsibility for securing agreed QIPP plans in each area
- A corporate portfolio across the borough with responsibility for ensuring the effective and appropriate performance management of each area of local commissioning

Each GP member of the BCCC is responsible to that committee for the performance of these roles and has agreed time commitments to undertake the roles. The table below provides details of the GP Leads and the areas for which they are responsible:

BCC Clinical Lead	Commissioning Portfolio	Corporate Portfolio	Locality
Dr Andrew Parson	• Acute Commissioning Contract review • Care Pathway redesign • Joint commissioning - Health and Well Being Board	• CEO Bromley Clinical Commissioning • Budgets – practice level and clinical commissioning • Locality lead • Governance	Bromley Locality Registered population: 115,373 Member practices: 14
Dr James Heathcote	• Care Pathway redesign – COPD	• Acute quality (SLHT) • Cluster quality representative • Locality leader	
Dr Ruchira Paranjape	• Care pathway redesign • Joint commissioning - Health and Well Being Board • Population Health Manager tool	• Performance Management – referral management and new schemes • Locality leader	Orpington Locality Registered population: 82,667 Member practices: 16
Dr Sarah Stoner	• Mental Health services – contract review • Care Pathway Redesign	• Locality leader	
Dr Jackie Tavabie	• Care pathway redesign • Joint commissioning - Health and Well Being Board • Reablement	• Patient and Public Engagement • Education • GP Incentive Scheme • Engagement with partners • Locality lead	Unity Locality Registered population: 116,428 Member practices: 19
Dr Mike Collins	• Community services – contract monitoring	• Locality leader	

In addition there are two GP prescribing leads in each of the three clusters, (Dr N Sabharwal, Dr A Bindra, Dr N Payne, Dr S Sahi, Dr R Vella and Dr A Arora) and Dr Mark Essop supports IT issues. There has also been significant input from over 25 other GPs into a range of Care pathway redesign projects in Bromley including MSK (orthopaedics, rheumatology, physiotherapy), cardiology, dermatology, gynaecology, ENT, pain services, neurology, neuro-rehabilitation, COPD and diabetes.

Two brief examples of pathway development work we have undertaken are set out below:

Atrial Fibrillation (AF):

Bromley Clinical Commissioning, together with the PCT vascular team and South East London Cardiac Network, have worked with 14 practices in Bromley and using GRASP AF software have been able to identify patients at increased risk of stroke. Medication for this cohort of patients has been reviewed and where appropriate adjusted to ensure optimum treatment and care.

Our findings concur with the results of other similar projects undertaken across the country and include:
• A clear variation in identification rates for AF across practices
• That opportunistic screening can significantly increase detection rates
• That many individuals who have already been identified to have AF and with known risk factors putting them at high risk of stroke, are not being treated with anticoagulants
• That the management of AF in primary care is both practical and a necessity.

The next step is to roll out the scheme to the remaining Bromley practices and also ensure that there is specialist clinical support available to GPs in reviewing the medication of their patients to ensure they are on optimal therapy.

MSK:

Meetings were arranged with hospital consultants to agree GP guidelines for MSK. The jointly agreed guidelines were launched to GPs in very well attended educational event that included case study style learning. To understand physiotherapy demand, a pilot service was put in place in one of the 3 localities for 6 months. As it was important to improve on the local hospital physiotherapy waiting time of 26 weeks, the service was specified and procured through a competitive tendering process. To support this pathway a further (very well attended) educational event for GPs has taken place and a bi-monthly 'MSK Club' is planned. Audit has shown a reduction in GP referrals of 30% and further pathway enhancements eg. Allowing ESP physiotherapists to order scans, is being taken forward.

Leadership infrastructure and support

- **Remuneration for the GP Clinical leads**–There are 25 sessions of clinical commissioning time a week to enable our six clinical leads to run BCC.
- **Wider GP involvement**–A number of other GPs provide support to the six clinical leads undertaking a wide range of commissioning and redesign work including a range of pathway and NSF work (eg. Cancer, Sexual Health and Cardiology) These roles recognise that the scale of change required by local QIPP plans requires capacity over and above the clinical leads time and that many highly skilled clinicians may wish to lead specific areas of change without being required to take on a full clinical lead role. This type of role is also very helpful in terms of succession planning.
- **Cluster management support teams**– Each Cluster is supported by managers from the BSU who assist the clinical leads with co-ordinating commissioning activities and ensuring good cluster engagement.
- **The BCC Clinical Executive**–There is also a multi-disciplinary clinical reference group for the BCCC.

This structure is designed to support the BCC leadership group undertake its commissioning roles with the required clinical capacity.

In addition the Clinical Leads are supported on a day-to-day basis by the Bromley BSU and the NHS SEL Cluster Directorates. .

Appointment of GP Clinical Leads

In 2008 the role of the clinical lead (one for each of the three GP clusters) was advertised to all GP principals. Applicants had to receive the support of their respective GP Cluster to apply. There was a formal appointment process led by the PCT. The roles were offered on a contract for services basis initially for a two year basis. In 2010 one of the posts was reappointed and two other GPs came in to replace cluster leads who had retired.

In 2010 one of the three clinical leads was interviewed and appointed by the PCT as the BCC Chief Executive.

In September 2010 three further GPs were appointed via a selection process led by BCC to help further strengthen the development of clinical engagement.

There are currently six GPs who are represented on the BCC Committee including the Clinical Chair. They represent the three Clusters of GP Practices in Bromley and have led the development of BCC including the Pathfinder Application and previously the development of Practice Based Commissioning.

An election process is underway to strengthen the mandate of the group. This includes elections for the Chair and Vice Chair.

Engagement of Consortium members

BCC is managed on a three GP cluster basis and both the BCC leadership and members have agreed that strong and effective engagement with constituent members is an absolute priority if Clinical Commissioning is to be successful.

Clusters work to design and implement Care Pathway changes and feedback ideas for further redesign and comments on the new Pathways.

Engagement with practices is undertaken with the GP clusters in a number of ways:

- Clusters meet on a bi -monthly basis, chaired by their Clinical Lead and supported by members of the BCC management team. These meetings provide the opportunity for two way communication between the GP Clinical Leads and their clusters and for agendas to be set that reflect commissioning issues at that time. These agendas focus on BCC development, service redesign, QIPP delivery and delegated responsibility.
- Each Clinical Lead is linked to between fourteen and nineteen practices. They directly engage with these through practices visits to address issues at a practice level and ensure they are brought back to the BCC decision making groups.
- BCC has established a number of communication routes, including an intranet, to facilitate this interaction. Any areas raised at the BCC meetings are discussed at the cluster meetings for practices to engage and make comments, which are fed back for report or action.

In addition to the activities above the BCC run Protected Learning Time (PLT) events that provide further opportunities for all practices across Bromley to come together and discuss commissioning issues and convey core messages.

The interaction between Commissioning Leads and consortium members is governed by a Bromley Practice Level Agreement which has been redesigned for 2012-13.

GP Commissioning incentive scheme

To support care pathway redesign and to encourage GPs to work differently to ensure the population of Bromley continue to be supported effectively as budgets tighten, Clinical Commissioning has offered a GP incentive scheme for the last two years. The scheme incentivises GPs in three different ways and they can sign up to any or all parts of the scheme.
Part 1 involves attendance at educational events
Part 2 is retrospective review of referrals (to discuss with colleagues alternative management and whether referral to hospital was really necessary)
And
Part 3 is live reviews (review before the referral is sent to hospital either by a colleague or as a practice team).

GPs although initially hesitant about peer review are now expressing this has been a very useful exercise and it is estimated that GP referrals have reduced by around 10% as a result of this work.

The 2011/12 Bromley Clinical Commissioning Incentive Scheme builds upon last year's scheme, many elements of which are now reflected in the new QOF domains. The funding available is £1 per patient which equates to £325,000 across the borough. This joined up approach targets the key clinical areas valuable to patients and practices which also support the delivery of QIPP. Prevention of illness, admission avoidance and service development/improvement are at the heart of this work. The focus is on:

- **Newly designed clinical pathways:** GP referring via choose and book for MSK, dermatology, gynaecology and ophthalmology intermediate services.

- **Admission avoidance and focus on long term conditions:** practices to identify patients at risk of admission using risk stratification tools and putting in place care plans to ensure appropriate community based support.

- **Peer live review across cardiology, ENT, urology and neurology:** Encouraging GPs within practice to share expertise and skills to maintain patients (where appropriate) in primary care. Guidelines will be available.

- **Engagement and Education:** attendance by GPs at least four clinical commissioning learning events during 2011/12 followed up by evidence of active feedback at subsequent practice meetings.

It is important to note that the incentive scheme is quite separate from development monies to be accessed by GP commissioners, although it does in itself build a number of critical parts of the practice engagement structure that will be required for the successful clinical commissioning group working. Access to the scheme requires sign up to the Clinical Commissioning practice agreement which incorporates an expectation that practices demonstrate their support in the following ways:

- Demonstrate their commitment to the consortium through active participation in the GP cluster meeting.
- Collaborate, share and learn from good practice with colleagues within and across practices e.g. through peer review schemes, utilising guidelines etc.
- Demonstrate engagement in clinical commissioning e.g. by holding in-house practice meetings to review practice referral activity, raise issues /alert clinical commissioning to areas which might benefit from closer inspection etc.
- Participate in developing and implementing new pathways of care.

There are a number of LES schemes in place that we use to support delivery of our objective to reduce reliance on secondary care by strengthening primary care and community services.

Leadership teams for delivery

Our leadership structure is designed to allow for engagement in all QIPP areas whilst taking specific areas of delegation. Whilst all GP leads will be involved in delegated areas named clinical leads (with BSU management support) will take responsibility for the individual delegated clinical areas.

Consortium member engagement for delivery

For each area of delegation the three clusters will work on implementation plans at practice and cluster group level. Agendas will be set to enable this and practice and cluster plans will be signed off and monitored by the BCCC led by the specific Clinical Leads.

Aligned incentives for delivery

Bromley Clinical Commissioning and the BSU has worked closely with NHS SE London Cluster to ensure that, where possible, other available incentive schemes in Bromley are aligned to the objectives of QIPP delivery, QIPP development and practice engagement and include:

- New QOF domains
- Prescribing Incentive Scheme
- Local Enhanced Service Schemes

In particular, Bromley Clinical Commissioning has led the interpretation and design of approach to the new QOF areas in conjunction with SE London Cluster colleagues; developing guidance, monitoring templates, performance activity packs and scheduling and offering to facilitate external peer review meetings.

South East London Cluster has asked to share the templates and guidance developed with other clinical commissioning groups in the cluster, in recognition of the exemplary work that we are undertaking.

Patient Referral Centre:

Much of our pathway redesign work relies heavily on a robust Patient Referral Centre (PRC). Following significant historical challenges with the processes and running of the PRC the BCC Clinical Chair is overseeing a project to ensure that robust processes are in place to rebuild the confidence of GPs and managers in this important service.

<u>Delivering against delegated responsibility</u>

BCC have developed the capability and capacity as a consortium to take delegated responsibility for a first tranche of commissioning budgets associated with Acute Out-patient services for those pathways where community services have been put in place, and the budgets for those community based services; Prescribing and the Bromley Healthcare Community Services, excluding urgent care. We have also established an effective leadership and engagement structure against which we can rapidly develop and take full delegation by the end of 2011/12.

SECTION TWO: Delivery through engagement with the wider system

BCC has made clear the priority it will place on partnership working and engagement in order to ensure delivery against initial areas of delegation and against the entire commissioning portfolio over time. In our Pathfinder application we set out how we work with partners and the section below outlines our delivery on those intentions and the work that still needs to be undertaken as part of our development.

Patient and Public Engagement

BCC regard work in this area to be critical and have prioritised early actions to develop our approach here in support of our delegated roles for the future.

BCC has taken some important steps in this area. The BCCC will be a Board committee held in public and we have established good relationships with the Bromley LINk who have agreed to sit on the committee. In addition the consortium has identified engagement as a significant issue for GP Clinical Leads and whilst it will be a part of everyone's role Dr Tavabie will take the lead.

BCC engages services users through its work with Bromley LINk and local voluntary agencies and we have close links to London Borough of Bromley user involvement processes including through the Health and Well Being Board and the voluntary sector network.

While some GP practices have patient advisory / participation groups, this is by no means universal and we have highlighted this as an important area for development to ensure that we receive balanced patient feedback from our whole population.

Feedback is regularly sought from patients and their representatives to inform the continuing development of services. But while some newly developed care pathways and wider service redesign work including procurement have had patient involvement (usually through the LINk) not all have and we recognise the need to build in better patient engagement in the delivery, monitoring and feedback process for care pathways.

We are aware that significantly more input from patients and the wider public is required as we continue to develop health services and are also aware that many voluntary groups, including many practice patient groups, are not currently associated with LINk. We are working with the Bromley LINk to establish a larger and more unified representative patient body and support the creation of a communication network (which will ultimately form the local Health Watchdog) with whom we can work not only to redesign services, but also to monitor performance of providers and implementation of changes. We have recently hosted a day that brought together representatives from over 20 stakeholder groups to further build engagement and prioritise the next steps.

A series of patient seminars are underway to educate the public about self-care in one of our clusters and we are looking to build this into a self-care strategy

The BCCC is fully committed to the adoption of the Equality Delivery Scheme, which is being developed across the whole sector to replace the Single Equality Scheme. We are committed to participating actively in the development of the Equality Analysis Tool, and as members of the South East London Cluster's equality group. Moreover, we are committed to ensuring that we include equalities considerations in all our commissioning decisions, making reasonable adjustments to services for vulnerable children and adults, and specifically to ensuring that we improve access to generic health services for people with learning disabilities.

Partnership Engagement

BCC has sought to build upon a track record of excellent partnership working across the system. Within the consortium we have stressed the importance of involving the entire practice team (demonstrated through our cluster delivery teams and our engagement activities) and within primary care we have been clear about the importance of involving wider clinicians such as nursing, pharmacists and optometrists.

BCC has prioritised work with the following partners to ensure the right relationships, forums and ways of working are in place to support the pace of delegation we seek to achieve:

South London Healthcare NHS Trust:

We work closely with South London Healthcare NHS Trust (SLHT) around service redesign, provision and monitoring. As this Trust is also the main hospital provider for Bexley and Greenwich it involves discussions with colleagues in neighbouring Clinical Consortia. Whilst this brings the threat of the needs of Bromley residents being compromised as the Trust seeks a 'best fit' for all three Boroughs, it also brings potential benefits in terms of economies of scale in the delivery of some common services, and brings the opportunity for sharing of ideas and resource between Clinical Consortia where it might benefit all parties.

Orpington Hopsital:

We are working with SLHT and other stakeholders to remodel the service offering at Orpington Hospital ensuring that the public understand and are engaged with propsed changes and that potential changes are affordable. We will work with SLHT and Bexley who have achieved recent similar changes at QMH. We will also work closely with colleagues at SE London Cluster around engagement, support with financial modelling and support to achieve change.

We established a Clinical Forum with Bexley and Greenwich (BBG Forum) and worked together to develop and implement "A Picture of Health" and agree a common service level agreement with SLHT for 2011-12. We are committed to continuing to work closely with Bexley and Greenwich consortia to move towards a position of long term stability for SLHT. We are currently developing a process for undertaking the 2012/13 contracting round in conjunction with colleagues from Bexley and Greenwich and will work together to better align our QIPP and pathway redesign work to enable SLHT to plan more effectively and consider whether there is scope to work together on referral management issues.

London Borough of Bromley:

One of our main developmental areas of engagement is with our Local Authority. We have the advantage in Bromley that our Consortium is coterminous with the London Borough of Bromley (LBB). This, together with the anticipated move of Public Health into the Local Authority, brings enormous opportunities for joint working, making a clear link between health and social care, and ensuring that the neediest in our society receive care and attention at a time that will prevent future ill health. We have an agreed memorandum of understanding in place with LBB that sets out how the two organisations will work together.

We have recently started a joint project of 'Reablement', using designated funds from government specifically to develop social care services that will directly benefit healthcare. Although initially focussed on early discharge from hospital and hospital avoidance, its focus on care in the community will facilitate debate and future developments on the specific healthcare needs of vulnerable groups in our society.

A number of BCC Clinical Leads are members of the Health and Well Being Board and we recognise the importance of this Board in terms of delivering integrated commissioning and future accountabilities.

Bromley Healthcare:

BCC has been supportive of the development of Bromley Healthcare, as a social enterprise and our new community provider. This is a new organisation and we are aware of the need for close working with them. We have been involved in their processes for selection of key leaders within their organisation and are represented on their Board of Governors in order to receive their comments and give feedback. We anticipate that, with the need to increase services for patients in the community that we will have significant common work in the year ahead, particularly in the areas of access to services, nursing support and effective communication between professionals.

Oxleas:

We work closely with Oxleas who provide a full range of specialist mental health and substance misuse services to our population. One of our Clinical Leads has lead responsibility for mental health for BCC. We are currently working with Oxleas to remodel older people's mental health beds and implement the dementia strategy.

Delivering against delegated responsibility

BCC has developed robust engagement mechanisms to take delegated responsibility for areas at the pace described by this plan. We have prioritised engagement with patients and the public, SLHT, the London Borough of Bromley and Bexley and Greenwich Consortia as those stakeholders that would require positive and joint action with in order to achieve our objectives.

BCC recognises the wider set of stakeholders that we will need to engage with in future, not least the voluntary and third sectors, and this will form a significant part of development plans going forward.

SECTION THREE: Governance and performance monitoring arrangements

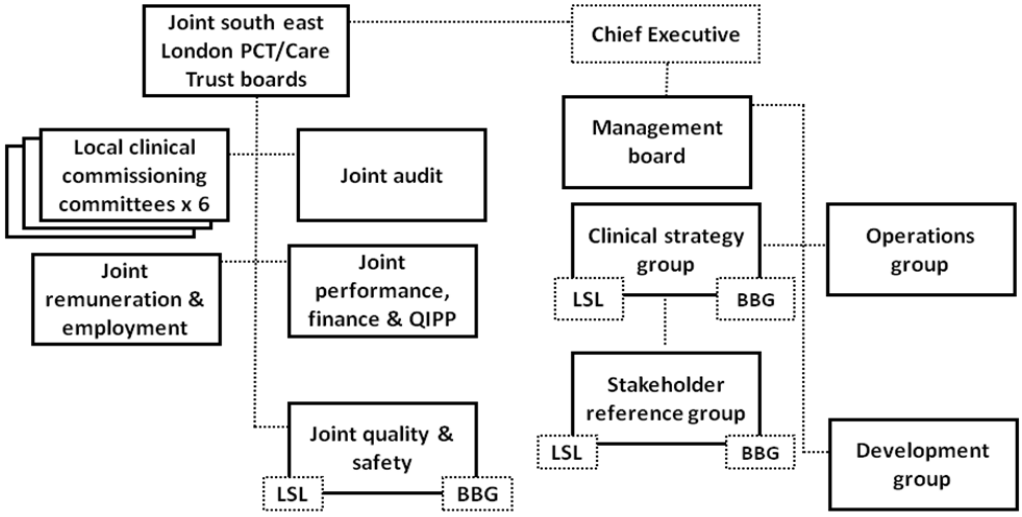
Following the establishment of the BCCC as a formal committee of the PCT Board with delegated responsibility for local commissioning, BCC has now been able to identify and agree the governance structures that will underpin the planned delegation of commissioning to the consortium over time.

The Bromley Clinical Commissioning Committee

As with all pathfinders in South East London the vehicle for delegation over the coming year will be the Local Clinical Commissioning Committee, BCCC. The terms of reference for the BCCC are attached as Appendix One. The BCCC allows the leadership team of the consortium to participate and lead in borough based commissioning across the whole PCT portfolio in advance of delegation.

Prior to any delegation to the Consortium members of the BCCC report formally to the Joint South East London PCT/ Care Trust Board and participate in the various committees and groups as appropriate within the structure. The Chair of BCC, the Bromley BSU Managing Director and the two NEDs with responsibility for Bromley all sit on the PCT Board and the BCCC to allow for this reporting and the BCCC minutes are reported formally to the PCT Board.

The BCCC membership brings together the senior management team of the Bromley BSU (and in particular the Managing Director, also an Executive member of the PCT Board to whom responsibility for local commissioning has been delegated by the Chief Executive of NHS South East London in advance of any delegation to the consortium), the Non-Executive Directors of the Board with responsibility for Bromley and the BCC Clinical Leads who represent their constituent clusters. All of the above constitute the voting members of the BCCC, in which the six Clinical Leads hold a majority. Members also include a LINks representative and a Local Borough of Bromley Director. A full list of BCCC members is included at Appendix One.



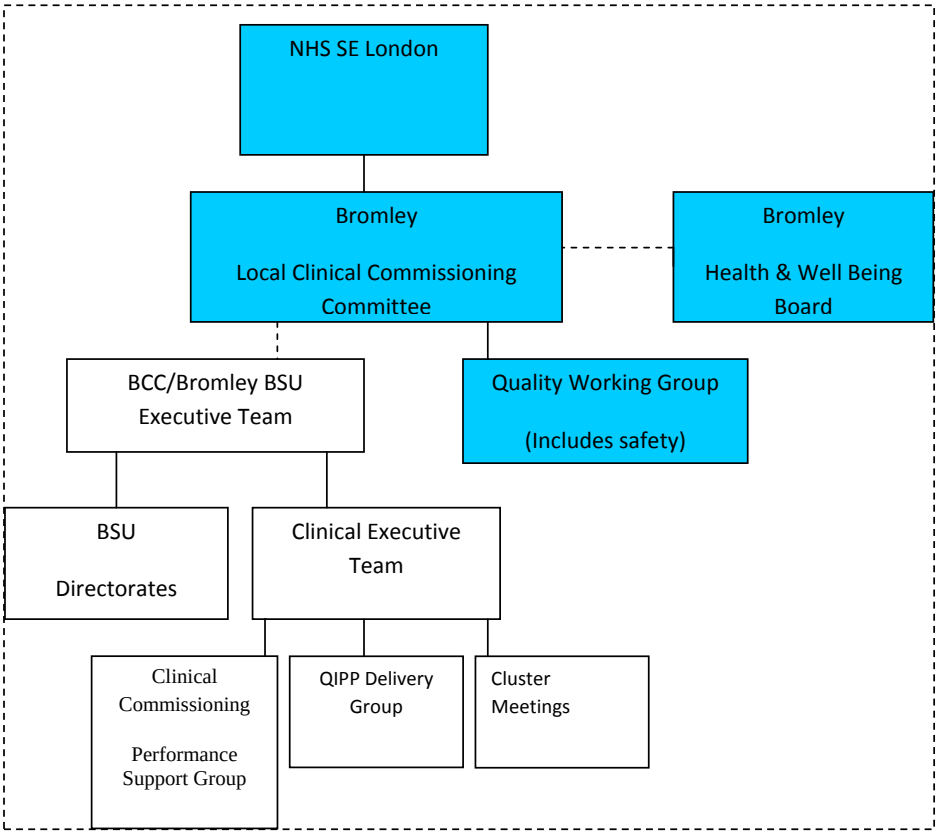
In order to facilitate this gradual transfer of responsibilities from the BSU Managing Director and the current BCCC to BCC over time the agenda of the BCCC will be separated in to two parts (each with the opportunity for a private section of the committee if required). The first part will focus upon the quality, performance and commissioning of areas delegated to BCC. It would also receive reports from each of the clusters regarding actions in relation to those areas of delegated responsibility. The second part will

receive those same reports on the remainder of the commissioning portfolio for which the committee is responsible. In practical terms the reports to the BCCC will not be duplicated but will clearly identify areas that are delegated to the consortium. The Chair and membership of the BCCC would remain unchanged during the meeting.

Over this period of delegation BCC will continue to be represented on the full range of NHS South East London groups through members of the BCCC

Delivery structure to support delegation over time

The existing delivery structure that supports the BCCC prior to any delegation is shown in the schematic below. The shaded boxes show the reporting arrangements from the BCCC to the SEL Cluster Board. The other boxes show the other significant management groups that are in place in BCC. We will continue to develop this structure as we take increased delegated authority through the year.



The BCC/BSU Executive Team will continue to report to the BCCC providing a formal interface role between the clusters and the BCC leadership group for the delivery of commissioning activities by practices in each locality.

The Executive Team will soon be chaired by the BCC Chair and GP Clinical Leads will be responsible for reporting the management activities of their clusters in each of the delegated areas of responsibility. The minutes of this group are reported to the BCCC.

Performance management and monitoring

Critical to the successful delegation to BCC will be the ability to performance manage and monitor its own performance, identify and manage risks and ensure delivery against the financial and outcomes measures against which it will be performance managed within its delegation. Moreover the consortium will be required to provide assurance to the wider SEL Cluster and the PCT Board about the areas for which it has taken delegated responsibility.

BCC has developed and agreed the processes and arrangements through which this will be managed for its planned delegation.

Internal

BCC will monitor and manage performance for delegated areas through the existing BSU structures upon which they are already represented:

BCC/BSU Executive Team: Co-ordinates the strategic and operational management of the BSU. Its key purpose is to provide advice to the BSU Managing Director and facilitate coordinated executive management across the BSU in line with the requirements of the BCCC and the Joint PCT Board. Terms of Reference and membership are at Appendix Two.

Quality Group - Provides the forum at which the safety, quality and clinical and corporate governance of commissioned services will be overseen and actively managed. Terms of Reference for the group are set out at Appendix Three. Like the QIPP Delivery group the agenda will be organised to reflect those areas which are delegated and those which are not. However, the nature of integrated governance will necessarily require a cross over in these areas where issues will be for the attention of both those holding delegated responsibilities and those holding responsibility under current arrangements. At present the group is chaired by the Quality and Prescribing Director of the BSU and this will continue until more than 50% of the commissioning portfolio is delegated to the consortium at which point one of the Clinical Leads will take over the chair of the group. Throughout the period of Transition the group will be supported by the BSU and Cluster team as it is now.

QIPP Delivery Group: Provides the forum at which the performance against QIPP and the development of local commissioning intentions will be undertaken. The agenda will be organised to separate consideration of delegated and non-delegated areas. The group reports to the BCCC. Throughout the period of Transition the group will be supported by the BSU and SEL Cluster team.

Clinical Executive: Provides direction to BCC activity ensuring that there is effective coordination, management and communication of work streams across existing locality clusters.

External

The BCCC bi-monthly meeting will receive, consider and report upon performance of all relevant areas across the year and reports to the SEL PCT Board.

Although the prime focus for performance management activity is at Borough level BCC also participates in the quarterly 'Stock take' meetings led by the Cluster Director of Operations. This existing arrangement currently includes GP members of the BCCC and will continue to do so post delegation.

The 'Stock takes' are a key forum for the Cluster's Performance Framework and they formally review the following on a quarterly basis:

- QIPP Delivery
- Performance against key metrics
- Contract activity and performance
- Financial position
- Key risks and agreement of mitigating / recovery actions

Provided the areas of delegation to BCC are well understood within the review the 'Stock take' sessions will continue to be used to review these areas as they relate to areas of delegated responsibility. These meetings are pivotal to the successful performance management of the system as delegation is made on an iterative basis as the group provides a key forum for the BSU and Cluster teams supporting BCC to review performance together.

Significantly the outputs of these 'Stock take' will provide assurance on whole system performance to a variety of forums within NHS South East London:

- Reports will be made to the Cluster Operations Group and the Cluster Management Board, Chaired by the Chief Executive
- Reports will be received by the BCCC to facilitate local review of performance
- Outputs will be routinely reported to the Cluster Finance, Performance and QIPP Committee as part of the assurance they will need to confirm that delivery is being systematically managed against plan. That Committee will report to the SEL PCT Board on performance risks associated with delegation to the consortium.

<u>Delivering against delegated responsibility</u>

The governance and reporting mechanisms that BCC have established with NHS South East London and the local BSU will allow for increasing delegation across 2011/12 by establishing and utilising structures that allow the consortium leadership team to be engaged in all aspects of local commissioning throughout the year whilst taking increasing areas of responsibility through the same structures. In this way the consortium can report to the PCT Board via the BCCC.

The groups that report to and support the BCCC will allow for the performance management and monitoring of the system at Borough, cluster and individual practice level.

SECTION FOUR: Delegated responsibilities, trajectories and process

BCC wishes to take increasingly levels of delegated responsibility for commissioning on a quarterly basis across 2011/12. The consortium's preferred process for delegation is by commissioning budget area of spend. The consortium's preferred trajectory for delegation will result in the full delegation of appropriate commissioning budgets in advance of April 2012.

BCC will, as it is now, be directly involved in the entirety of commissioning activity over this period working as the clinical leadership of the BCCC. This plan sets out the arrangements and development that the consortium have and will undertake to secure the right capacity and capability to effectively operate with delegated responsibility for all commissioning budgets. The rationale for the phased approach to delegation outlined below is to allow those arrangements to 'bed in' given that both NHS South East London Cluster and the consortium's management arrangements are relatively new.

Trajectory for delegation

The table below outlines the phased delegation that will be supported by this PDP.

	Phase One	Phase Two	Phase Three
Date	**October 2011**	**January 2012**	**April 2012**
			• Acute Commissioning • IFR
		• Mental Health • Joint Commissioning • Continuing Care • Remaining Community Services	• Mental Health • Joint Commissioning • Continuing Care • Remaining Community Services
	• Prescribing • Acute Out-Patients and Community Services (relating to redesigned Care Pathways) • Bromley Healthcare Community Services Contract	• Prescribing • Acute Out-Patients and Community Services (relating to redesigned Care Pathways) • Bromley Healthcare Community Services Contract	• Prescribing • Acute Out-Patients and Community Services (relating to redesigned Care Pathways) • Bromley Healthcare Community Services Contract
Total Budget	£86,975,000	£145,601,000	361,040,000
% of Total Budget	24%	40%	100%

The £361m commissioning budget equates to 71% of the total funding for 2011/12 of £508m received by Bromley PCT. In addition BCC would wish to take delegated responsibility for the BSU pay budget of £2.8m in order to continue to develop a robust management infrastructure to provide effective clinical commissioning support. Primary Care and Public Health costs have been excluded in arriving at the delegated commissioning budgets. We are aware that the 2% surplus and contingencies will continue to be held by Cluster to help to provide financial stability

Delegation of budgets with a balanced financial plan

The table above outlines BCC's intention to increase its delegated responsibility from £87m of the total commissioning budget of £361m, to full delegation in quarter four, 2011/12, with the exception of primary care budgets.

We wish to take the delegated budgets in this order as we recognise the need to strengthen primary care and community services in order to deliver the required changes in hospital services.

We have a strong prescribing team and broad GP engagement in this area giving us confidence that our medicine management approaches will continue to support people with long term conditions more effectively minimising the need for urgent admissions.

We wish to take the joint commissioning budgets in the second tranche and work closely with LBB to agree priorities and approaches in these key areas including Reablement and admission avoidance schemes.

Finally we will take the acute commissioning budgets and as part of the 2012/13 planning process we will work closely with Bexley and Greenwich consortia to design QIPP plans and modernised pathways that assist us to move towards financial stability for SLHT and the BBG economy.

The governance structures to support delegation are already in place, with the local QIPP Delivery group, the Quality group, and delivery teams managing individual projects. In Bromley planning and implementation has benefitted from GP involvement in these performance and planning committees for a number of years through PBC, and all groups are attended by GP Clinical Leads and additional clinical members.

The QIPP Delivery group scrutinises the savings and redesign programme relating to all budget areas and examines finance and performance reports in detail. It then recommends actions to the BCCC, with timeframes for delivery.

The BCCC utilises performance data from the BSU analysts and the Cluster Performance and Acute Contracting teams to evaluate progress and take remedial action as necessary.

Bromley has set a balanced financial plan this year, and is recurrently in balance. In 2010/11 Bromley PCT reported a surplus of £6.9million and is planning to achieve a surplus of £6m in 2011-12.

The GP members of the BCCC considered draft budgets and contract negotiating information at its meetings from December 2010 to May 2011, when final budgets and reserves were approved.

BCC Clinical Leads were engaged in the process that has agreed contracts with all providers, including significant QIPP savings as part of the overall £20M gross savings programme. For the acute contracts there are improved risk share agreements which should reduce the call on reserves this year. £5m of the Bromley QIPP programme savings is embedded in these contract agreements.

Delegation of budgets and management of financial risk

The QIPP Delivery group and the BCCC receive financial reports each month which highlight current and new risks, and the mitigation being put in place to deal with them. As part of governance processes our Quality group receives an overall and departmental risk register, again risk rated and showing remedial actions. In this way BCC Clinical Leads do and will continue to have ample opportunity to agree or recommend alternative approaches to managing these risks. The QIPP Delivery group receives a RAG rating of each scheme and this is challenged by the SEL Cluster at the quarterly stock take meetings.

We will work with the SE London cluster to agree performance, quality and financial targets that will pass from Cluster to BCC as delegation occurs and to agree parameters where issues move from informal support to formal intervention in the event of quality, performance or financial challenges. We will also work with Cluster to set up systems that monitor delegated budget, performance and QIPP targets alongside the Cluster Stocktake process.

The Bromley QIPP schemes are set out in the table below and BCC is currently developing additional schemes to ensure that sufficient contingencies are in place. Most of the schemes are linked to our first tranche of delegation and we will continue to use the QIPP process to both modernise our services and achieve sustainable financial balance.

Bromley QIPP Schemes:

AREA	QIPP/ CIP	VALUE	DESCRIPTION/STATUS
Out-patients	Gynaecology	465,000	Triage and intermediate community based clinics. The financial benefits modelled reflect a part-year effect with both services expected to be fully operational by September following a recent AWP procurement
	Dermatology	300,200	
	MSK	357,000	The fully operational MSK service comprising triage and enhanced community based physiotherapy has had a dramatic impact on physiotherapy waits and GP referrals into Trauma & Orthopaedics
	Referral Management	237,070	A practice-based referral review initiative supported by referral guidelines is reducing the number of inappropriate referrals across a number of key specialities
	Ophthalmology (PEARS)	55,890	An alternative to hospital-based minor eye injuries now fully operational
Planned	Intermediate care	250,000	A 25% reduction in the number of beds is being negotiated.
	Extended MSK	125,000	Further enhancements to the pathway and the benefits of early access to high quality physiotherapy are anticipated to be extending the impact of the scheme beyond outpatient activity (GP referrals) into reductions in surgical procedures
Urgent and Unscheduled Care	A&E	404,000	Two Urgent Care Centres with triage are ensuring that patients with minor problems are not treated in A&E
	Admission avoidance	1,810,000	Established hospital-based community provider case-finding team helping to avoid admissions and effect early and safe discharge
	COPD	597,000	Established community provider specialist nurse-led team managing a COPD caseload helping to reduce the need for hospital care and providing pulmonary rehab.
	Risk Stratification	500,000	GP practice based information tool being rolled out that will allow practices to identify "at risk" patients and ensure that they have in place appropriate care plans to help avoid admissions
Prescribing		905,000	The use of alternative drugs and an examination of situations where drugs are used excessively results in cost savings
Other	Pathology	200,000	A proposed three Clinical Commissioning Group initiative to refine blood test profiles is expected to deliver significant savings
Total *		6,206,160	*The total excludes sector, contracts and estates QIPP (cost improvement) initiatives

The 2011/12 plan has set aside a 0.5% contingency of £2.4m and has an additional commissioning reserve to counter activity levels above plan should this occur. There is also a general reserve of £800k included in the plan. Additionally BCC has worked with the BSU to bid against the 2% non recurrent resources that have been set aside from our own budget. Bromley's contribution is £9.8m. The discussions continue, with a strong view that a proportion of this funding, circa 58% could be released now to ensure QIPP delivery and acceleration of 2012/13 plans into this year.

Delegation for Phase One

BCC commissioning worked directly with local commissioners to provide the Bromley contribution to the NHS South East London Integrated Plan and to develop and agree the local Bromley QIPP Plan. Taken together these documents outline the financial, quality and activity outcomes for the areas BCC wishes to take delegated responsibility for.

BCC's delivery groups for each of these areas have been established in advance of delegation and have devised clear implementation plans that are approved at the BCCC. Each implementation plan is overseen by the Bromley QIPP Delivery Committee and is reviewed by the Cluster 'Stock take' process.

BCC has been involved in every stage of QIPP plan development and implementation and has a good understanding of the in-year risk assessments that have been undertaken and the proposed mitigations that have been agreed between the Bromley BSU and the GP Clinical leads. These will be critical to ensuring the full implementation of QIPP plans.

Capability and capacity for future phases of delegation

Although BCC seeks phased delegation over time we believe the processes, governance and arrangements that are in place allow for full delegation. Delivery teams and clinical leadership has been established across the entire commissioning portfolio and approval of this PDP will establish more formally those dates at which governance and reporting will change to reflect delegation and significantly the points in time where constituent practices will become more directly involved in the commissioning of any given area.

A great deal of financial support is provided to BCC by SE London cluster. In addition it is vital that there is effective local senior financial planning support in place. This role is currently covered by interim support and we are taking steps to make this more robust.

Delivering against delegated responsibility

We will judge success by:

- Achievement of QIPP and performance targets
- Achievement of pathway redesign
- Achievement of 2011/12 financial targets
- Achievement of a balanced budget for 2012/13

The BCCC performance, risk management and financial controls coupled with the history of successful financial management in Bromley provide confidence that delegation can be achieved effectively and safely.

SECTION FIVE: Support requirements

BCC has considered the support requirements that will be required to support delegated responsibility over the transition period. They have been considered in three areas:

- Management capacity and support
- GP Commissioning Support funds (£2 per patient)
- Organisational Development

Timely access to these resources will be critical to support each phase of planned delegation in Bromley.

Management capacity and support

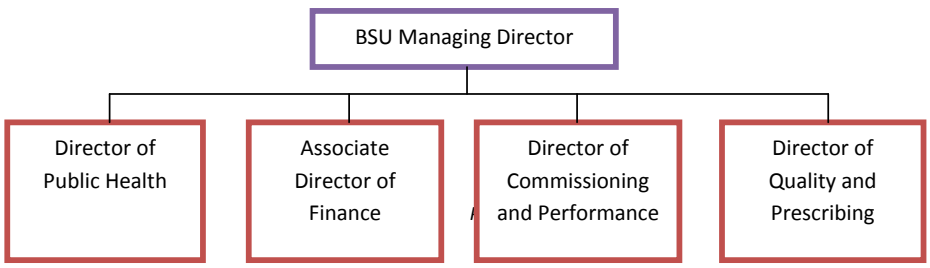
BCC will require the support of the Bromley Business Support Unit (BSU) and of the relevant Cluster Directorate teams over the period of planned delegation. At present BCC believes the current arrangements for support from these NHS South East London Directorates is effective and will support the pace of delegation outlined in the PDP. BCC anticipates the establishment of service level agreements with these Directorates to ensure the level of support currently provided is secured across the period and BCC welcomes the current approach of the Cluster Management Board, which has emphasised and places as much support at the local level as possible.

Bromley Business Support Unit
BCC was able to play the lead role in the design of the Bromley BSU (including a presence on the recruitment panels for the senior positions in the directorate). We have, as a result, an excellent working relationship with that team. The BSU will continue to support the governance and delivery structures described locally and delivery teams will continue to support BCC in their delivery of QIPP areas. BCC has played a lead role in the development of the current QIPP plan and the local aspects of the NHS South East London Business Plan 2011/12 – this has allowed the Clinical Leads to link with and align objectives with the BSU senior management team.

Senior members of the BSU teams are closely linked to Clinical Leads and BCC is well represented on all governance and delivery groups. The cluster structure of BCC is also directly supported by members of the BSU. Key features of the BSU that will support delivery against delegation include:

- Shared objectives between BCC and the BSU
- Shared governance and delivery structures
- Co-production of the current QIPP and performance targets set for local services
- Direct links between the BSU teams and the GP Clinical Leads and their clusters
- Senior financial / Governance advice and support through the BSU Chief Financial Officer and wider BSU Director team
- Local and dedicated analytical support
- Local and dedicated communications and engagement support
- Senior management positions supporting the commissioning of acute, community and client group care
- Good access to Public Health expertise

The senior management team of the BSU is set out below.



NHS South East London Functional Directorates

Cluster Directorates make themselves available for the local delivery groups as required by our terms of reference and BCC will require the financial, performance and quality reports currently provided to those structures to continue. In addition BCC is well represented at the 'Stock take' meeting with all Cluster Directorates and regard this as the appropriate forum through which to address any concerns that may arise.

GP Commissioning Support funds

The NHS London Pathfinder development programme provides for £2 per registered patient funding to be made available to GP Commissioners to support their work over the transition period. The BCC management team has aligned our proposed use of these funds against our delegation trajectory. Key areas of support are identified in that application including:

- Clinical backfill to support the leadership team and wider GP involvement in delegated areas
- Organisational Development work to strengthen commissioning capability across BCC
- Expert resources to support QIPP delivery

Organisational Development

BCC has self assessed itself against the NHS London Pathfinder Development Toolkit domains with our delegation trajectory in mind. A summary of the prioritised needs by domain is provided below:

Domain	Priority given at May 2011 1 = Very Low, 5 = Very High					Confidence Level
	1	2	3	4	5	
Empowering patients and the public		•				High
Vision and Strategy					•	Low
Finance				•		Some
Leadership				•		Some
Clinical Governance / Corporate		•				High
Planning				•		Some
Agreeing			•			Some
Monitoring		•				High

Delivering against delegated responsibility

BCC believe that the level of managerial capacity and support is appropriate to support the planned levels of delegation over time provided:

- Service Level Agreements for the continued delivery of support can be agreed with the Cluster
- The timely release of GP Development support monies is secured
- BCC is able to engage with providers of Organisational Development support throughout the transition period

CONSORTIUM DECLARATION

The Pathfinder Development Plan outlined above represents outlines the Bromley Health Commissioning consortium proposed pace for delegation of commissioning responsibility over the transition period up to April 2013.

Signed:

Name: Dr Andrew Parson

Date:

For and on behalf of Bromley Health Commissioning

GP Leadership Team:

Dr Andrew Parson
Dr Ruchira Paranjape
Dr Mike Collins
Dr Jackie Tavabie
Dr James Heathcote
Dr Sarah Stoner

NHS Greenwich

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.

Pathfinder Development and Delegation

Context;

At the Joint Boards meeting on 19 May 2011, six Local Clinical Commissioning Committees (LCCCs) were established as the vehicles through which Pathfinders would take on delegated responsibilities for commissioning in SE London. The Boards also approved the process for approving delegation to Pathfinders, through a Pathfinder Delivery Plan.

Working with each of the clinical consortia, through the borough-based Business Support Units, a more detailed local assurance process has been agreed and followed as was reported to a meeting of the Joint Boards in July.

The Joint Boards have previously noted that delegated budgets exclude those which relate to the London Ambulance Service, specialised commissioning, primary care contracting, prison health, costs related to non-commissioned services, and nationally required contingencies and reserves.

The July meeting of Joint Boards agreed for the Chair to take Chair's Action to AGREE Greenwich's Pathfinder Delegation Application.

Supporting Documentation;

This report makes recommendations on delegation for the Greenwich Pathfinder (below).

In considering such recommendations Greenwich PCT will be aware of the process and framework outlined to the Joint Boards at their meeting on 21st July.

The detailed assurance process undertaken in respect of this and all applications for Pathfinder Delegation has provided the following supporting information;

- Revised Delegation Application (Delegation Delivery Plan)
- Delegation Application Panel Meeting Action Notes

(Greenwich PCT via Chair's Action):
Approve the phased delegation of commissioning responsibilities from the Chief Executive to the Greenwich Pathfinder as outlined in the Greenwich Delivery Plan

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

Further Action required:

Greenwich PCT will wish to report the outcome of this Chair's Action to the next appropriate meeting of its LCCC

Reporting

A notice of this decision will be provided to the next meeting of the PCT Board on 22 September 2011.

Supporting NED / ED input;

Confirmed with Susan Free and Jeremy Fraser (lead non executive directors) – 22/8/2011.

C K Hewitt — 22 August 2011

Greenwich PCT Chair — **Date**

NHS South East London

Action Points: Greenwich Pathfinder Delegation Meeting

1pm, 18 August 2011

Present: Dr Hany Waba (Chair, Greenwich CCG); Dr Rebecca Rosen (Vice-Chair, Greenwich CCG), Dr Niraj Patel (Vice-Chair, Greenwich CCG), Annabel Burn (MD, Greenwich BSU), Simon Robbins (CE, SE London Cluster); Jane Schofield (Director of Operations, SE London Cluster); Marie Farrell (Director of Finance, SE London Cluster); Simon Hall (SE London Cluster – taking notes).

Apologies (but input via email): Gill Galliano (Director of Development, SE London Cluster).

The application for delegation was received, and SR explained the process to be followed. He particularly noted the high quality of Greenwich Health's delivery plan. HW introduced the plan, and outlined how this fitted in with the Pathfinder's plans for development as part of the NHS London procurement.

1. Engagement of constituent practices of the Pathfinder

HW outlined how the Pathfinder was taking forward this work, and noted that every practice (bar one, which he would be visiting shortly) had already been visited and that all were positive about the way the Pathfinder was proceeding. All practices are invited to a monthly forum, at which the seven elected GP representatives are held to account. Each of the practices is in a syndicate (of about 6-8 practices) and each of the GP representatives works with one or more syndicates to get them involved in the work of the Pathfinder. Already prescribing indicative budgets have been devolved through syndicates to practice level. It is intended to do this with other indicative budgets (e.g. referrals) in order to facilitate good practice and learning.

SR welcomed the refreshing acknowledgement of the past history in Greenwich, and that the Pathfinder had been able to draw a line under this with new leadership and different voices. In response to a question about how the syndicates work, RR indicated that the fact that they were non-geographic, but of similar practices, has helped to get them working so well. NP also outlined how different the ethos was now, and outlined that all practices had signed up to the vision and principles.

2. Relationship with local authority and Health & Wellbeing Board

NP outlined that the Pathfinder has an excellent relationship with the local authority, building upon the substantial joint commissioning and section 75 arrangements that were put in place by the PCT. The Pathfinder is involved in an innovative market testing piece of work with Greenwich Council around mental health services in the community. HW added that the local authority has been involved fully on the board of the Pathfinder since its inception, and even ran its GP election process. AB added that developing the Memorandum of Understanding now would assist the local authority in understanding the relationship between the BSU and the Pathfinder. It was also noted that Greenwich has a Pathfinder Health & Wellbeing Board.

3. Engagement of patients and the public

RR outlined the approach of the Pathfinder, again building upon previous good work by the PCT. It was noted that there is a layperson on GCCC, and Greenwich Council of Voluntary Services has already given a presentation to the board. In future task and finish syndicate groups will involve interested patients, building on the patient groups that some of the practices have. It was noted that in the past big consultation events have not always worked and are overly expensive for the outcomes one may achieve. RR outlined work with the NHS Institute and Citizen UK that links in communities and community activists to involvement, and that the Pathfinder hopes to learn from these approaches. SR urged the Pathfinder to work with the others in SE London to share experiences of these approaches.

4. Change management

SR asked about the relationship between the BSU and the Pathfinder, and how management through the changes over the next eighteen months would be approached. RR outlined the good relationships, and the supportive role that the BSU was undertaking for the Pathfinder. It was also noted that SLHT was undergoing considerable change, which GPs often found confusing – and that the BSU were able to help with navigating this. SR further outlined that the cluster had to now switch its role from leading to supporting.

5. Rationale for delegations proposed

AB outlined that the Pathfinder had wanted to make ownership of the delegation real and that the process began back in May when the Pathfinder developed commissioning intentions. Areas of priority emerged, and in the discussions around delegation the Pathfinder had wanted to align and position delegation to where it could be most meaningful and enable real change. There are huge workplans for all those involved already to shift services to the community, and for the first step of delegation it was felt important to take on those areas that the Pathfinder's members are already leading on and making their leadership real with the clinicians now having the levers. With respect to acute services, the Pathfinder wants to be involved fully in the development of the commissioning strategy for 2012/13, and want to describe their gradual taking on of acute as "mobilisation" from now until April 2012.

This was then examined in more detail, using the referral management and booking service as an example. In response to detailed questioning from SR and MF, both NP and RR outlined the importance the Pathfinder is attaching to commissioning integrated pathways using cardiology as an example. Moreover it was also argued that community services – which the Pathfinder is wishing to take on now – should be the key change lever in referral management rather than seeing things always from the acute end of the pathway. NP also outlined his experience of seeing the data relating to how the QIPP schemes were panning out, and he stated very strongly how seriously GPs are taking this and that they are definitely feeling the responsibility for this area. RR outlined here views on referral management, and noted that she was an adviser to the King's Fund research on this. However, she did believe that Greenwich's linkage to QoF and having referral management as a key part of the local incentive scheme should assist this for the ten highest volume conditions. She outlined how real time useable data would be generated from the pilot, and that work would then be targeted to the top and bottom quartile referrers. SR agreed that this was rational, sensible and evidence based.

6. Finance and risk

There was considerable discussion of the financial position of the QIPP, and it was agreed that this section needed to be rewritten substantially in the document. RR and NP, in particular, outlined how they saw delegation being able to enable them to take more control of QIPP delivery and both outlined how useful they found the Stocktake meeting.

It was agreed that the Pathfinder's understanding of financial risk needed to be strengthened in the document. It was also agreed, in response to questioning from MF, that further work to strengthen the joint approach with Bexley and Bromley to SLHT needed to be outlined. RR outlined the meetings that they had had with acute clinicians already on this.

7. Phase 1 delegation

Overall it was agreed to recommend delegation for all the areas applied for in Phase 1 for Chair's action with the following amendments:

- On mental health it was noted that the interface between general and specialist needed to be drawn out more, telling more of the story that was clear from the meeting but not as clear in the documentation.
- BSU corporate budget: to be taken on. HW had not thought this was urgent as is working well, but understood the cluster's rationale for suggesting it and supported it.
- It was agreed that learning disability services were for Phase 2 given the work that had been done to date, and the need to let the new LD service (which the clinicians were happy with) bed in.
- MF to agree the final set of finance figures.

8. Phase 2 delegation

There was clear agreement on taking on all other areas (chiefly acute commissioning) from April 2012, with a mobilisation phase up until this point. One of the key aspirations expressed in the discussion was with respect to improving services for the over 65s. It was agreed that Greenwich would initiate these discussions with Bexley and Bromley to take forward this across the three boroughs.

9. Next steps

It was agreed that Greenwich Pathfinder would resubmit the documentation with these minor alterations by Wednesday 24 August at the latest in order that the revised documentation can be made available prior to the cluster's meeting with NHS London. On Monday 22 August the Chair will consider the notes of the meeting and the recommendation of the Chief Executive with a view to agreeing Chair's action in a manner similar to that which has already happened for Bromley and Lewisham.

A Compact (Delivery Agreement) will be produced that will be broadly similar for all the delegated Pathfinders in SE London, including success criteria and tolerances with respect to Phase 2 being agreed. The Compact will outline the finances, performance targets, quality and safety indicators, and QIPP schemes explicitly, indicating where responsibility will sit (i.e. cluster or Pathfinder). Simon R gave a commitment to the Pathfinder that the Compact would also include a clear statement

of the cluster resources available to the Pathfinder, and how these will be accessed. The Compact will also outline how reporting of information and “early warnings” would happen, how monthly touch points would happen, and state the expanded role of the existing Stocktake Meeting as the formal monitoring mechanism for delegated responsibilities through the Compact.

Simon Hall
21 August 2011

Pathfinder Delivery Plan
Greenwich Health
2011/12

Consortium Name	Greenwich Health
Cluster	NHS South East London
Primary PCT for Consortium	NHS Greenwich
Lead for Application	Dr Hany Wahba
Designation	Chair of Greenwich Health
E mail address	Hany.wahba@nhs.net
Telephone number	020 8317 6868
Consortium membership	45 practices
Consortium registered population	275,322

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List of Appendices

A. Principles of Engagement (draft)

B. 'Commissioning Voice' – Issue 2, July 2011

C. 'Going Live in Greenwich' – Issue 3, July 2011 D. Greenwich Health Clinical Strategy

D. Greenwich Clinical Commissioning Committee – Terms of Reference (draft – track change version)

E. Greenwich Clinical Commissioning Committee – Finance, QIPP & Performance Monitoring Report, 27th July 2011

F. Enabling, Driving, Assuring the QIPP Programme. Greenwich BSU Gateway Process July 2011

G. Clinical leads and BSU teams (50p piece chart)

PURPOSE

The purpose of this document is to outline the arrangements for the Greenwich Health Board (GH) to function within the governance arrangements of NHS Greenwich so that they can take on delegated responsibility of all relevant commissioning responsibilities between now and April 2012, prior to full authorisation in the year 2012/13.

This Pathfinder Delivery Plan (PDP) describes the current and future arrangements in the following areas:

1. Leadership and consortium structures (Section 1)

2. Delivery through engagement with the wider system (Section 2)

3. Governance and Performance Management arrangements (Section 3)

4. Areas for delegation (Section 4)

5. Support requirements (Section 5)

BACKGROUND

Greenwich Health (GH) is a consortium of all general practices serving the residents of the London Borough of Greenwich. The combined registered population of Greenwich's 45 general practices is circa 275,000 and the consortium is coterminous with the existing NHS Greenwich and the Local Authority.

Since September 2010, GPs from across Greenwich have been meeting together with colleagues at NHS Greenwich and the London Borough of Greenwich, to develop a vision for a Greenwich wide GP commissioning consortium. In October 2010 a GP Commissioning Interim Steering Group was formed, comprising eight GPs and two practice managers as voting members and representatives from the London Borough of Greenwich (Chief Executive), NHS Greenwich (Chief Executive, Director of Public Health and Well-being, a Non Executive Director and the GP Governance Manager), and the Greenwich LMC (Chair).

The GP Commissioning Interim Steering Group was mandated to design a Shadow Board structure for a Greenwich wide GP commissioning consortium, to organise an election process for Shadow Board members and to implement the Shadow Board within an appropriate timescale. GPs in Greenwich were invited to nominate themselves for election during December 2010 and twelve candidates stood for the seven posts. A postal election process using the STV voting system was administered by the Borough Returning Officer in January 2011, supported by Electoral Reform Services. There were 109 valid votes cast, a turnout of 70%, and seven GPs were duly elected to form a shadow board.

The Greenwich GP Commissioning Consortia Board (the Shadow Board) was duly established to lead the transition from PCT commissioning to GP Commissioning in Greenwich, guiding the Shadow Consortia through a two year process preparing the foundations for the Greenwich GP Commissioning Consortia Board which is expected to come into effect from April 2013.

Building on a strong track record of local clinical commissioning the members of the consortium have been able to demonstrate compliance with the three tests set by the secretary of state (relating to local GP leadership and support, local authority engagement and an ability to contribute to the delivery of the local QIPP agenda) and have now worked with the NHS South East London

Cluster to develop the capacity and capability to assume delegated responsibility for some areas of commissioning in 2011/12, and for further aspects of commissioning beginning in 2012/13.

Planned delegation

This Pathfinder Delivery Plan (PDP) outlines the steps taken by the consortium to prepare for and undertake delegated responsibility in line with the approach to delegation adopted by the NHS South East London joint Boards in May 2011.

The GH Board has agreed its key areas of focus for the 2012/13 CSP. These are discussed further on P17 in the context of "Clinical Strategy".

The consortium leadership are members of the Greenwich Clinical Commissioning Committee (GCCC)[1], a formal committee of the PCT Board. The GCCC is chaired by the Consortium Chair and its members include the seven mandated clinical leads of the consortium, as follows:

Dr Hany Wahba

GP Chair

Dr Hany Wahba has been a GP principal in Greenwich since July 1986, and has a special interest in surgery. He was the Vice Chair of Greenwich LMC until he took responsibility for this new role, and has been an LMC member for over 12 years. He was the Medical Director of Grabadoc for 5 years between 2003 and 2008 during which time he helped reshape its structure and functions to make it an efficient, reliable and stable out of hours quality service provider. He also led GP appraisal for NHS Greenwich.

Dr Niraj Patel

GP Vice Chair

Dr Niraj Patel is a GP Partner at Gallions Reach Health Centre. He was the PBC Chair at NHS Greenwich and the Greenwich Representative on the BBG Clinical Cabinet. He holds a Masters in Healthcare Commissioning from the HSMC, and has attended the King's Fund Leadership Programme for Clinical Directors/Lead Clinicians. He is co-author of The Royal Society of Medicine's Handbook of Practice Management and is a GP Trainer for the London Deanery.

[1] Terms of Reference for GCCC attached at Appendix D

Dr Rebecca Rosen

GP Vice Chair

Dr Rebecca Rosen has been a salaried GP in Greenwich for over 10 years. She is also a Greenwich resident, so ensuring good local health and care services is important to her both personally and professionally. She works part time as a salaried GP in Woolwich and part time at the Nuffield Trust – a policy institute which analyses the impact of health care policy. She was a senior fellow in health policy at the Kings Fund 1990 – 2006 working on commissioning, long term conditions, primary care and patient choice and was Medical Director of Humana Europe 1997 – 1998 - an organisation offering commissioning support to NHS PCTs.

Dr Nayan Patel

Dr Nayan Patel has been a Principal at the Blackheath Standard Surgery since 1997. During this time he has gained considerable clinical and management experience and an appreciation of the health needs of the local population. He is involved in education through teaching medical students and in GP training in his capacity as a GP Trainer. He has been actively involved in the management of Grabadoc, firstly as a board member then as the Clinical Governance lead and more recently for the last two years as the Medical Director of the organisation. His educational activities have also been expanded into the area of appraisals, which he has been doing since appraisal was first established in Greenwich.

Dr Eugenia Lee

Dr Eugenia Lee is a young GP in Greenwich. Alongside her clinical work, she also works part-time in Public Health in NHS Greenwich. This role has given her strong partnership working experience with the Council, Police, Health Protection Agency, patients group and the third sector. She has completed an MSc in Primary Health Care at Kings College London and is currently undertaking further study with a second postgraduate degree in a Masters of Public Health at University of Liverpool. She was a member of the Professional Executive Committee (PEC) in NHS Greenwich and completed a year long leadership programme, Prepare to Lead, with NHS London. She is a Board member for South London Faculty of RCGP, a clinical adviser for NICE in the

Community Infection Guideline Development Group, a clinical fellow for Map of Medicine and a reviewer for NIHR for research proposals.

Dr Ram Aggarwal

Dr Ram Aggarwal has been a GP since 1995 and is a lead GP for his practice. His practice has commissioned services during fund holding and he has experience in negotiating contracts with providers. He is presently a member of the strategy group for West Kent PCT and helped to redesign care pathway for minor surgery, skin cancer and carpal tunnel. He has managed and owned nursing homes; hence he has experience of working with the local authority, social services and the voluntary sector. He believes in team work, fairness and transparency.

Dr Rob Hughes

Dr Rob Hughes has over 25 years experience as a GP, gained both locally and nationally. He was a co-founding medical director of Grabadoc and planned, set up and ran Grabadoc between 1994 and 1999. Grabadoc was created to shift the burden of Out of Hours (OOH) care from individual GPs on-call from home. His involvement in the Local Medical Committee over the last 19 years, 15 as Chairman, has given him much experience in both leading an advocating the role of the GP. He maintains a special interest in improving mental health care services.

SECTION 1
LEADERSHIP AND CONSORTIUM STRUCTURE

The Greenwich GP Commissioning Consortium is named Greenwich Health (GH) and is led by the GH Board of 7 GPs. The leadership and consortium structures are supported by the Greenwich Business Support Unit (BSU) and the South East London Cluster Directorates. The Greenwich BSU is newly designed to ensure an alignment to the needs of the consortium over the transition period[2].

Consortium leadership structure and roles

The GH Board members have a contractual relationship with NHS Greenwich (either through secondment or employment as an officer of the Trust) and are governed by the corporate, clinical, financial, and information governance policies of the NHS Greenwich including the Standing Orders and Standing Financial Instructions. Greenwich Health Board members are full members of the Greenwich Clinical Commissioning Committee (a full committee of NHS Greenwich Board) and this is the legal framework in which clinical commissioning will operate until 2013 when the GP Consortia aims to become the statutory body responsible for clinical commissioning in Greenwich. The GCCC has membership drawn from public health, the local authority, GBSU, Non-Executive Directors and has a patient representative (chair of LINKs). There is a nurse post but this is currently vacant and recruitment has been put on hold pending further guidance. The GPs therefore work in a multi-disciplinary/ multi-agency environment to transact their commissioning business.

The Board of GH Consortium is accountable to its constituent members who are the GPs that elected them i.e. all Greenwich GPs. Each of the seven GP clinical leads holds both a clinical and a business portfolio (see Table 1 below), and is responsible for co-ordinating communication with its associated syndicates. They engage clinicians from a wide range of professions and patient and public representatives, as required, and this is described more fully Section 2.

[2] Alignment between GH Board portfolios and BSU support functions and staff – Appendix G

The GPs are supported by members all of Greenwich BSU all of whom have objectives aligned to the NHS South East London Business Plan, the NHS South East London Operating Plan and the Greenwich QIPP Plan. The Shadow Board is committed to supporting these current plans and draws its clinical priorities from these plans, the Greenwich Joint Strategic Needs Assessment; and the Greenwich Health and Wellbeing Strategy.

GH GP Lead	Clinical portfolio	Business Portfolio
Dr Hany Wahba (Chair)	Urgent Care	Organisational development
Dr Niraj Patel	Maternity	IT and data
Dr Rebecca Rosen	Long Term Conditions	Quality and Safety
Dr Nayan Patel	Planned Care and Electives	Contract Monitoring
Dr Ram Aggarwal	End of Life and Cancers	GP Engagement & PC Improvement
Dr Rob Hughes	Mental Health	Communications and Engagement
Dr Eugenia Lee	Children	LA Collaboration

Table 1 : Clinical and Business Portfolio leads

Members of the GP Leadership team have three key responsibilities that will allow them to operate with increasing delegated responsibility over time:

- A leadership, management and engagement role for their syndicates;
- A commissioning portfolio across the borough with responsibility for securing agreed QIPP plans in each area; and
- A business portfolio across the borough with responsibility for ensuring the effective performance management of each area of local commissioning.

Each Board member covers 3 sessions per week in order to fulfil their contractual obligations. They all attend the Board meetings and GCCC meetings. In addition, the Chair and 2 Vice Chairs of the Board attend the Cluster 'stock take' meetings.

The tenure of these positions is for the transition period running for the duration of the Shadow Board (no longer than 31 March 2013) and the Board has recently identified its strategic priorities, which are addressed in Section 1, Clinical Strategy.

Consortium members and Syndicates

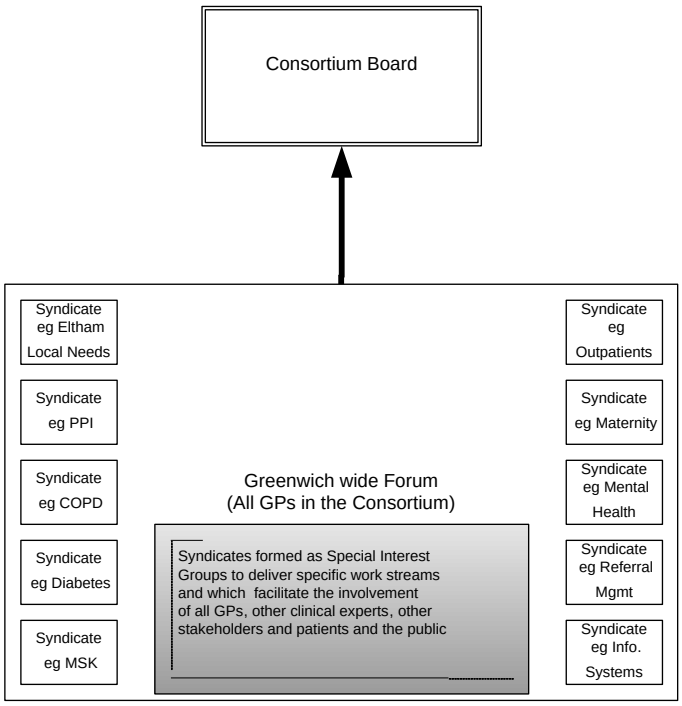
GP membership of the Greenwich GP Commissioning Consortium will be based on 'Principles of Engagement'[3] , the formal agreement of which will be determined through consultation with practices by the Shadow Board. This is currently in a very draft format.

Greenwich Health is keen to ensure that the consortium structures are kept simple, transparent and with as little bureaucratic process and structures as possible. As a result a Greenwich wide Forum has been established, comprising all Greenwich GPs and practices, with a flexible syndicated structure which groups together GP practices.

Syndicates are, therefore, formed around 'natural partnerships' which share a combination of geographical proximity, shared or complimentary clinical skills, and/or information systems. GPs and practices are able to join more than one syndicate at a time in order that all aspects are covered. Syndicates based on clinical areas of interest and clinical experience will influence commissioning and the provision of clinical services. Syndicates based on a geographical basis will ensure all the population of Greenwich, whether registered with a GP or not, are represented. Coupled with shared information systems this ensures that the syndicates are able to take a pan Greenwich population based approach and ensures best practice is shared throughout the Consortium. This syndication is new, as the previous clustering arrangements for GP practices in Greenwich (which were entirely geographical), were not (through the fullness of time) proven to be the best format for GPs to work together in Greenwich.

[3] Principles of Engagement – Appendix A

Greenwich Health Draft Organisation Structure



A project manager is being appointed to support the creation, development and sustainability of syndicates. This will provide for a secondment opportunity and is likely to be a local practice manager or member of staff from GBSU/ Cluster with deep knowledge of general practice. It is anticipated that this position will be filled in September 2011.

Engagement of Consortium members

The Greenwich wide Forum provides a key opportunity for GPs across Greenwich to meet and influence plans and strategies being developed by the Board. Board members have recently completed visits to all Greenwich GP practices but one to develop a deep understanding and to build a consensus for how the consortium will work and make progress together. As a result, the role of the elected Board in commissioning has been clarified and engagement in the development of syndicates and other key workstreams for the implementation of QIPP, has been gained (including 14 practices coming forward to be pilot practices for the Referral Management and Booking Service

which goes live in September 2011). In response the Board has made the following commitments:

The Board has committed to:

- Transparency and openness in its dealings with member general practices in regard to Board decisions;
- Supporting member general practices to deliver and improve health care for patients and the population of Greenwich;
- Providing a voice for GPs on the commissioning decisions in Greenwich;
- Be answerable to member practices to ensure that local clinical opinion is a key driver in the future strategic direction for local secondary and acute services; and
- Paying particular attention to identifying the needs of different types of practice (large and small, single and multi-site etc) and of different localities when developing commissioning plans in order to understand the preferences and support the needs of different GPs in different areas in relation to service changes.

In addition, member practices have committed to:

- Attend local and borough meetings, including educational events to actively engage with the Consortium to help improve services within Greenwich;
- Share data with the Board, such as via clinical audits etc,;
- Implement Board strategies and policies at their respective practices;
- Follow clinical pathways and referral protocols agreed by the Board; and
- Work collectively to help achieve the aims and objectives of the Board.

The syndicates, or local practice groupings, will, henceforth, be responsible for developing and implementing the functions of the Board at a local level. Each syndicate will have a Syndicate Lead. Syndicates will comprise a minimum of six practices to enable them to also undertake the QOF peer review process. The core roles of the syndicates are as follows:

- Peer led review and quality improvement; and
- Local implementation of clinical pathways for their populations.

These will be supplemented, as needed, by Topic Specific Syndicates which may be “task and finish” groups focused on specific conditions or care groups.

In order to strengthen and further develop the local syndicates, the Greenwich-wide Forum has been meeting regularly since April 2011. These meetings have been held monthly in this start-up phase and have experienced greater attendance at each meeting. As syndicates form and create an effective place for communication and engagement, the Greenwich-wide meetings are likely to be reduced to every other month. There is a real commitment to enhancing engagement across the borough and this is reflected in the increased joint planning and activity already taking place.

From this early engagement activity (individual practice meetings and the Greenwich wide meetings) communication and clarity on expectations was identified as a key gap needing to be filled. Greenwich Health has responded by producing a monthly newsletter, 'Commissioning Voice'[4], which aims to both inform and involve local GPs in a two-way process of communication, in order to maintain and enhance GP practice knowledge of the emerging commissioning agenda. This gives details of progress made on consortium developments, and provides dates for monthly meetings (see Appendix B). In addition the Board members have become aware from their own experience and that of local GPs about the lack of awareness in their provider role of the range of newly commissioned out of hospital services now available. A second newsletter called 'Going Live'[5] is also issued regularly and has been welcomed.

GP Commissioning incentive scheme

A local incentive scheme to encourage engagement of GPs in commissioning is currently being designed and tested with practices and plans to go live on 1st October 2011. The Greenwich Health GP Commissioning Local Incentive Scheme seeks to engage practices routinely in GP commissioning, specifically for October 2011 – April 2012 through:

- Involvement in the commissioning, decision-making and service improvement activities of Greenwich Health including its syndicates; and
- Improved and effective management of patients who attend Accident & Emergency services frequently and/ or have frequent admissions to hospital (3 or more).

[4] Commissioning Voice – Appendix B
[5] Going Live – Appendix C

Effective management of the urgent and unplanned care system is just one of the key priorities of Greenwich Health[6]. Attendances at A&E at Queen Elizabeth Hospital have increased in 2011. Good management of patients with long-term conditions within primary and community care is one of the major ways to improve quality of care and experience for patients, and also reduce unnecessary use of A&E.

Engagement of other clinicians

Legacy organisations in Greenwich, such as PEC, have a long history of working closely together with other clinicians, including Allied Health Professionals who were included as PEC members. The GH Board wish to ensure that clinicians are engaged beyond 'token' or 'representative' board and committee membership in a manner that draws on appropriate skills and knowledge for particular work streams and projects. The appropriate clinicians will be asked to support various work streams with other clinical leaders and also invited to the Board to support discussion and decision around their specific agenda items. These clinically led work streams will tie in to the proposed GP syndicates within the consortium structures to enable a more focussed and robust approach to engagement and the ongoing delivery of strategic plans.

This work will build on the already very successful clinical round tables that have supported the QIPP work in Greenwich during previous years. Allied Health Professionals and secondary care clinicians have been involved in clinical round tables for all of the community schemes. In addition district nurses and community nurses were closely involved in the JET scheme, the virtual admissions avoidance scheme and the enhanced end of life strategy.

The Board is also clear that it will need to work and engage with clinicians beyond the Greenwich boundaries and will seek to build new clinical alliances with the clinical commissioners and experts across South East London and in particular with Bexley and Bromley.

Infrastructure and support

Greenwich Health and Greenwich BSU are working effectively together in order to secure the required infrastructure necessary to support the future delegated responsibilities, and leadership of the team. The pathfinder money is being used to enhance capability and GBSU is being used as the employing /

[6] GH Priorities outlined in full in the context of the Clinical Strategy, post.

contracting body for this work. Greenwich Health has submitted its Statement of Works through the NHS London process to procure development support as part of batch 2, and it is about to select its preferred provider. This workstream will help develop both the Board and the wider Consortium towards achieving commissioning competencies which are fit to receive full authorisation by April 2013.

Code of Conduct/managing Conflicts of Interest

All GH Board members are required to follow the Nolan Principles of Standards in Public Life. They are also required to follow the standing orders of NHS Greenwich which mandates a code of conduct and any interests that are relevant and material. All members are required to declare such interests on appointment and any new interests that arise are subsequently declared at each GH Board and/or GCCC meeting.

In preparing for delegation one of the Non Executive/ Vice Chairs of NHS Greenwich, Rev. Jeremy Fraser, has agreed to undertake the role of Conflict of Interest Guardian, to oversee this area, and provide appropriate advice and support to the committee in determining the most appropriate approach to be taken in each case. He will chair any GCCC meeting where the current GP Chair, Dr Hany Wahba, has a conflict of interest.

The register of interests for GCCC members is systematically maintained by the Greenwich BSU Transitional Business Development team and is made publicly available. These details will also be published in the NHS Greenwich Annual Report. The remuneration of Greenwich Health Board members will also be made publicly available within relevant board papers.

The NHS South East London Cluster Management Board considered a paper on Conflict of Interests at its August 2011 meeting and this sets out clearly a framework which GCCC will adopt for all future meetings.

Delivering against delegated responsibility

GH is being supported by Greenwich BSU in order to develop appropriate capability and capacity to take delegated responsibility with the aim of acquiring full responsibility for all services that will be commissioned by Clinical Commissioners, post April 2013.

It is not proposed at this point to delegate responsibility for Greenwich BSU as a management team as this will not add any value. The Managing Director, as a full member of GCCC, would remain accountable for day-to-day management of the team, and the work of GBSU is already fully aligned so this is seen as a non-value-added, and artificial, step at this point.

Clinical Strategy

Robust strategic plans and commissioning intentions are required in order to ensure financial health and clinical quality are maintained, or improved, in 2012/13 and beyond. The GH Board has run 3 workshops to identify the areas they want to focus on for the Commissioning Strategy Plan/ Operating Plan for 2012-13. These key areas, where they believe they can add value and which need to be urgently addressed in Greenwich, are:

- Long Term Conditions;
- Urgent Care;
- Mental Health;
- End of Life Care; and
- Planned Care.

And for each priority area the Board is now identifying one or more specific goals (e.g. reduction in emergency admission for Long Term Conditions (which fits with QIPP); and for each goal, we would plan to commission services/tools to deliver the goal. Medicines management would be a workstream within each of these areas.

Having identified these priority areas the Board is seeking delegation so that it can control the levers to drive these areas namely:

- Delegation of specific contracts; and
- Delegation of QIPP plans.

These are set out in Section 4.

Greenwich Health Board members are already aligned to workstreams through their portfolios. Once formal delegation has been agreed they will be involved more fully in the detailed work of commissioning including attending contract meetings with providers, Clinical Quality Groups, Partnership Forums as well as leading service redesign (which they are already doing). Involvement with

Medicines Management will be through the Medicines Management Sub Committee.

Greenwich BSU staff are meeting with Board members on a regular basis so that Board members develop a better sense of the total role of commissioning. There is an open invitation for Board members to attend the monthly Greenwich BSU Business Meeting and Board members attend the QIPP Programme Board and this will continue.

To take on these roles it has been recognised that the seven GP Board members alone cannot do all clinical commissioning in Greenwich. Role descriptions for additional support from Greenwich GPs are being drawn up to support service redesign and change workstreams. In addition, the GPs have been allocated administrative support, funded for three days a week via GBSU, and have an expert working with them on commissioning intentions for a short term period. This is a rapidly developing picture linked to developing Commissioning Intentions but at this stage includes:

- Clinical time for Finding the Vulnerable Project;
- Clinical time for the Cardiology Integrated Pathway redesign;
- Review of urgent care (potentially being led across NHS South East London through the Clinical Strategy Group); and
- Review of planned care (potentially with Bexley and Bromley) to bring a more strategic approach to this workstream.

Greenwich BSU has established teams in place to fulfil its non-acute commissioning and service redesign functions. These are supported by local finance and transitional business development teams (which include governance, engagement, PALs & Complaints and programme and admin functions). Greenwich Health Board members work with these teams within the systems and processes put in place and together they will be adapted as the Board members exert more leadership in this area.

The Managing Director of GBSU, Annabel Burn, routinely meets with the Chair Dr Hany Wahba and two vice chairs, Drs Niraj Patel and Rebecca Rosen, on a monthly basis to ensure that operational management of Greenwich BSU and the work plans of Greenwich Health are fully aligned. Senior members of Greenwich BSU attend Greenwich Clinical Commissioning Committee to inform discussions and to ensure that their work aligns with the aspirations of the Committee and Greenwich Health Board members.

SECTION 2: DELIVERY THROUGH ENGAGEMENT WITH THE WIDER SYSTEM

Greenwich Health places high priority on partnership working and engagement and is committed to working in partnership with all local agencies, patients, carers and the public. The Board recognises that it cannot, alone, deliver the significant changes planned so partnership working is recognised as essential to meeting its strategic aims.

Communications Strategy

GH and GCCC have developed a communications strategy in order to engage and inform stakeholders. This is particularly important during this period of considerable change. The relevant stakeholders are as follows:

- London Borough of Greenwich & Greenwich Health and Well Being Board;
- Overview and Scrutiny Committee;
- Local NHS Providers;
- Local clinicians (in Greenwich and across SE London);
- Local health Committees including the Local Optometrists Committee, the Local Pharmacy Committee, the Local Dental Committee, and the Local Medical Committee;
- Neighbouring PCTs and GP Consortia;
- The public, patients and carers – patient representative groups, Greenwich, Pensioner's Forum, Greenwich LINk (and Health Watch)
- Voluntary sector organisations;
- London Ambulance Service; and
- HM Prisons Service.

In order to encourage engagement across the borough, Greenwich Health Board members have already visited and developed relationships with key stakeholders in their portfolio areas of responsibility (e.g. LINks/Pensioners Forum/SLHT/Oxleas etc). The Board Chair and the BSU MD have presented and answered questions at the Greenwich Local Strategic Partnership.

GH and GCCC are, also, working closely with the South East London NHS Cluster in order to ensure that there is shared learning and that any Greenwich communications channels are consistent with those developed across a wider platform.

The London Borough of Greenwich – partnership engagement

The Greenwich Health consortium is committed to working in partnership with the Local Authority and this is reflected in the GH vision. It is important to have a needs based approach to commissioning and the expertise provided by public health and encapsulated within the Joint Strategic Needs Assessment is essential. The NHS Greenwich Director of Public Health and Well-Being was a key member of the Interim Steering Group to help establish the consortium.

The Chief Executive of the Local Authority was a member of the Interim Steering Group and either she, or her deputy, the Director of Adult Social Services, attended all consortium meetings, including the wider GP engagement events. The input from the Local Authority has been crucial in the development of the "Principles of Agreement" and the Consortium's objectives.

The Local Authority Returning Officer and her staff managed the elections process for Shadow Board members and ensured that the elections were administered effectively and fairly.

Greenwich has a long history of successful joint commissioning with the Local Authority in areas such as care for older people and for people with mental health conditions. The intention is to build on this firm relationship to bring about the best possible health care and health outcomes for all people in Greenwich.

Health and Wellbeing Board Development

Greenwich is a Department of Health Early Implementer for Health and Well Being Boards. The Greenwich Health consortium is committed to working with the Local Authority to establish an active Health and Well-Being Board. The Health and Wellbeing Board will develop the Joint Strategic Needs Assessment and lead the implementation of the borough wide Health and Wellbeing Strategy.

The Health and Well Being Board is chaired by the Leader of Greenwich Council, Cllr Chris Roberts, and has strong membership comprising council chief officers, and the NHS, represented by Greenwich Business Support Unit and

Public Health. It also includes the non-Executive Director members of the GH Board and three GP members of the GH Board (including the Chair).

Regular meetings are taking place about the transfer of public health responsibilities to the council, and the new relationships here with the consortium and Public Health England and the NHS Commissioning Board when they arrive. A Memorandum of Understanding between NHS South East London Cluster and the London Borough of Greenwich is being jointly developed to capture the relationship which is both in place, and aspired to, with reference to closer working with the Greenwich Health Board.

In addition, members of the Board have attended and presented at the Overview and Scrutiny Committee and will be presenting their commissioning intentions in early September so that they share their thinking openly at an early stage.

The Board of NHS Greenwich approved the "Greenwich Health and Well-Being Strategy" developed jointly by NHS Greenwich and Greenwich Council, the first ever joint health strategy. A member of the Greenwich GP Consortium, Dr Eugenia Lee, contributed to the development of this strategy and this will inform the work of the Consortium going forward. The strategy sets out a clear vision for improving public health and well being in Greenwich:

"By working together with our partners in the community, voluntary and private sector we believe we can:

- Create environments in which people live, work, study or relax that are good for mental and physical health and wellbeing;
- Encourage all people in the Borough who are able to strive to be economically active and to make a contribution to their community, avoiding unnecessary reliance on public support and provision, and promoting ambition and aspiration to escape dependency.
- Ensure that our services are efficient and responsive to the needs of our population, based on what we know to work (evidence based); using innovation and creativity where evidence is limited, and ensuring robust evaluation processes to measure effectiveness; and
- Work with local people in the planning and review of services, making changes to improve the quality of services we commission.

There are three imperatives driving this strategy:

- Prevention is a priority and cost effective;
- Inequalities in health mean that new approaches are needed; and
- Greater integration in our working & our commissioning.

This is an ambitious strategy which fits well with the stated clinical priorities of the Consortium and the NHS Greenwich QIPP and Operating Plans.

Local NHS Providers - Oxleas NHS Foundation Trust (mental health and community services) and South London Healthcare NHS Trust (SLHT)

The main providers for acute, community and mental health services across Greenwich are Oxleas NHS Foundation Trust and South London Healthcare NHS Trust (SLHT). The GCCC are determined to ensure that there are open and collaborative working relationships with the main community and acute providers in order to address the quality and financial challenges in the borough. Members of the GH Board have visited both Oxleas and SLHT to discuss their portfolio areas of responsibility.

The main engagement with these partners is undertaken by:

- Regular 1 to 1 meetings with the clinical directors at Oxleas NHS Foundation Trust and South London Healthcare NHS Trust;
- Clinical round table discussions;
- Clinical networks;
- Contract review meetings;
- Quality review meetings;
- Discussions through specific redesign programmes;
- Discussions through the Clinical Strategy Group; and
- Discussions through the Stakeholder Reference Group.

'A Picture of Health' (APOH), a clinical strategy was developed across South East London in order to address some of the financial and quality issues within the local health economy. This outlined an agreed clinical strategy and commissioning intentions about service configuration. This was reviewed by partners across BBG last year, and Dr Niraj Patel (GH vice chair) was part of the clinical review. All GPs involved agreed that this collaborative way of working was useful. GH will be working with the consortia in Bromley and Bexley, via the new Clinical Reference Group, in order to work around the geographical configuration of the acute hospital, the South London Healthcare NHS Trust (SLHT).

Conversations with the senior medical teams at SLHT during the review has also led to SLHT setting up a consultant cabinet which will align with the commissioning group so that senior clinical conversations, debate and challenge can occur, enabling local clinicians to effectively take a shared view on health strategy which in turn will drive local redesign to deliver increasingly effective and sustainable services.

Patient and Public Engagement

It is essential to develop and implement commissioning plans in close collaboration with patients and with the wider Greenwich population. GH engages with these groups through attendance at key meetings, e.g. GPs have attended all the local LINKS group meetings, and have presented to the Pensioners Forum, to explain the role of the commissioning consortium and explore their members' views about local services.

GH is reviewing the feasibility of different approaches to patient and public engagement given available resources. In addition the consortium has identified engagement as a GP lead portfolio, and Dr Rob Hughes is leading on this aspect for the consortium, with support from Greenwich BSU. In particular GH is exploring the use of community engagement methods and community activation to create forums for local people to participate in the commissioning process. NHS Greenwich is part of a Knowledge Transfer Partnership with the University of Greenwich on Patient and Public Engagement and GH are keen to support and learn from this work.

A formal engagement plan is currently under development and will build on local experience of engagement throughout the commissioning cycle.

The public and patients have been asked to contribute their ideas to the proposed redesign of services across the sector, and 100 questionnaires have been completed by the public. There are on-going PPI consultations as the plan progresses.

In addition, current QIPP initiatives have been designed in consultation with local communities and patient groups. Work is underway to shape GH's approach to this area including:

- Ensuring all QIPP plans have detailed engagement plans;

- Prioritising development of the knowledge and capacity of clinical commissioners in this area (including policy guidance, legislation and best practice);
- Forging purposeful and constructive relationships with local MPs, Local Overview and Scrutiny Committees and representatives of community groups; and
- Building a strong and unified approach to community engagement with partners in the development of Greenwich's Health and Wellbeing Board.

SECTION 3: GOVERNANCE AND PERFORMANCE MONITORING ARRANGEMENTS

Greenwich Clinical Commissioning Committee

The GCCC works as a Committee of the NHS Greenwich Board with membership drawn from the Greenwich Health consortium Shadow Board, BSU managers, and other representatives. Membership includes:

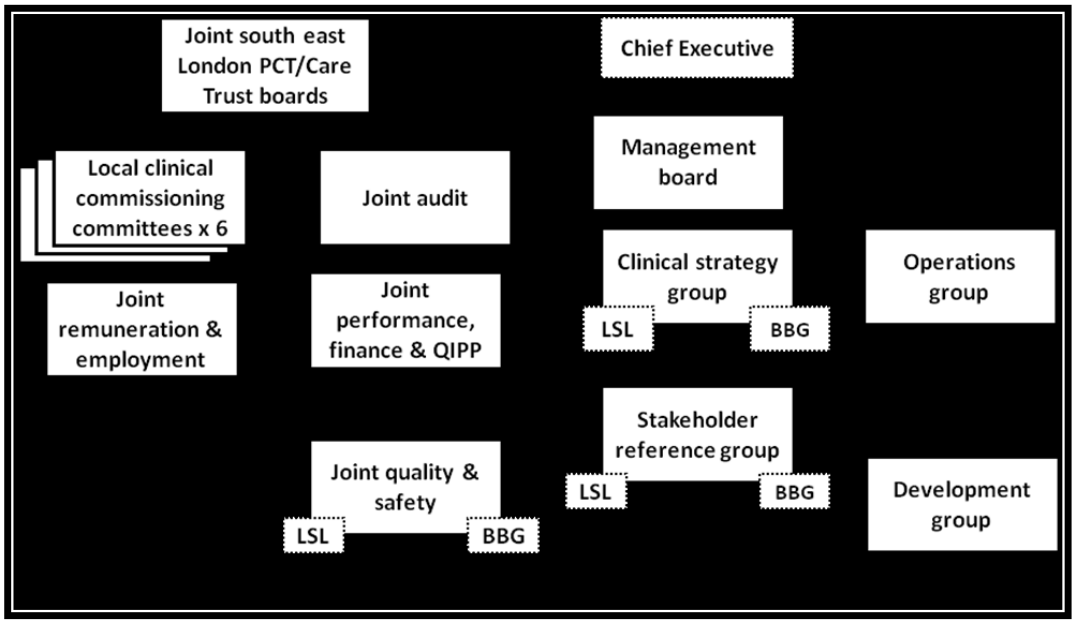
- The seven elected GP members of Greenwich Health (the local GP commissioning consortium) one of whom shall be the Chair;
- The Greenwich Business Support Unit (BSU) Managing Director;
- A representative for the London Borough of Greenwich;
- The Greenwich BSU Head of Financial Delivery;
- The Greenwich Director of Public Health and Well-Being;
- A nurse representative (vacant – pending national guidance); and
- 2 Greenwich NEDs (who will share a vote).

In attendance (non-voting members):

- 1 Greenwich LINk representative;
- Head of Non Acute Commissioning and Partnerships – Greenwich BSU;
- Head of Service Redesign and Delivery – Greenwich BSU; and
- Head of Transitional Business Support – BSU.

The GCCC has executive powers as set out in the Board's Scheme of Delegation. The terms of reference for the GCCC are attached as Appendix D. These Terms of Reference were agreed at the NHS South East London Cluster Board in May and have been further refreshed in August 2011 to reflect the governance changes required of GCCC to receive delegated responsibility. The 'track change' version is attached for reference and these will be presented for final approval in September 2011.

GCCC works within the current governance structure for NHS South East London. Through members of the Committee, including GH Board members, GCCC reports formally into the Joint South East London PCT/ Care Trust Boards and participate in the various committees and groups as appropriate within the overall structure, as seen below. Five members of GCCC are full members of the Board (Chair, Vice Chair, NED member, MD, DPH). These, and others, attend committees and groups referenced below including Quality and Safety, Clinical Strategy, Stakeholder Reference and the Management Board.



Joint Audit & Risk Committees

The Audit & Risk Committees will operate as Joint Audit and Risk Committees of the five SEL PCTs and Bexley Care Trust. The reports that are prepared for this committee will also be reviewed by GCCC at Clinical Commissioning Committee meetings.

Joint Performance, Finance and QIPP Committees

The SEL Performance, Finance and QIPP Committee is a Committee of the five SEL PCTs and Bexley Care Trust to provide oversight of performance, financial management and QIPP delivery for the area.

Financial and performance management and progress against delivery of the QIPP plan will be reviewed by this Committee where the Cluster Director of Finance will present their progress against QIPP delivery, following discussion

with the GCCC and discuss financial and performance risks and controls. The Director of Performance will bring performance reports to this Committee and to the GCCC. Performance issues will be escalated either through this committee or directly by GCCC.

Joint Quality and Safety Committees

The Joint Boards are establishing a Committee to oversee the clinical governance framework for the five PCTs and Bexley Care Trust. It will provide assurance to the Joint Boards and GCCC that commissioned services are safe and of high quality and that there are adequate plans in place to respond to issues of poor quality. Reports will be received by both the Joint Boards and also by GCCC in the future.

Joint Remuneration and Employment Committees

A joint Remuneration and Employment Committee will serve all five PCTs and Bexley Care Trust. The aim of this committee is to assist the joint boards and GCCC in meeting their responsibilities to ensure appropriate remuneration, allowances and terms of service for the Chief Executive, Directors and senior staff, having proper regard for the organisations circumstances and performance and to the provisions of any national arrangements where appropriate.

Clinical Strategy Group

This group brings together all six local CCC Chairs and other clinical leaders to review strategic clinical priorities. The purpose of the Clinical Strategy Group is to determine, design and recommend service changes across more than one borough. Examples of this will be changes to cancer or vascular services or changes to SLHT. The forum will take advice from the Stakeholder Reference Group, before reporting to the audit and risk committee, with relation to matters of substantial change, for assurance purposes.

Stakeholder Reference Group

This is the forum where engagement on strategic change in health services across more than one borough can be reviewed collectively with patient representatives and stakeholders. The Stakeholder Reference Group has evolved from the existing BBG Stakeholder Reference Group that has been successful in improving stakeholder engagement following A Picture of Health (APOH) and reviewing the programme against the two reconfiguration tests on patient engagement and Choice.

The role of the GCCC is to develop and recommend to the joint Boards of NHS Greenwich a commissioning plan that meets the health needs of the local people and GCCC is authorised to establish any sub-committee or working groups to support this role.

Performance management and monitoring

It is essential that the GCCC is able to monitor and manage performance, identify and manage risks and ensure delivery against financial and outcomes measures. The responsibility delegated to GCCC already is to monitor all services commissioned for the population of Greenwich. It does this through receiving a suite of performance reports[7] at each monthly meeting with the latest data so that performance against plan can be measured. As a minimum, these reports cover finance, performance and delivery against the NHS Operating Framework headline and supporting measures, existing Public Health indicators, and patient safety. A sub committee of GCCC has recently been established to ensure that all the quality and safety dimensions of all contracts are appropriately monitored as it has not proved possible to do this sufficiently in the routine GCCC meetings. This Sub-committee is chaired by one of the GPs from Greenwich Health who will represent Greenwich at the Quality and Safety Committee of the board. From September, this Sub-committee will report to GCCC so that all members are appropriately sighted on significant quality and safety issues.

Reports are provided on the delivery of the QIPP plan against plan and the impact of schemes on headline performance. A copy of the latest report is attached at Appendix E. The contents of these reports are discussed by the GCCC prior to the quarterly 'stock take' meeting held by the Cluster (see below).

The delivery of the QIPP programme in Greenwich is key to reaching financial balance in 2011/12 and going forward. To ensure that the locally owned elements of the QIPP programme are on track and delivering a Programme Management approach is being taken. This occurs at 2 levels:

- A gateway meeting comprising two GPs (one of the Chair/Vice Chairs plus one other preferably with the lead in the area being considered), and a team from GBSU led by Annabel Burn, MD (who will Chair the

[7] Performance reporting – Appendix E

meeting) who meet formally to sign off all of the steps required to move forward on QIPP schemes (sign off a business case or allow the scheme to go live eg out to procurement or variation of a current contract). This gateway will check that all clinical, safety, financial and procurement aspects have been completed appropriately and that a risk and communication plan is in place; and

- An oversight meeting attended by all GPs on the GH Board, plus the GBSU team which will take place 3 times a year and will ensure that the whole QIPP programme is on target and that plan Bs/ Cs are being progressed where slippage has been identified.

Full details are attached at Appendix F. The outcome from these deliberations will be reported back to GCCC via the performance report.

The GCCC has been actively involved in preparing the QIPP Plan and has contributed improvement schemes to the design of the programme. Greenwich BSU has benchmarked Greenwich performance using NHS Better Care, Better values Indicators (NHS Productivity Indicators) for emergency activity, outpatients and surgical thresholds. The shadow board has been actively engaging with local GPs regarding the QIPP plan having set the context of financial difficulties and aspiration to deliver better, safer care for patients in partnership with all providers. Representatives have engaged across South East London and NHS London to enable Greenwich to be part of wider schemes which are being driven centrally, ensuring they are appropriate locally.

Risk Assessment

The risk register for Greenwich is presented to each GCCC and an assurance framework tracking delivery of the objectives set out in the Greenwich Business Plan is being developed and will be presented of the first time in September. In addition, through the Corporate Risk Register, the Operations Directorate will maintain an overview of performance risk across the Cluster and update the Risk Register. These reports will also be discussed by the GCCC at their meetings.

Stocktake meetings

The governance arrangements to support delegation are constantly developing. In August a paper on Delegation, Performance Management,

Assurance and Escalation Procedures was approved at the August Cluster Management Board meeting. This includes a description of the quarterly stocktake meetings and this is presented below:

A process of quarterly Stocktakes is the Executive function that has been set up to bring together all the 'prime owners' for each of the six borough based Pathfinders. These Stocktakes are therefore attended by:

- Director of Operations [Chair];
- BSU MD for Borough concerned [plus any key BSU players they wish to invite which for Greenwich is the Head of Financial Delivery and QIPP Manager];
- Chair of GP consortia for Borough concerned [or nominated Rep which for Greenwich is the two Vice Chairs];
- DPH for Borough concerned [whilst Public Health a Cluster responsibility];
- Director of Primary Care [whilst Primary Care a Cluster responsibility];
- Director of Acute Commissioning;
- Director of Performance;
- Director of Strategy and QIPP; and
- Director of Finance.

Each quarterly Stocktake meeting formally reviews, for that borough:

- QIPP delivery;
- Performance against key metrics [key national plus key local];
- Contract activity and performance;
- Financial position; and
- Key risks and agreement of mitigating/recovery actions and named owner of these.

The output of the quarterly stocktake meetings is a key plank in the assurance process within the Cluster and will therefore routinely be summarised and available for the use of a variety of forums.

- The output from the relevant borough stocktake will be reported to each of the Clinical Commissioning Committees [committee of the Board established as a governance vehicle for delegating responsibility to the Pathfinders] in order for them to review and take forward the local leadership and action required to support local progress;

- The output from all six borough stocktakes will be reported to the Cluster Operations Group & Cluster Management Board who will review the picture across the six boroughs in order to identify and take forward any Cluster wide actions that are required. Equally consideration will be given to the need to establish a formal recovery Board within the Cluster arrangements in the event of major failures of delivery;

- The output from all six borough stocktakes will be routinely reported to the Finance, Performance and QIPP committee as part of the assurances they will need to confirm that delivery is being systematically managed against plan and as a means of supporting the identification of major risks to Cluster for more in depth consideration by the Committee and onward reporting to the Board; and

- For briefing the CEO as Accountable Officer.

In between the quarterly Stocktakes a monthly finance report and performance report is produced and progress against key milestones is assessed. These are considered by the Operations Group in order that early variances from plan are tracked and action taken where necessary in conjunction with the 'prime owner' or relevant Director.

In the event of significant failure of delivery either across a function, or within an area, the matter is escalated to the CEO and a 'Recovery Board' convened chaired by the Director of Operations or Director of Performance and involving relevant Clinical leads, Directors and senior managers from the Cluster. This course of action is / will be triggered where the failure is of a scale sufficient to jeopardise the overall stability of the PCT/Cluster in terms of:

- Management of Patient safety issues or significant deterioration of quality;
- Delivering the statutory financial duties; and/or
- Failure to deliver multiple national headline measures.

Further details, with respect to how finance and performance issues will be addressed, including escalation parameters, is outlined below and represent section 5 & 9 of the full paper.

5. Further detail on assurance and escalation for financial management

Status of measure	Assurance requirements
Green	Ongoing dialogue between cluster and pathfinder. Monthly pathfinder budget statements pathfinders provided by the assigned BSU Head / AD Finance who will review in detail with the pathfinder leads. Routine monthly meetings determined locally, but expected to be chaired by the BSU Managing Director and attended by the BSU Head / AD Finance. Monthly Finance Report to Cluster Director of Finance as part of Borough / PCT financial reporting requirement.
Amber	Overspend (actual or forecast) or non delivery of QIPP will require increased dialogue and updates on progress to resolve concerns (subject to monthly / quarterly updates as appropriate e.g. to Finance Committee) Appropriate senior Finance representation at monthly meetings.
Red	Significant overspends (actual or forecast) or failure to deliver on QIPP will require regular updates on progress to resolve concerns (frequency will be agreed e.g.: daily / weekly /monthly / quarterly reports dependent upon frequency of available data and level of risk) Remedial reporting regime to include monthly Finance meeting with

	Cluster Director of Finance

Reasons for escalating the frequency and level of assurance for Finance will be linked to:

- Failure to deliver (forecast or actual) on QIPP targets; and/or
- Failure to secure agreed financial position /expenditure limits – actual or forecast.

As with performance, there is no absolute trigger – the decision to escalate will be made in the overall context of pathfinder delivery.

9. Formal intervention in the light of variation from plan

The Escalation arrangements that will be used to intervene in light of variation from plan are as follows:

Status of measure	**Assurance requirements**
Green	Would be subject to monthly checks that performance is not masking a failure in data or wider concerns. Ongoing dialogue between cluster and pathfinder. Routine monthly meetings to: •Seek assurance and agree strategies to deliver improved performance •Provide a level of challenge and support for areas of underperformance
Amber	Persistent Amber (2 or more) will require increased dialogue and updates on progress to resolve concerns (subject to monthly / quarterly updates as appropriate)
Red	All red targets will require regular updates on progress to resolve concerns (frequency will be agreed e.g.: daily/ weekly/ monthly/ quarterly reports dependant on frequency of available data and level of risk)

Reasons for escalating the frequency and level of assurance for a specific target

will be linked to:

- Performance concern resulting from systemic problem within the pathfinder/local health economy;
- Persistent failure to secure agreed change in performance/target delivery Profile of target at a London/national level; and/or
- As with Finance, in all instances, judgment will be applied – there is not always an absolute trigger and therefore escalation will be considered in the context of overall pathfinder delivery.

Equalities

The GCCC is fully committed to the adoption of the Equality Delivery Scheme, which is being developed across the whole sector to replace the Single Equality Scheme. We are committed to participating actively in the development of the Equality Analysis Tool, and as members of the cluster's equality group. Moreover, we are committed to ensuring that we include equality considerations in all our commissioning decisions, making reasonable adjustments to services for vulnerable children and adults, and specifically to ensuring that we improve access to generic health services for people with learning disabilities.

SECTION 4: AREAS FOR DELEGATION

The GCCC seeks to increase its responsibility for commissioning from September 2011 through submission of this Pathfinder Delivery Plan. GCCC will move from reviewing and monitoring services commissioned to taking direct responsibility for developing commissioning intentions, delivery of specific QIPP projects and management of specific contracts and budgets. Having spent focused time considering commissioning intentions for 2012-13 GH Board members are now very clear which areas they would like delegated to GCCC in the first instance.

Benefits of delegation

GH Board members have identified that there are benefits to delegation. Namely that GH Board GPs will be closer to day to day decision making in the areas they seek to influence intensely in the coming months as they shape the Commissioning Strategy Plan. Therefore they will be better informed as they

engage with the wider GP body to impact on commissioned services in these areas.

GCCC Delegated Responsibilities

In addition to those responsibilities already delegated, GCCC seeks specific responsibilities to be delegated through the Chair of the GCCC as follows:

- Responsibility for the performance management of specific contracts including budgetary responsibility, performance and quality of delivery;
- The delivery of specific QIPP projects including design, implementation, monitoring and delivery of specific schemes;
- GP commissioning development at a borough level;
- Linkages between Health and Wellbeing Boards and GP commissioning operating arrangements, based on an agreed Joint Strategic needs Assessment and Health and Wellbeing Strategy; and
- Leadership of the local contribution to commissioning intentions in the areas identified as priorities.

Delegation will take place in two steps.

Step 1: Delegation in September 2011 of non acute contracts set out in the table below and delivery of specific QIPP projects in table below.

Step 2: Delegation in April 2012 of all commissioned services including acute contracts that are likely to become the responsibility of clinical commissioners post April 2013. To ensure that the GPs will experience a full cycle of commissioning the GPs on Greenwich Health Board want to be fully engaged in contract setting for 2012-13. Taking delegated responsibility for these areas late in the financial year does not fit well in the business cycle so instead GCCC is seeking 'a mobilisation phase' from January – March 2012 so that the Board of GPs are fully involved in all contact negotiations including those with acute providers not just those areas that have been delegated.

Delegation of QIPP Plans (Step 1)

The total QIPP plan for Greenwich includes schemes across all components of commissioned services – acute, primary care and community. The GPs on the Board seek to take specific responsibility for schemes that support the areas they have identified as requiring focused attention in Greenwich this year and

next. Therefore the following projects will be delegated to the GPs with the full support of GBSU teams.

Scheme title and code	Goal	Investment/ saving	Timeline
RR07 RM&BS	Establish a referral management and booking service with the GP body in Greenwich fully engaged with the aim of reducing unnecessary referrals to secondary care and utilising primary and community services more effectively	Net target save £92k in 2011-12 rising to £366k in 2012-13	New service commissioned and rolled out in pilot form by September with full roll out in January 2012
UC04, PR01, PR02	Service improvement and prevention work for people Long Term Conditions. The aim is to reduce unnecessary emergency admissions by increasing support at home, early detection and management of conditions and early supported discharge to reduce hospital length of stay.	Net target save £619k in 2011-12 rising to £2.4m in 2112-13	Enhance out of hospital services aligned to winter planning by November 2011 building up risk stratification and improved linkages between community and primary care services on a month by month basis
E01 End of Life Care	Increase the number of people who choose to die at home to do so through running a 'Test and Learn' pilot managed by Bexley and Greenwich	Net cost £2k in 2011-12 realising cost benefits in 2012-13	Contract for test and learn was signed in May 2011 for 1 year with a view to developing a specific tender to

	Hospice		procure the service substantively once the model has been refined.

In addition GCCC, working with the Health and Wellbeing Board seeks to take responsibility for the development of mental health commissioning intentions for Child and Adolescent Mental Health, Complex Mental Health Needs services and services that interface between primary and secondary care which are being reviewed currently. This is not a QIPP scheme for 2011-12 but is likely to be a key plank in the CSP for 2012-13 and thereafter.

There are also a range of schemes being delivered through GCHS and Oxleas, and through the delegation of these contracts (see below) the GPs will take responsibility for these QIPP schemes as well (MSK, Diabetes, heart failure).

Delegation of QIPP (Step 1)

All QIPP schemes apart from primary care.

Delegation of contracts (Step 1)

Area	**2011/12 budget to be delegated £000s**	**Notes**
Non Acute Commissioning:		
• Mental health – Oxleas	53,037	Core SLA, DPSD, LIG, Non Block, TILT, CAMHS
• Mental health – other	2,422	IAPT now, SLAM and cost per case April, forensic not to be delegated
• Continuing Care – Hospice	1,970	Greenwich and Bexley Hospice
• Continuing care – other	6,893	Medical loan equipment, LTC, NRC & Palliative care now, cost per case April
• Community –	202	Calea, BUPA & Clinovia

Healthcare at home		now
• Community – MS Drug	318	Contract with Southwark PCT – home administered drugs
• Children	416	ADHD, Community Nursing, Wheelchairs & Paediatric Dietetics now
• GCHS	35,669	GCHS contract
GP Prescribing	34,862	GP Practice prescribing, Centrally Retained Resources, Computer Costs
– Referral Management & Booking Service	250	Referral Management system – QIPP Investment
Non acuteQIPP investment eg Finding the VulnerableOther	2,852	Other QIPP investments, carers, HVs
Total	**138,891**	

Delegation of contracts (Step 2)

Area	**2011/12 budget to be delegated £000s**	**Notes**
• Acute Commissioning:	206,217	Acute, specialist, HIV, ambulance & NCA
• BSU	13,649	BSU Corporate and cluster contribution
• Learning disabilities	3,374	
• Mental health other	5,783	SLAM etc
• Continuing care – other	4,861	Cost per case
• Smaller out of hospital contracts - various	3,002	Wide range of contracts each small
• UCC	1,004	New contract will have been let

Total	**237,890**	

Note: the excluded budgets include prison health, national treatment agency and public health, as these are not destined for clinical commissioning. In addition, the reserves will remain outside this delegated responsibility but will be managed through the NHS South East London cluster management arrangements in conjunction with GCCC.

Financial Position and Financial Challenges

Greenwich has always achieved its financial targets in the past and has an impressive delivery record. However, there is to be minimal growth over the Spending Review period (0.4% over the next four years) therefore existing resources must also now fund national priorities (cancer, IAPT, carers, health visitors), local priorities, and the cost pressures of demographic changes and technological advances.

The QIPP programme has a target to deliver efficiencies of £109m over four years (£15m in 11/12, £24m in 12/13, £34m in 13/14, and £36m in 14/15). Due to the financial challenge presented by future income projections in the face of rising demand, QIPP has a crucial role to play.

The biggest risk for Greenwich Clinical Commissioning Committee is management of the acute element of its portfolio. Already at month 3 there is considerable over performance against this contract. Work is being done between Greenwich BSU and the central cluster teams to understand this more fully and ensure that the service redesign effort is having the intended impact. The two areas of over performance at this stage are outpatients and non-elective admissions. The Referral Management and Booking Service and new pathways of care should have a positive impact on the out patient referral rate which should be visible in late Q3 and Q4. The Finding the Vulnerable Project is also set to make an impact late in the financial year. It is likely that Greenwich will need to draw on the 2% lodged with NHS London to maintain its financial position in 2011-12 and with this is on target to enable NHS Greenwich to meet all of its financial obligations.

The Greenwich Health Board members have made considerable progression in shaping their commissioning intentions for 2012-13 mindful of the position in 2011-12 and requirements of the QIPP programme going forward.

Governance and Monitoring

Having first established governance and monitoring systems through GCCC since April, these are now fit for purpose for the level of delegation sought here, and do not, at this stage, need to be enhanced any further.

SECTION 5: SUPPORT ARRANGEMENTS

There are three types of support required to support the delegated responsibility:

- Management capacity and support;
- GP Commissioning Support Funds; and
- Organisational development.

Management capacity and support

GCCC will fulfil its delegated responsibilities through collaborative working between the GH Board members, the Greenwich BSU teams and of the relevant Cluster Directorate teams. Senior members of Greenwich BSU teams are directly linked to GH Board members in their lead roles as shown in Appendix G, attached.
Key features of Greenwich BSU that will support delivery against delegation include:

- Shared objectives between GCCC and Greenwich BSU staff linked through cascaded objectives(see Business Plan);
- Shared governance and delivery structures;
- Co-production of the current QIPP and performance targets set for local services;
- Direct links between Greenwich BSU teams and Greenwich Health Board members around workstreams;
- Senior financial advice and support through Greenwich BSU Head of Financial Delivery;
- Local and dedicated analytical support; and
- Senior management and OD support through MD and Head of Transitional Development.

In addition there is good access to Greenwich Public Health expertise.

Links with the central cluster teams exist through acute contracting meetings and Committees but these relationships need to be developed in the run up to taking delegated responsibility in April 2012.

GP Commissioning Support funds

The NHS London Pathfinder development programme provides for £2 per registered patient funding to be made available to GP Commissioners to support their work over the transition period. The consortium management team has aligned the proposed use of these funds against support areas. Key areas of support are identified as follows:

- Clinical backfill to support the leadership team and clinical associates for work on service redesign and for input into various working groups including the incentive schemes for GP practices to participate in commissioning in specific areas;
- Organisational development in the following areas:
    - Development of syndicates;
    - Communication with GPs and other clinicians;
    - Communication and engagement with local residents/LINks etc,;
    - Implementation of Solis PBC and a risk stratification system; and
    - Development of an information plan .
- Training and development in the following areas (although dependent what is available from the NHS London development procurement which is in train – see below):
    - Negotiation skills;
    - Media management; and
    - Coaching

Organisational development

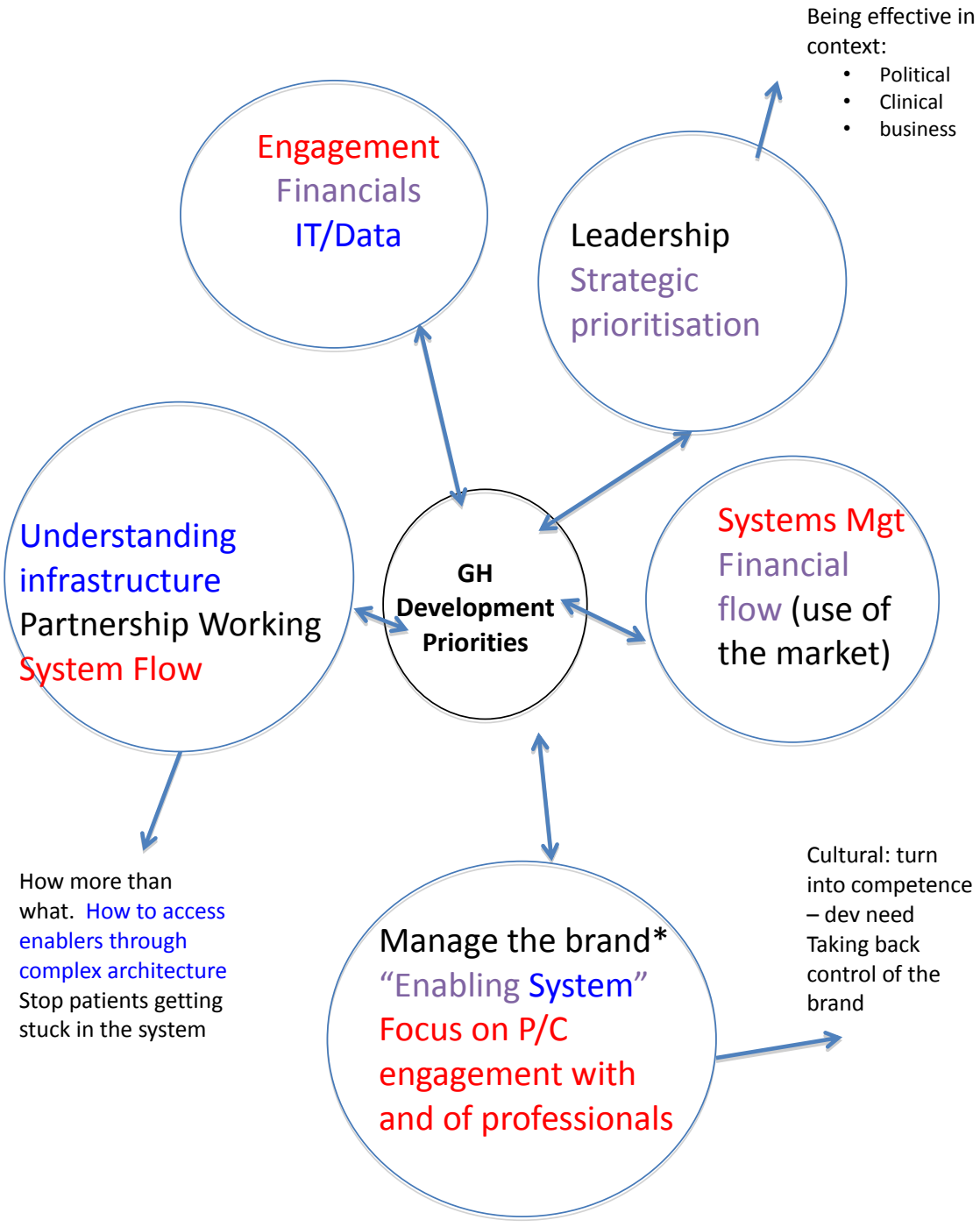
The London Pathfinder Toolkit has been designed to provide pathfinders with a structured development programme that focuses on the development of individuals, organisations and teams within the pathfinder. Greenwich Health has self-assessed against the toolkit domains and submitted its Statement of Works. A summary of the prioritised needs by domain is provided below:

Domain	Priority 1=very low, 5=very high	Confidence level
Empowering patients & the public	2 = Low	4 = High
Vision & strategy	3 = Some	5 = Very high
Finance	2 = Low	5 = Very high
Leadership	3 = Some	4 = High
Clinical governance/Corporate	3 = Some	5 = Very high
Planning	2 = Low	4 = High
Agreeing	3 = Some	4 = High
Monitoring	2 = Low	2 = Low

In addition to priorities in these standard domains, GH has indicated that individuals will need development in terms of working in syndicates. This form of working requires significant behavioural change to become effective within the short timescales available and insight of national/international best practice to gain momentum quickly. Due to the timescales involved, learning by doing will be highly sought after as a general approach.

Overall key priority areas for development are centred around five key areas:

Understanding infrastructure;
Engagement;
Leadership;
Systems Management; and
Managing the 'Brand' i.e. providing a quality service.



* = assuring quality of NHS commissioned services and ensuring that they link across the system however they are procured

Delivering against delegated responsibility

GH believes that the current level of managerial capacity and support is largely appropriate to support the proposed levels of delegation, as long as:

- Support from the central Cluster teams can be secured;
- GH secures a provider of Organisational Development and Support throughout the transition period;
- The pathfinder money already available in 2011-12 and being invested in short term support to enhance capacity locally continues; and
- Greenwich Business Support Unit's capacity and capability continues.

NHS Lewisham

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.

Pathfinder Development and Delegation

Context;

At the Joint Boards meeting on 19 May 2011, six Local Clinical Commissioning Committees (LCCCs) were established as the vehicles through which Pathfinders would take on delegated responsibilities for commissioning in SE London. The Boards also approved the process for approving delegation to Pathfinders, through a Pathfinder Delivery Plan.

Working with each of the clinical consortia, through the borough-based Business Support Units, a more detailed local assurance process has been agreed and followed as was reported to a meeting of the Joint Boards in July.

The Joint Boards have previously noted that delegated budgets exclude those which relate to the London Ambulance Service, specialised commissioning, primary care contracting, prison health, costs related to non-commissioned services, and nationally required contingencies and reserves.

The July meeting of Joint Boards agreed for the Chair to take Chair's Action to AGREE Lewisham's Pathfinder Delegation Application.

Supporting Documentation;

This report makes recommendations on delegation for the Lewisham Pathfinder (below).

In considering such recommendations Lewisham PCT will be aware of the process and framework outlined to the Joint Boards at their meeting on 21st July.

The detailed assurance process undertaken in respect of this and all applications for Pathfinder Delegation has provided the following supporting information;

- Revised Delegation Application (Delegation Delivery Plan)
- Delegation Application Panel Meeting Action Notes

(Lewisham PCT via Chair's Action):
Approve the phased delegation of commissioning responsibilities from the Chief Executive to the Lewisham Pathfinder as outlined in the Lewisham Delivery Plan

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

Further Action required:

Lewisham PCT will wish to report the outcome of this Chair's Action to the next appropriate meeting of its LCCC

Reporting

A notice of this decision will be provided to the next meeting of the PCT Board on 22 September 2011.

Supporting NED / ED input;

Confirmed with David Whiting and Rona Nicholson (lead non executive directors) – 18/8/2011.

Lewisham PCT Chair — **Date** 22 August 2011

NHS South East London

Action Points: Lewisham Pathfinder Delegation Meeting

12.30 pm, 27 July 2011

Present: Dr Helen Tattersfield (Chair, Lewisham Clinical Commissioning Collaborative / Lewisham Federation); Dr Judy Chen, Dr Hilary Entwistle, Dr Marc Rowland, Dr David Abrahams, Dr Arun Gupta, Mr Martin Wilkinson (MD, Lewisham BSU), Mr Simon Robbins (CE, SE London Cluster); Ms Gill Galliano (Director of Transition, SE London Cluster); Ms Marie Farrell (Director of Finance, SE London Cluster), Ms Carol Byrne (SE London Cluster – taking notes).

Apologies: Ms Jane Schofield (Director of Operations, SE London Cluster) (with input via email), Dr Faruk Majid.

The application for delegation was received, and it was noted that the application was based on satisfactory documentation underpinned by a history of GP and clinician involvement in commissioning in Lewisham. The following areas were explored in more depth in the discussion, with the actions outlined below agreed:

1. Engagement of constituent practices of the Pathfinder
It was agreed that this section be strengthened in the documentation, on the basis of the points made in the discussion – particularly the engagement with the clinical networks and neighbourhood boards. This also needs to be reflected in the statement of works development area.

2. Primary care challenges
It was agreed to strengthen the linkages across to primary care commissioned services, as delegation should enable a growing maturity and understanding of how all the different commissioned services link – and there may well be decisions to be taken during this transitional process by the cluster that affect primary care.

It was agreed that Immunisations being a local priority would be used to work up as an example of working together

3. **Commissioning Support**
It was also agreed to strengthen the alignment of Public Health, BSU team and cluster central team commissioning support aligned to Lewisham Pathfinder LCCC to ensure it is effectively supported in transition to achieve 100% delegation by 1 April 2012

4. Phase 1: delegation from 1 August 2011 (subject to NHS London assurance of the NHS SEL cluster delegation process at the panel meeting on 24 August 2011).

- The service line delegation was agreed, for prescribing and planned care including In-patient, out-patient and diagnostics, adult community health services
- BSU operational budget agreed
- All other budget lines to remain central and released on agreement e.g. 2% non-recurrent and 1% surplus requirements
- Other: this needs to be discussed separately off line.

5. Phase 2: delegation from 1 January 2012
Specialist commissioning needs to be omitted explicitly.

The service line delegation was agreed for the remainder of acute commissioning including unscheduled care including self referrals to A&E, emergency inpatient and client group joint commissioning including children and young people and adult mental health.

It was agreed that Lewisham should increase its focus on the Local Authority interface in the next steps to achieve the aspiration of 100% delegation by 1 April 2012.

With support from the cluster central team including performance, finance and delegation staff, Martin Wilkinson will support the LCCC to resubmit the Lewisham documentation in 2 stages of delegation with these alterations by Friday 5 August 2011 to:

1. review the finances and phasing of the delegated budgets,
2. reshape and align areas for delegation,
3. define which QIPP schemes are aligned to delegated areas,
4. agree targets for performance quality and safety.

It was agreed to work together (Carol Byrne / Simon Hall to co-ordinate) to agree success criteria and tolerances with respect to Phase 2 being agreed.

Carol Byrne agreed to circulate the draft 4 NHS SEL Delegation, Performance Management, Assurance & Escalation procedures including information regarding the quarterly formal role of the stocktake meetings and monthly finance and performance reporting requirements, including reporting of information and “early warnings” between the stocktakes meetings.

It was agreed that the Pathfinder via Helen Tattersfield as Chair will participate with the cluster in providing formal feedback to Lewisham Healthcare in its Foundation Trust (FT) application

The Board report will be produced by Friday 12 August that summarises the process undertaken with Lewisham, areas explored at the meeting, and the recommendations for the PCT Board to be taken as Chairs action prior to the NHSL panel assurance meeting with NHS SEL on 24 August 2011.

Carol Byrne
28 July 2011

ADDENDUM

Subsequent to the meeting at the end of July 2011, further discussions took place between the clinical leaders in Lewisham and the lay members (Non-Executive Directors) of the Lewisham Clinical Commissioning Committee.

As a result of these discussions it was agreed that delegation would still happen in the two phases planned. However, it was proposed by the Pathfinder that the second phase of delegation take place from 1 April 2012. As a result this amended version of the Lewisham Delegation Delivery Plan was agreed by the Chair.

South East London

A meeting of the SEL PCT Boards* and Bexley Care Trust 22nd September 2011

ENCLOSURE 14

ENCLOSURE 14

NHS SEL ASSURANCE FRAMEWORK

DIRECTOR RESPONSIBLE: Gill Galliano, Director of Development

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

TO BE CONSIDERED BY: All Boards

SUMMARY:
The Joint Boards are asked to consider;

- NHS SEL Assurance Framework
- Summary exception reports / action plans

The Boards approved a Joint Board Assurance Framework at their meeting on 21 July. The agreed approach has been embedded during the summer with common reporting now in place.

Going forward borough specific risks and risks identified by cluster directorates (at a threshold consistent with local approaches) will be considered by LCCCs on a regular basis. The Audit Committee plans to review the local approach at its October meeting. It will be increasingly important for each GP Pathfinder to assume greater oversight as delegation develops.

KEY ISSUES:
All directorates have continued to review their risk profile in the context of the organisation's objectives and business plan.

The Development Group (on behalf of the Cluster Management Board) have agreed and reviewed the aggregation of locally identified risks for presentation to the Boards.

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

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 against a specific performance indicator (c.diff)
- Delivery of QIPP and operating plan
- Management of Issues of Concern
- Emergency Planning (zero tolerance)
- Retaining a grip on finances
- Quality of care delivered by our commissioned providers
- Safeguarding (zero tolerance)

Movement of risks (de-escalation) since the last publication of a then indicative NHS SEL risk register;

- Incorporation of Primary Care staffing specific risks within the identified HR risk in this area
- Incorporation (transferral) of borough specific QIPP risks at that appropriate local level rather than through the Operations Directorate
- Potential impact of national tariff inflation, assessed to be reflected in financial delivery risks
- Reduction in level of identified risk related emergency planning owing to embedded arrangements in place and its reclassification as a zero tolerance risk

Emerging risks;

- Failure to deliver on a specific performance measure (c.diff)
- Risks identified within boroughs

Action Plans are included for all high rated risks to the rear of the detailed framework with some exceptions;

PC1 – Issues of concern. Detailed action plans for each outstanding case are reported to the Boards in the well understood way. Full details of such information are available to the members of the Boards upon request from the Primary Care team

OP1a – Failure to deliver on a specific performance measure (c.diff) and a subset of an overall risk to achievement of performance reporting. Detailed action plans are

held by each acute trust, monitored through contract quality review meetings with relevant actions for NHS SEL reported through the Boards' Performance Report

Appendices

a) NHS SEL Assurance Framework
b) Summary exception reports / action plans

INVOLVEMENT:

The NHS SEL Assurance Framework has been discussed by the Development Group and Cluster Management Board.

The Audit Committee will consider NHS SEL's arrangements at its meeting on 4/10/11.

Where LCCCs have met they will have reviewed developing BSU risk registers and cluster risks reported at a locally relevant threshold.

RECOMMENDATIONS:

The Boards are asked to:-

1. RECIEVE the current iteration of the NHS SEL assurance framework

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ENCLOSURE 14

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
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 NHS SEL 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 in place which framed development of staff objectvies and appraisals	Possible	Major	12	Mitigate (See action plan)	End state for all parts of business yet to be fully defined	Establishment of cluster staff partnership forum. Regular meeting cycle in place Single NHS SEL change process in place (tba October)	Possible	Major	12	Monthly	↔	Open
Op1a	Operations	2. Sustain an effective grip on finance, performance and QIPP	Performance	05/09/11	Operations	Jane Schofield	There is a risk of failing to deliver a specific key (headline) performance measure in 2011/12 - C. diff. trajectories (HQU02)	Likely	Major	16	The oversight of HCAIs is dealt with through the monthly Clinical Quality Review Group meetings with each acute trust. HCAIs are also raised at the monthly Contract Management meetings. Action plans have been produced by each Trust. There is a Cluster infection control group coordinated by Public Health.	Likely	Major	16	Mitigate (See action plan)		Action plans are at Trust level. The C. diff. trajectories for 2011/12 require a 25% reduction on the previous year. GSTT is detecting more cases than in the baseline period following the introduction of a new test. The actions each Trust is taking are set out in the Performance Report. GSTT has agreed to participate in a new 'critical friend' review process which is currently being organised.	Likely	Major	16	Monthly	↑	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	16	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	↔	Open
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	↔	Open
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 and July 2011 Boards brieifing 4NEDs identified to support swift establishment of IoC panels 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
PH 2	Public Health and all BSUs	1. Improve health, quality and maintain safety of local NHS services.	Public Health	01/05/11	Operations	DPH and all BSU MDs	Emergency Planning. There is a risk that loss of control and coordination may be caused by insufficiently robust Cluster Command, Control and Communications systems. This risk is enhanced by events surrounding the London Olympic Games with consequent risks of severe disruption and reputational damage	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 MI Plan and relevant specific incident plans i.e. Heatwave. Detailed Action Plan for NHS SEL produced as a result of NHS London Assurance process. Olympic Senior Coordinating Group established - executive led "task-and-finish" group to ensure robust systems are in place to meet the challenges of the Games as detailed in the London Olympic Resilience Planning Assumptions (LORPA), NHS London Games Planning Pack and NHSL 2012 Assurance Processes.	Possible	Major	12	Mitigate (See action plan)	BIA (Business Impact Assessment has been distruibuted to all Business Units for completion - Once this has been completed information will be integrated into individual BC Plan for organisation i.e. BSU and NHS SEL Cluster. Business Continuity planning in relation to Primary Care. Pandemic Flu Plan in line with latest Pandemic Flu Guidance. Mass Casualty Plan Multiagency Training & additional training and support for on-call exective team maanaging the impacts of Games Time.	NHS SEL Olympic Steering Group established and invites sent out - Chair Jane Schofield Meeting 9th September 2011. NHS SEL MI Plan Version 1 to go to September Q&S committee for ratification.. Each PCT/BSU borough to supply completed template Heatwave Plan. Heatwave period ends 15th Sept 2011. BIA under completion and deadline given of 15th September 2011. Monthly EPRSG meetings to continue with EP particpants from NHS SEL, BSU, PC . Paper being sent out as part of Governance arrangements to GP which highlights importance of BC to Practices	Possible	Moderate	9	02/08/11	↓	Open

ENCLOSURE 14

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 deliver high quality care for all.	Likely	Catastr ophic	**20**	Clinical Quality Groups meeting bimonthly with providers LCCCs Quality Working Groups NHS SEL Joint Quality and Safety Committee Regular Performance and Quality Report to Joint Boards NHS London scrutiny and support Centralised reporting of Serious Incidents Further development of quality metrics Agreed SI Cluster Reporting Process	Possible	Catastr ophic	**15**	Mitigate (See action plan)	Tested cycle of Clinical Quality Group meetings System resilience	Development of Quality Metrics – agree Dashboard for reporting 1/4 Clinical Quality meetings per provider Acute contracting and performance meetings QIPP schemes	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 Assurance Framework to Quality and Safety Committee 05/09/11	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 SEL Workplan for Adult Safeguarding	Development of single NHS SEL policy required Capacity review Develop QA process led by BSUs Agree a SEL Work plan for Adult Safeguarding	Unlikely	Catastrop hic	**10**	01/10/11	↔	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 SEL Workplan for Child Safeguarding	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 Agree a SEL Work plan for Child Safeguarding	Rare	Catastrop hic	**5**	01/10/11	↔	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 SEL Workplan for Child Safeguarding	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 Agree a SEL Work plan for Child Safeguarding	Rare	Catastrop hic	**5**	01/10/11	↔	Open
FB2	**Bexley BSU**	2. Sustain an effective grip on finance, performance and QIPP	QIPP	01/04/11	Financial	Jo Medhurst / Jane Schofield	There is a risk that overperformance and data quality with providers remains poor and unchallenged caused by insufficient capacity and lack of systems leading to the inability to break even. There is a risk that if demand management is not robustly monitored and further QIPP schemes developed to close unidentified gap and mitigate under-achievement of identified schemes caused by insufficient capacity and lack of systems leading to the inability to break even. This risk is further worsened by the potential lack of capacity within procurement that may delay the implementation of schemes.	Almost Certai n	Major	**20**	QIPP management structure in place; Weekly Operational / Strategic QIPP meetings in place; leads identified for each scheme both in BSU and in respect of acute in Cluster; GP visits and support in place to manage activity where possible. GP event held to explain the importance of QIPP and help develop further schemes. Primary care scorecard developed. Risk Strat tool developed to identify LTC patients. Mede system detailing all acute and precribing activity paid for by BSU and rolled out to all GPs.	Likely	Major	**16**	Mitigate (See action plan)	Development of robust Claims management sytem incorporating all GP challenges by Cluster. Recruitment of substantive staff within Cluster Finance and Commissioning teams. Verification of savings identified by BSU. Identification of new schemes to close QIPP gap. Roll out to GPs of Primary care scorecard and Risk Strat tool. Further training for GPs on Mede.	1. Recruitment of cluster staff. 2. Development of robust cluster claims managemnt system with established links to GP validation. 3. Verification of QIPP savings already identified. 4. Identification and quantification of new schemes to close QIPP gap. 5. Roll out of Primary care scorcard and risk strat tool by 31/7/11. 6. Training on Mede for GPs arranged for 15 & 16/6/11.	Possible	Moderate	**9**	15.9.11	↔	Open
FB3	**Bexley BSU**	2. Sustain an effective grip on finance, performance and QIPP	Financial management	01/04/11	Financial	Marie Farrell / Theresa Osborne	There is a risk that the Care Trust will not breakeven caused by the absence of agreed SLA values for the two of the three highest providers; the lack of reserves within the budget, other than the statutory 0.5% contingency; the pressures with regards to the continuing care, NCA, IFR and high cost drugs budgets; the possibility that LBB, including schools, will mitigate their own cost pressures by transferring costs to the Care Trust, leading to a failure to deliver statutory financial duties and the inability to progress the Government agenda on clinical commisisioning.	Almost Certai n	Major	**20**	0.5% contingency held. Agreement that a proportion of the 2% non-recurrent funding can be used to mitigate the impact of the SLHT arbitration decision. Agreement for contract for continuing care that removes the costs of 1:1 and specialing. Robust arrangements for assessing eligibility of continung care patients. Close working relationships with LBB and MDs of BSU to look at cost sharing as opposed to cost shunting.	Likely	Major	**16**	Mitigate (See action plan)	Robust IFR process for Bexley to challenge eligibility of requests (Cluster); Robust high cost drugs and NCA validation and challenge process to be put in place (cluster); Final agreement of SLHT & DVH SLA values so that financial position can be fully assessed and action plans put in place; Continually assess budgets set with a view to reduction; Additional QIPP schemes to be identified.	1. SLHT & DVH SLAs to be finalised and signed. 2. Robust process for reviewing IFRs to be implemented. 3. Robust process for validating and challening NCAs and high cost drugs billed to be implemented. 4. Additional QIPP to be identified. 5. Exisiting budgets to be continually monitored.	Possible	Moderate	**9**	15.9.11	↔	Open

FB5	**Bexley BSU**	3. Proactively manage the transition to the new commissioning system.	Statutory obligations & core business	01/04/11	Governance	Pam Creaven / Julie Witherall / Jane Schofield	There is a risk that there will be a lack of clarity regarding the roles and responsibilities in respect of gathering information and reporting of performance targets caused by the recent restructuring, reduction in staffing, number of vacancies and turnover leading to the failure to meet and report performance targets accurately and inability to progess the Government's Clinical Commisisoning agenda.	Likely	Major	**16**	Experienced Information Analyst responsible for recording performance data in post within BSU. Cluster have a team in post responsible for performance liaising with BSUs. Definitive list of all targets created by BSU.	Likely	Major	**16**	Mitigate (See action plan)	Recruitment to vacancies within cluster. Regular performance target monitoring meetings between cluster & BSU to be set up. Final agreement of roles and responsibilities for monitoring and submisison of target data needed. List of targets to be distributed to BSU staff to inform monthly requirements & owbership. Vacant head of performance within BSU needs to be resolved.	1. Recruitment of cluster staff. 2. Resolution of BSU Head of Performance post. 3. Schedule of cluster and BSU meetings to discuss performance target monitoring to be set up. 4. Comprehensive list of targets to be distributed to BSU staff.	Possible	Moderate	**9**	15.9.11	⟷	Open
BRO 1103	**Bromley BSU**	1. Improve health, quality and maintain safety of local NHS services.	Acute Commissioning	1.4.11	Governance	Angela Bhan / Sonia Colwill/Meredith Collins	There is a risk that failure to effectively monitor and manage the quality and safety of services at the local acute provider will lead to unacceptable and unsafe conditions for patients	Likely	Catastrophic	**20**	SLHT Clinical Quality Review Group meets monthly and includes BSU and GP representation. Quality Working Group of LCCC reviews all sources of quality information and reports to the LCCC on an exception basis. Joint Quality and Safety Committee at Cluster also reviews and reports to Joint PCT Boards.	Possible	Catastrophic	**15**	Mitigate (See action plan)	Further development of quality metrics and monitoring. Scale of management challenge for SLHT.	Development of GP alert system within the BSU. Monitoring of complaints.	Possible	Major	**12**	Monthly	⟷	Open
BRO 1104	**Bromley BSU**	2. Sustain an effective grip on finance, performance and QIPP	Acute Commissioning	1.4.11	Financial	Angela Bhan / Meredith Collins	There is a risk that failure to effectively monitor and manage activity levels and costs at the local acute provider will lead to breach of financial control	Almost Certain	Major	**20**	Contract management process established at Cluster level. Improved and timely submission of data by local acute provider.	Likely	Major	**16**	Mitigate (See action plan)	Develop and refine contract management arrangements. Further improve quality and timeliness of activity data.	Further development of processes within South East London Cluster. Cluster progressing arrangements for joint acute contract management with SW London PCTs.	Possible	Major	**12**	Monthly	⟷	Open
G1	**Greenwich BSU**	1. Improve health, quality and maintain safety of local NHS services.	Safeguarding	31/08/11	Legal & Compliance	Annabel Burn	There is a risk that safeguarding arrangements may be insufficiently rigorous.	Almost Certain	Catastrophic	**25**	Experienced designated nurse in post; Cluster Medical Director providing cover for Designated Doctor issues;All main Greenwich providers have Named Professionals in post; Greenwich SIT Visit Action Plan complete; Named GP appointed 3 session per week; General Practice leads appointed; Named midwife appointed SLHT (QE site); PCT participating fully in LSCB; Agreement with SLHT to recruit joint Paediatrician / Designated Doctor post; vacancy rate in HV successfully reduced; Safeguarding executive group in place and monitoring improvement action plans	Possible	Catastrophic	**15**	Mitigate (See action plan)	Designated doctor post remains unfilled; Safeguarding improvement report to GCCC	Work with SLHT to recruit joint post (designated doctor/ paediatrician) to be in post by Autumn 2011(interview 21/10/11); Continue cover from Cluster Medical Director until post is filled; Contract monitoring of new service specification for LAC; Include safeguarding improvement monitoring in GCCC performance report (including primary care contractors); All BSU staff to undertake safeguarding training.	Unlikely	Catastrophic	**10**	01/11/11	⟷	Open
G3	**Greenwich BSU & Cluster**	2. Sustain an effective grip on finance, performance and QIPP	Finance	31/08/11	Financial	Annabel Burn, Marie Farrell, Jane Schofield	There is a risk that QIPP savings will be insufficient to absorb the additional cost of acute over-performance.	Almost Certain	Major	**20**	Cluster wide quarterly stock take; monthly QIPP reporting and monitoring to cluster PMO, BSU management team and GCCC ; QIPP implementation plans in place, BSU QIPP structures and processes and GCCC monitoring arrangements including highlight/exception reporting; Development of QIPP Plan Bs; Arrangements for GP delegation and development task group; Pathfinder application; Federation and cluster structure; PMO structures; Reserves including 0.5% contingency reserve.	Likely	Major	**16**	Mitigate (See action plan)	Difficulty in quantification of risk (lack of real time data on contract overperformance and QIPP programmes); Lack of alignment with contracting teams; Delay in identification of GP executive responsibilities and GCCC supporting committees; Incomplete engagement plans; KPIs to be agreed; ; Pace of change in clinical behaviour ; Acute PbR contracts- risk of unsigned contracts.	Continued implmentation of QIPP initiatives and development of Plan B initities including development of "Finding the Vulnerable" programme of work to increase case finding, capacity and co-ordination of services; Embed performance and risk framework in all QIPP projects; challenges as part of validation / contract monitoring processes SLHT Contract manager; action to develop / implement / monitor engagement plans; Monitoring and allocation of financial reserves as needed; Development of information and reporting functionalities; Refresh of strategic commissioning plan.	Possible	Major	**12**	01/10/11	⟷	Open
LEW 01	**Lewisham BSU**	2. Sustain an effective grip on finance, performance and QIPP	QIPP	03.05.11	Financial	Martin Wilkinson / Head of Service Redesign	There is a risk that failure to deliver sufficient local QIPP Initiatives in a timely manner caused by a lack of GP ownership and engagement, lack of stakeholder management including appropriate patient and public / provider involvement, insufficient tracking of delivery plans and associated KPI's, lack of pipeline schemes and alignment of enablers leading to breach of financial control total and non delivery of local QIPP Plan.	Almost Certain	Major	**20**	Pathfinder application & GP Executive Team Federation and Cluster structure GP Interactive BSU Structure including Facilitators Executive Team Chair agreed. Clinical Commissioning Committee with QIPP on the agenda since September 2010 Implementation plans in place HCSC reviewed QIPP in March 2011 & July 2011 QIPP in Contracts PMO Operational and Strategic Meetings. Agreed Highlight / Exception Reporting Framework with LCCC (shared with Cluster) Paper to LCCC on QIPP Plan B (April) Cluster QIPP Structure and meetings, and quarterly stock take £2.9m non-recurrent bid accepted RAG Financial adjusted, QIPP being monitored PPE Steering Group Joint Service and System Redesign Group with LHCT and position statements and development of gateway approach to projects.	Likely	Major	**16**	Mitigate (See action plan)	Alignment with Contracting teams LCC Sub-committees Engagement Plans Strengthen Implementation Plan KPI to be agreed	Development of mechanisms to deliver changes across Consortia Practices and GP Community via OD Plan (CMS) Sub Groups of Lewisham CCC agreed. Quality and Safety Group set. Engagement Plans are in place for most schemes. Implementation Plan (AO'S/CG) Agree KPIs (AO'S/CG/GP/MH)	Possible	Major	**12**		⟷	Open

ENCLOSURE 14

L1.2	**SBSU**	1. Improve health, quality and maintain safety of local NHS services.	HR	01/12/09	Change	Andrew Bland / Malcolm Hines	Maintaining staff in key positions and ensuring staff capacity to meet Operating Plan requirements e.g. safe services, business intelligence, organisational knowledge. Challenge of expensive cost envelope	Likely	Major	**16**	Established HR procedures. Staff turnover reporting to Joint Audit Ctte. Recruitment panel process in place. SMT oversight. Circa 50% management efficiencies made as part of QIPP. Pay/non-pay cost review ongoing	Likely	Major	**16**	Mitigate (See action plan)	Ongoing London-wide & National budget pressures	SBSU finance team ongoing reporting to CFO.	Possible	Minor	**6**	01/10/11	⟷	Open

EXCEPTION REPORT - RISK MANAGEMENT BOARD ASSURANCE

Date submitted	**1/9/11**
Name of Risk Workstream	**F1 (finance)**
Description of Risk	There is a risk that reduced capacity and increased transition agenda leads to understatement of financial risk and insufficient focus leading to poor monitoring and reporting
Risk Owner	**Marie Farrell**
Residual Risk Score	**16**
Target Risk Score	**8**
Date for achievement of Target Risk Score	**1/4/12**

Current Controls	Gaps in Controls / Assurance
• 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.	• 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

Action Plan Summary(date / by who)

1) Reconciliation of 10/11 outturn to 11/12 budgets
2) Establish development agenda to retain key skills.
3) appoint PM team

ENCLOSURE 14

Action	Priority	Resource	Contingency / Dependency	Progress	Evidence	RAG
1) Reconciliation of 10/11 outturn to 11/12 budget	High	Finance	Reconciliation of 10/11 outturn to 11/12 budget hampered by lack of common coding structure between years and BSU's	Model to provide quick and detailed analysis of commissioning support and other operational costs in place. Analysis underway of bottom-up 2011-12 budgets as per operating costs model.	Budget reports to be issued to budget holders from month 6. This will result in a budget book detailing and clarifying the makeup of corporate budgets and assumptions underpinning them	Green
2) Establish development agenda to retain key skills	High	Finance		PDP's for all staff completed	PDP's completed and with Cluster HR	Green
3) Appoint PM team	High	Finance	Utilise existing staff	Team in place and working on migration.	New system go live date agreed as 1st October	Green

EXCEPTION REPORT - RISK MANAGEMENT BOARD ASSURANCE

Date submitted	**1/9/11**
Name of Risk Workstream	**F2 (finance)**
Description of Risk	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
Risk Owner	**Marie Farrell**
Residual Risk Score	**16**
Target Risk Score	**8**
Date for achievement of Target Risk Score	**1/4/12**

Current Controls	Gaps in Controls / Assurance
• 4 year strategic plan in place with risk assessed QIPP.	• Sensitivity analysis based on revisions to Operating Framework planning assumptions • Modelling of impact on providers of worst case and alignment with Trust plans

Action Plan Summary(date / by who)

1) Review base case planning assumptions
2) sensitivity modelling of QIPP delivery
3) Analyse financial trend and identify additional savings needed to maintain underlying financial position.

ENCLOSURE 14

Action	Priority	Resource	Contingency / Dependency	Progress	Evidence	RAG
1) Review base case planning assumptions	High	Finance		QIPP monitoring process is currently being reviewed with the objective of standardisation and setting a clear timetable for monthly monitoring. Financial planning process will refresh the original 4 year model for what is now 3 years to identify a revised savings requirement in light of current performance.	Month 6 + reporting and future quarterly stocktakes will utilise standardised reporting This will be reported to cluster management board & joint board in November.	Amber
2) Sensitivity modelling of QIPP delivery	High	Finance		QIPP monitoring process is currently being reviewed with the objective of standardisation and setting a clear timetable for monthly monitoring.	Month 6 + reporting and future quarterly stocktakes will utilise standardised reporting	
3) Analyse financial trend and identify additional savings needed to maintain underlying financial position	High	Finance		Financial planning process will refresh the original 4 year model for what is now 3 years to identify a revised savings requirement in light of current performance.	This will be reported to cluster management board & joint board in November	

EXCEPTION REPORT - RISK MANAGEMENT BOARD ASSURANCE

Date submitted	**1/9/11**
Name of Risk Workstream	**F3 (finance)**
Description of Risk	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.
Risk Owner	**Marie Farrell**
Residual Risk Score	**20**
Target Risk Score	**8**
Date for achievement of Target Risk Score	**1/4/12**

Current Controls	Gaps in Controls / Assurance
• Envelope set for Pay and WTE • Vacancy review panel in place	• Current Costs exceed original envelope. • Discussions ongoing re running cost funding

Action Plan Summary(date / by who)

1) Reconciliation of 10/11 outturn to 11/12 budgets and identify gaps/opportunities.
2) Set targets for cost reductions via Clusters not achieved.
3) Development of priorities at BSU level and bedding in of structures will increase opportunities of cost reduction

ENCLOSURE 14

Action	Priority	Resource	Contingency / Dependency	Progress	Evidence	RAG
1) Reconciliation of 10/11 outturn to 11/12 budgets and identify gaps/opportunities .	High	Finance		Model to provide quick and detailed analysis of commissioning support and other operational costs in place which gives an idea of the additional savings requirement to meet the target which is assumed at £25 per head Cost reduction action plan will follow from this piece of work but requirement will be informed by more detailed guidance on costs to be transferred to new NHS structures and organisations	Internal Audit have been tasked with validation of the model prior to its use and distribution	Green
2) Set targets for cost reductions via Clusters not achieved	High	Finance		Cost reduction action plan will follow from the above piece of work but requirement will be informed by more detailed guidance on costs to be transferred to new NHS structures and organisations	As above	Amber

EXCEPTION REPORT - RISK MANAGEMENT BOARD ASSURANCE

Date submitted	18/08/2011
Name of Risk Workstream	Clinical
Description of Risk	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 deliver high quality care for all.
Risk Owner	Jane Fryer
Residual Risk Score	15
Target Risk Score	10
Date for achievement of Target Risk Score	31/3/11

Current Controls	Gaps in Controls / Assurance
• Clinical Quality Groups meeting bimonthly with providers • LCCCs Quality Working Groups • NHS SEL Joint Quality and Safety Committee • Regular Performance and Quality Report to Joint Boards • NHS London scrutiny and support Centralised reporting of Serious Incidents • Further development of quality metrics • Agreed SI Cluster Reporting Process	• Tested cycle of Clinical Quality Group meetings • System resilience • SE London wide Clinical Governance policies • With recent integration of community services into Acute and Mental Health Trusts, a quality assurance framework and process is required

ENCLOSURE 14

Action	Priority	Resource	Contingency / Dependency	Progress	Evidence	RAG Acute	RAG Non Acute
1) Development of Quality Metrics	High	Performance Team	Availability of Data/Information	Q1 Quality & Safety Committee Report	Papers for Q&S Committee 5th September 2011	Amber	Amber
2) Bimonthly Clinical Quality meetings per provider	High	Acute Contracting Team Non Acute Contracting BSU Teams		Rotation of meetings yet to be fully tested but will be assessed as part of the drafting of the Quality and Safety Committee papers	Papers for Q&S Committee 5th September 2011 (currently being drafted)	Amber	Red
3) SEL Cluster pre-met / agenda planning for Quality meeting	High	Acute Contracting Team	Availability of staff across SEL to meet to discuss each provider quality issues	A timetable of pre-meets currently being arranged to coincide with Clinical Quality meetings with providers		Amber	Amber
4) Collation/triangulation of data from across sources to link into evidence to support agenda planning for Clinical Quality Group meetings	High	Performance Team Governance Team BSU based complaints/ PALS teams	Availability of Data/ Information	This will be tested once pre-met has been arranged		Red	Amber
5) Process for Assurance of Trust Clinical Governance Systems	High	Governance and Acute Contracting Team	External Reporting on SIs assurance from NHS London	Rotation of meetings yet to be fully tested. Clinical Quality Meetings will include this on the agenda	Clinical Quality Meeting Agendas	Red	Red

Action	Priority	Resource	Contingency / Dependency	Progress	Evidence	RAG
6) Development of SEL wide clinical governance policies eg SI and Safeguarding	Medium	Governance Team Medical Director Director of Nursing	Current SI policies within BSUs Consultation with BSU Governance Leads on new policy	SI Policy to be present to Q&S Committee 5th September 2011	SI policy	Amber
7) Centralisation of reporting on Serious Incidents	Medium	Governance Team	Reporting via Foundation Trusts through BSU	Reporting process now agreed across both foundation, non foundation Trusts, corporate and primary care	Datix Report to Quality and Safety Committee SI policy	Green

NB : Acute and Non Acute actions have been RAG rated separately as the issues regarding quality assurance and implementation of these processes are at different stages of development due to the more recent integration of community services with Acute and Mental Health Trusts.

EXCEPTION REPORT - RISK MANAGEMENT BOARD ASSURANCE

Date submitted	**31/5/11**
Name of Risk Workstream	**Safeguarding (Adults)**
Description of Risk	There is a risk that Adult'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.
Risk Owner	Donna Kinnair
Residual Risk Score	15 (3; likelihood, 5; impact)
Target Risk Score	10
Date for achievement of Target Risk Score	01/11/10

Current Controls	Gaps in Controls / Assurance
• Review learning from Children's 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 • Held ASG seminar 11/7/11, identify and agree actions (end July / Donna Kinnair) • Assurance Framework to Quality and Safety Committee 05/09/11	• One localised source for multiple NHS policies • Expanding expectations and remit covering Learning Disabilites, Care Homes and Vulnearable adults

ENCLOSURE 14

Action Plan Summary

1) Development of single NHS SEL policy (Donna Kinnair)
2) Capacity review (Donna Kinnair)
3) Establish local arrangements and practice with Adult Safeguarding (ASG) leads (Donna Kinnair)
4) Annual work plans for safeguarding in place (via Local Authorities)
5) Safeguarding training at appropriate level for each staff group (Donna Kinnair)
6) Safeguarding and domestic violence policy and procedures (Donna Kinnair)

Action	Priority	Resource	Contingency / Dependency	Progress	Evidence	RAG
1) Development of single NHS SEL policy	High	Chief Nurse / Cluster Governance team	Resource / Capacity	Programme of work in place	- Executive lead and clinical lead for safeguarding - Draft policy - Annual Safeguarding reports expected from providers; ▪ Adults – May ▪ Children's November - Reporting to Q&S Committee	Green
2) Capacity review	High	Chief Nurse	Identified post holders	Complete	- Designated professionals to cover primary care - Cover arrangements in place in Greenwich - Reporting to Q&S Committee	Green
3) Establish local arrangements and practice with Adult Safeguarding (ASG) leads	Medium	Chief Nurse	Requests made from local leads - responses received	Programme of work in place	- Multi-agency safeguarding boards in place reporting to the board - Reporting to Q&S Committee	Green
4) Annual work plans for safeguarding in place (via Local Authorities)	Medium	Chief Nurse	Attendance required from local leads	Programme of work in place	- Reporting annually to Q&S Committee	Green
5) Safeguarding training at appropriate level for each staff group	Medium	Chief Nurse	Attendance required from local leads	Programme of work in place	- Needs Assessment work plan priorities - Reporting annually	Green

					to Q&S Committee	
6) Safeguarding and domestic violence policy and procedures	Medium	Chief Nurse	Attendance required from local leads	Programme of work in place	- Mandatory Training Report - Reporting annually to Q&S Committee	Green

NHS SEL RISK ACTION PLAN FOR ALL RISKS OF 15 OR MORE

This action plan is to be submitted with the Directorate Risk Register for all risks of 15 or more

Date submitted	**24/8/11**
Name of Risk Workstream	**FB2 Finance & Business (Bexley)**
Description of Risk	**There is a risk that overperformance and data quality with providers remains poor and unchallenged caused by insufficient capacity and lack of systems leading to the inability to break even. There is a risk that if demand management is not robustly monitored and further QIPP schemes developed to close unidentified gap and mitigate under-achievement of identified schemes caused by insufficient capacity and lack of systems leading to the inability to break even. This risk is further worsened by the potential lack of capacity within procurement that may delay the implementation of schemes.**
Risk Owner	**Cluster / Jo Medhurst**
Residual Risk Score	**16**
Target Risk Score	**9**
Date for achievement of Target Risk Score	**31/12/2011**

Current Controls	Gaps in Controls / Assurance
QIPP management structure in place; Weekly Operational / Strategic QIPP meetings in place; leads identified for each scheme both in BSU and in respect of acute in Cluster; GP visits and support in place to manage activity where possible. GP event held to explain the importance of QIPP and help develop further schemes. Primary care scorecard developed. Risk Strat. tool developed to identify LTC patients. Mede system detailing all acute and prescribing activity paid for by BSU and rolled out to all GPs.	Development of robust Claims management system incorporating all GP challenges by Cluster. Recruitment of substantive staff within Cluster Finance and Commissioning teams. Verification of savings identified by BSU. Identification of new schemes to close QIPP gap. Roll out to GPs of Primary care scorecard and Risk Strat tool. Further training for GPs on Mede.

ENCLOSURE 14

Action Plan Summary(date / by who)

1) Recruitment of cluster staff – Cluster (Cluster to advise)
2) Development of robust cluster claims management system with established links to GP validation Cluster (Cluster to advise)
3) Verification of QIPP savings already identified – Cluster & BSU by 31/7/11
4) Identification and quantification of new schemes to close QIPP gap – BSU GPs by 31/3/12
5) Roll out of Primary care scorecard and risk strat tool – Darren Blake by 31/7/11.
6) Training on Mede for GPs arranged for 15 & 16/6/11 Training on Mede for GPs arranged for 15 & 16/6/11 – Maria Daly 30/6/11

Action	Priority	Resource	Contingency / Dependency	Progress	Evidence	RAG
1) Recruitment of cluster staff	Medium	Recruitment to vacancies continues	Market Vacancy Recruitment process agreed by CMB	New AD joined team September	Clarification of respective expectations / roles agreed within NHS SEL	AMBER
2) Development of robust cluster claims management system with established links to GP validation	Medium	System in place to analyze data, provided unified list of challenges to providers and report monthly on outputs	Engagement structures in place at LCCC level Ability of providers to amend SUS data after challenge process concluded Claims being valid within contract.	System in place for reporting and challenge in place feedback required. Challenge cycle now completing and feeding back into reporting.	Savings realised. Commissioners to now be provided with access to data and claims correspondence.	AMBER
3) Verification of QIPP savings already identified	HIGH	NHS SEL teams to work together.	Communication between cluster & BSU	Complete as far as possible. Agreed with cluster that plan will remain as is. BSU responsible for monitoring 4 schemes. Cluster to monitor others.	Evidence available for BSU plans and 3 of 4 actuals to date.	AMBER
4) Identification and quantification of new schemes to close QIPP gap	HIGH	Bexley teams working with GPs within current resource.	Needs clinical input to identify but view that there is little more possible.	Unidentified QIPP gap closed by re-prioritising investments. Few new real QIPP schemes identified or likely to be.	Reduced QIPP gap reported in monthly FIMs returns.	AMBER
5) Roll out of Primary care scorecard and risk strat tool	HIGH	Bexley teams working with GP practices	Time and willingness of GP practices to participate	Risk strategy tool rolled out.	Practices using risk strategy to help monitor patients and control non-elective referrals. Evidenced by achievement of QIPP.	GREEN
6) Training on Mede for GPs arranged for 15 & 16/6/11 Training on Mede for GPs arranged for 15 & 16/6/11	HIGH	Mede training arranged. GP and practice manager attendance	Time and willingness of GP practices to participate Availability of Mede representatives to train	Training days complete	More practices using Mede to review referral data and influencing non elective referrals and QIPP	GREEN

NHS SEL RISK ACTION PLAN FOR ALL RISKS OF 15 OR MORE

This action plan is to be submitted with the Directorate Risk Register for all risks of 15 or more

Date submitted	**24th August 2011**
Name of Risk Workstream	**FB3 Finance and Business (Bexley)**
Description of Risk	**There is a risk that the Care Trust will not breakeven caused by the absence of agreed SLA values for two of the three highest providers; the lack of reserves within the budget, other than the statutory 0.5% contingency; the pressures with regards to the continuing care, NCA, IFR and high cost drugs budgets; the possibility that LBB, including schools, will mitigate their own cost pressures by transferring costs to the Care Trust, leading to a failure to deliver statutory financial duties and the inability to progress the Government agenda on clinical commissioning.**
Risk Owner	**Cluster – Marie Farrell / BSU – Theresa Osborne**
Residual Risk Score	**16**
Target Risk Score	**9**
Date for achievement of Target Risk Score	**31/12/2011**

Current Controls	Gaps in Controls / Assurance
0.5% contingency held. Agreement that a proportion of the 2% non-recurrent funding can be used to mitigate the impact of the SLHT arbitration decision. Small SLA reserve held. Agreement for contract for continuing care that removes the costs of 1:1 and specialing. Robust arrangements for assessing eligibility of continung care patients. Close working relationships with LBB and MDs of BSU to look at cost sharing as opposed to cost shunting	Robust IFR process for Bexley to challenge eligibility of requests (Cluster); Robust high cost drugs and NCA validation and challenge process to be put in place (cluster); Final agreement of SLHT & DVH SLA values so that financial position can be fully assessed and action plans put in place (cluster); Continually assess budgets set with a view to reduction; Additional QIPP schemes to be identified.

ENCLOSURE 14

Action Plan Summary(date / by who)

1) SLHT & DVH SLAs to be finalised and signed. - Cluster
2) Robust process for reviewing IFRs to be implemented - Cluster
3) Robust process for validating and challenging NCAs and high cost drugs billed to be implemented – Cluster.
4) Additional QIPP to be identified – GP responsibility with BSU staff primarily. This is ongoing.
5) Existing budgets to be continually monitored – Cluster & BSU. This is ongoing.

Action	Priority	Resource	Contingency / Dependency	Progress	Evidence	RAG
1) SLHT & DVH SLAs to be finalised and signed	High	Regular dialogue with providers. Escalation being pursued	Cluster to complete. 0.5% contingency and small SLA reserve held.	Contract values agreed	Signed SLAs tbc	RED
2) Robust process for reviewing IFRs to be implemented	High	Resource and process in place and being applied	N/A	Clarification of respective expectations / roles agreed within NHS SEL	Incorporated in to contract management arrangements	AMBER
3) Robust process for validating and challenging NCAs and high cost drugs billed to be implemented	High	Resource and process in place and being applied	N/A	Clarification of respective expectations / roles agreed within NHS SEL	Incorporated in to contract management arrangements	AMBER
4) Additional QIPP to be identified	High	Bexley staff working with GPs within current resource Cluster to identify for acute & primary care	Needs clinical input to identify but view that there is little more possible.	Unidentified QIPP gap closed by re-prioritising investments. Few new real QIPP schemes identified or likely to be.	Reduced QIPP gap reported in monthly FIMs returns.	AMBER
5) Existing budgets to be continually monitored	High	NHS SEL staff within current resource	Needs input from GPs and budget holders as well as good communication with cluster in respect	Budgets continually reviewed to release funds into the position.	Reduced QIPP gap reported in monthly FIMs returns.	AMBER

NHS SEL RISK ACTION PLAN FOR ALL RISKS OF 15 OR MORE

This action plan is to be submitted with the Directorate Risk Register for all risks of 15 or more

Date submitted	**5th August 2011**
Name of Risk Workstream	**FB5 Finance and Business (Bexley)**
Description of Risk	There is a risk that there will be a lack of clarity regarding the roles and responsibilities in respect of gathering information and reporting of performance targets caused by the recent restructuring, reduction in staffing, number of vacancies and turnover leading to the failure to meet and report performance targets accurately and inability to progress the Government's Clinical Commissioning agenda.
Risk Owner	**Cluster/Pam Creaven/Julie Witherall**
Residual Risk Score	**16**
Target Risk Score	**9**
Date for achievement of Target Risk Score	**31/12/2011**

Current Controls	Gaps in Controls / Assurance
Experienced Information Analyst responsible for recording performance data in post within BSU. Cluster have a team in post responsible for performance liaising with BSUs. Definitive list of all targets created by BSU.	Recruitment to vacancies within cluster. Regular performance target monitoring meetings between cluster & BSU to be set up. Final agreement of roles and responsibilities for monitoring and submission of target data needed. List of targets to be distributed to BSU staff to inform monthly requirements & ownership. Vacant head of performance within BSU needs to be resolved.

ENCLOSURE 14

Action Plan Summary(date / by who)

1) Recruitment of Cluster Staff – Cluster will need to provide
2) Resolution of BSU Head of Performance post – Julie Witherall 30/09/2011
3) Schedule of Cluster and BSU meetings to discuss performance target monitoring to be set up – Cluster to advise – Julie Witherall by 30/09/2011
4) Comprehensive list of targets to be distributed to BSU staff – Julie Witherall 30/09/2011

Action	Priority	Resource	Contingency / Dependency	Progress	Evidence	RAG
1) Recruitment of cluster staff	Medium	Performance and information team	Market Vacancy Recruitment process agreed by CMB Reporting on mandatory performance measures has been delivered	Recruitment process to vacant positions continues	2 staff joining / returning to team in September	Medium
2) Resolution of BSU Head of Performance post	High	Decision required internally	Will depend on whether post is required, availability of person with required skills			RED
3) Schedule of cluster and BSU meetings to discuss performance target monitoring to be set up	High	No additional resource required	Need schedule of meetings from Cluster so that local meetings can feed into them etc			RED
4) Comprehensive list of targets to be distributed to BSU staff	High	No additional resource required	Need clarity on certain targets and who is responsible			RED

ENCLOSURE 14

EXCEPTION REPORT - RISK MANAGEMENT BOARD ASSURANCE

Date submitted	05/09/2011
Name of Risk Workstream	Bromley BSU BR01103
Description of Risk	There is a risk that failure to effectively monitor and manage the quality and safety of services at the local acute provider will lead to unacceptable and unsafe conditions for patients
Risk Owner	Sonia Colwill/Meredith Collins
Residual Risk Score	15
Target Risk Score	12
Date for achievement of Target Risk Score	31/03/2012

Current Controls	Gaps in Controls / Assurance
• SLHT Clinical Quality Review Group meets monthly and includes BSU and GP representation. • Quality Working Group of LCCC reviews all sources of quality information and reports to the LCCC on an exception basis. • Joint Quality and Safety Committee at Cluster also reviews and reports to Joint PCT Boards. • Further development of quality metrics and monitoring. • Scale of management challenge for SLHT.	• Tested cycle of Clinical Quality Group meetings • System resilience • Quality assurance framework required

Action Plan Summary(date / by who)

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

ENCLOSURE 14

Action	Priority	Resource	Contingency / Dependency	Progress	Evidence	RAG
1) Development of Quality Metrics	High	Cluster Performance Team SLHT Clinical Quality Review Group	Availability of Data/information	Quality Report to Bromley LCCC	Report to Bromley Quality Working Group October 2011	Amber
2) Monthly meetings of SLHT Clinical Quality Review Group	High	Cluster Acute Contracting Team Bromley LCCC representatives Bromley Quality Working Group		In Place	SLHT Clinical Quality Review Group notes	Green
3) Development of GP Alerts system	High	Bromley Quality Working Group	Availability of data/information	Process to be agreed and implemented	Bromley Quality Working Group minutes	Amber
4) Monitoring of acute provider complaints	High	SLHT Quality Review Group	Availability of data/information	Process to be agreed and implemented	SLHT Clinical Quality Review Group notes Reports to Bromley Quality Working Group/LCCC	Amber
5) Serious Incident Reporting	High	SLHT Quality Review Group	STEIS Reports	In place	STEIS Reports SLHT Clinical Quality Review Group notes Reports to Bromley Quality Working Group/LCCC	Green

EXCEPTION REPORT - RISK MANAGEMENT BOARD ASSURANCE

Date submitted	05/09/2011
Name of Risk Workstream	Bromley BSU BRO1104
Description of Risk	There is a risk that failure to effectively monitor and manage activity levels and costs at the local acute provider will lead to breach of financial control
Risk Owner	Meredith Collins
Residual Risk Score	16
Target Risk Score	12
Date for achievement of Target Risk Score	31/03/2012

ENCLOSURE 14

Current Controls	Gaps in Controls / Assurance
• Contract management process established at Cluster level. • Improved and timely submission of data by local acute provider.	• Develop and refine contract management arrangements. • Further improve quality and timeliness of activity data.

Action Plan Summary(date / by who)

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

Action	Priority	Resource	Contingency / Dependency	Progress	Evidence	RAG
1) Further development of processes within South East London Cluster.	High	Cluster Acute Contracting Team	Availability of data/information		Minutes of Cluster Quality and Safety Committee Meeting 5 Setember 2011	Amber
2) Cluster progressing arrangements for joint acute contract management with SW London PCTs	High	Cluster Acute Contracting team			Papers for Joint Boards Meeting - 22 September 2011	Amber

EXCEPTION REPORT - RISK MANAGEMENT BOARD ASSURANCE

Date submitted	02/09/11
Name of Risk Workstream	Safeguarding children at risk - Greenwich
Description of Risk	There is a risk that safeguarding arrangements may be insufficiently rigorous.
Risk Owner	Annabel Burn
Residual Risk Score	3x5 15
Target Risk Score	2x510
Date for achievement of Target Risk Score	December 2011

Current Controls	Gaps in Controls / Assurance
• Experienced designated nurse in post • Cover provided by Cluster Medical Director for Designated Doctor issues • All main Greenwich providers have Named Professionals in post • Greenwich SIT Visit Action Plan complete • Named GP appointed 3 session per week • General Practice leads appointed • Named midwife appointed SLHT (QE site) • PCT participating fully in LSCB • Agreement with SLHT to recruit joint Paediatrician / Designated Doctor post • Vacancy rate in HV successfully reduced • Safeguarding executive group in place and monitoring improvement action plans	• Designated doctor post remains unfilled • Safeguarding improvement report to GCCC

Action Plan Summary(date / by who)

1) Work with SLHT to recruit joint post (designated doctor/ paediatrician) to be in post by Autumn 2011 Lead – Liz Kennard / HR partner
2) Contract monitoring of new service specification for LAC – Community / Oxleas contract manager, quarterly during 2011-12
3) Include safeguarding improvement monitoring in GCCC performance report (including primary care contractors) (This action arises from SIT action plan -"Embed safeguarding within PBC") Liz Kennard/Andrew Thomas, quarterly in 2011-12

ENCLOSURE 14

Action	Priority	Resource	Contingency / Dependency	Progress	Evidence	RAG
1) Recruit Designated doctor post	High	2.5 days funded by NHSG	Joint HR process with SLHT Up to 3 month notice period for successful candidate	JD /pers spec agreed Recruitment process /timetable agreed	JD/Pers spec	Green
2) Contract monitoring of Oxleas against service spec for LAC	High	Contract mgt meeting / manager time	Provision of complete and timely data by provider	Contract management structure set up and meetings scheduled	Quarterly contract review papers	Amber
3) Performance report on Safeguarding Improvement action plan to go to GCCC	High	Designated Nurse time	n/a	To be scheduled within upcoming GCCC agendas	Report, minutes	Amber

EXCEPTION REPORT - RISK MANAGEMENT BOARD ASSURANCE

Date submitted	02/09/11
Name of Risk Workstream	QIPP/ Finance (BSU2 in 27/7/11 GCCC report, Op4 in July 11 Encl 10?) - Greenwich
Description of Risk	There is a risk that QIPP savings will be insufficient to absorb the additional cost of acute over-performance.
Risk Owner	Annabel Burn
Residual Risk Score	16
Target Risk Score	12
Date for achievement of Target Risk Score	January 2012

Current Controls	Gaps in Controls / Assurance
• Cluster wide quarterly stock take • Monthly QIPP reporting and monitoring to cluster PMO, BSU management team and GCCC • QIPP implementation plans in place, BSU QIPP structures and processes and GCCC monitoring arrangements including highlight/exception reporting; • Development of QIPP Plan Bs; • Arrangements for GP delegation and development task group; • Pathfinder application; • Federation and cluster structure; • PMO structures; Reserves including 0.5% contingency reserve.	• Difficulty in quantification of risk (lack of real time data on contract overperformance and QIPP programmes); • Lack of alignment with contracting teams; • Delay in identification of GP executive responsibilities and GCCC supporting committees; • Incomplete engagement plans; KPIs to be agreed; • Pace of change in clinical behaviour ; • Acute PbR contracts- risk of unsigned contracts.

Action Plan Summary(date / by who)

1. Continued implementation of QIPP initiatives and development of Plan B initiatives including development of "Finding the Vulnerable" programme of work to increase case finding, capacity and co-ordination of services; (QIPP leads)
2. Embed performance and risk framework in all QIPP projects (BSU QIPP Business Manager)
3. Challenges as part of validation / contract monitoring processes (SLHT Contract manager);
4. Action to develop / implement / monitor engagement plans; (BSU Engagement Lead)
5. Monitoring and allocation of financial reserves as needed; (Cluster/BSU Finance)
6. Development of information and reporting functionalities; I(Cluster & BSU information leads)
7. Refresh of strategic commissioning plan. (Cluster & BSU QIPP leads)

ENCLOSURE 14

Action	Priority	Resource	Contingency / Dependency	Progress	Evidence	RAG
1. Continued implementation of QIPP initiatives and development of Plan B initiatives including development of "Finding the Vulnerable" programme of work to increase case finding, capacity and co-ordination of services;	High	QIPP leads	Multiple dependencies, including resources, engagement of clinicians and patients.	As per stock take	QIPP Stocktake and monthly monitoring	Amber
2. Embed performance and risk framework in all QIPP projects (BSU QIPP Business Manager)	High	QIPP Business Manager	Availability/engagement of QIPP leads to capture detail.	Existing monthly monitoring templates capture risks and have been collated. Now require ongoing updates and incorporation into BSU risk reporting.	Development of BSU risk register	Amber
3. Challenges as part of validation / contract monitoring processes (SLHT Contract manager);	High	Acute contract management team	n/a	TBC	Contract monitoring reports	Amber
4. Action to develop / implement / monitor engagement plans; (BSU Engagement Lead)	Medium	BSU engagement lead	Availability of relevant QIPP leads	Templates for monitoring QIPP engagement developed.	Completion of engagement templates as evidence of engagement activities undertaken	Amber
5. Monitoring and allocation of financial reserves as needed;	Medium	Finance leads		Ongoing monitoring and allocation of reserves to cover financial position	FIMS, internal finance reports	Green

(Cluster/BSU Finance)						
6. Development of information and reporting functionalities; I(Cluster & BSU information leads)	Medium	Information leads		Roll out of contract reporting to GP practice level imminent	Completion of roll-out	Amber
7. Refresh of strategic commissioning plan. (Cluster & BSU QIPP leads)	High	QIPP Business Manager and various leads	Multiple dependencies on various contributors from across NHS SEL	First draft in production for early September	Completed document	Amber

EXCEPTION REPORT - RISK MANAGEMENT BOARD ASSURANCE

Date submitted	**20/7/11**
Name of Risk Workstream	**QIPP**
Description of Risk	**There is a risk that failure to deliver sufficient local QIPP Initiatives in a timely manner caused by a lack of GP ownership and engagement, lack of stakeholder management including appropriate patient and public / provider involvement, insufficient tracking of delivery plans and associated KPI's, lack of pipeline schemes and alignment of enablers leading to breach of financial control total and non delivery of local QIPP Plan.**
Risk Owner	**Head of Service Redesign**
Residual Risk Score	**16**
Target Risk Score	**12**
Date for achievement of Target Risk Score	**October 11**

Current Controls	Gaps in Controls / Assurance
• Pathfinder application & GP Executive Team • Federation and Neighbourhood structure • GP Interactive • BSU Structure including Facilitators • Clinical Commissioning Committee with QIPP on the agenda since September 2010 • Implementation plans in place • HCSC reviewed QIPP in March 2011 & July 2011 • QIPP in Contracts • PMO Operational and Strategic Meetings. • Agreed Highlight / Exception Reporting Framework with LCCC (shared with Cluster) • Paper to LCCC on QIPP Plan B (April) • Cluster QIPP Structure and meetings, and quarterly stock take • £2.9m non-recurrent bid accepted • RAG Financial adjusted, QIPP being monitored • PPE Steering Group • Joint Service and System Redesign Group with LHCT and position statements and development of gateway approach to projects	• Alignment with Contracting teams • LCCC Sub-committees • Engagement Plans • Strengthen Implementation Plan • KPI to be agreed

Action Plan Summary(date / by who)

1) Development of mechanisms to deliver changes across Consortium Practices and GP Community via OD Plan (CMS) - ongoing
2) Sub Groups of Lewisham CCC agreed. Quality and Safety Group/Strategy Group (MH) - complete
3) Engagement Plans are in place for most schemes. Healthier Communities Select Committee have not deemed any schemes a substantive variation (MH/GB) - ongoing
4) Appropriate KPIs to be agreed for individual QIPP project areas (AOS/CG) - ongoing
5) Use of QOF quality and productivity indicators to strengthen GP new referrals and emergency admissions projects (AOS) – September 11
6) Pipeline schemes for 11/12 and beyond to be considered drawing on experiences of neighbouring BSU areas (Redesign team) - ongoing
7) Confirmation of community and acute contracting arrangements for LHT to ensure enforcement of agreed KPIs (MW) – September 11

Action	Priority	Resource	Contingency / Dependency	Progress	Evidence	RAG
1) Development of mechanisms to deliver changes across Consortium Practices and GP Community via OD Plan	High	(CMS)		Ongoing	Confirmation of GP executive team portfolios Sign off of GP consortium delegation plan	Amber
2) Sub Groups of Lewisham CCC to be agreed. Quality and Safety Group/Strategy Group.	High	MH		Complete	Formal group terms of reference	Green
3) Engagement Plans agreed for schemes. Healthier Communities Select Committee have not deemed any schemes a substantive variation	Medium	MH/GB		Ongoing	Engagement Plans	Amber
4) Appropriate KPIs to be agreed for individual QIPP project areas	Medium	AOS/CG		Ongoing	Service specifications	Amber
5) Use of QOF quality and productivity indicators to strengthen GP new referrals and emergency admissions projects	High	AOS		Ongoing – to be completed by September 11	QOF intentions form	Amber
6) Pipeline schemes for 11/12 and beyond to be considered drawing on experiences of neighbouring BSU areas	Low	Redesign team		Ongoing	Telehealth and proactive primary care pilots already in development	Amber
7) Confirmation of community and acute contracting arrangements for LHT to ensure enforcement of agreed KPIs	High	MW/Cluster		Ongoing – to be resolved by September 11		Red

ENCLOSURE 14

EXCEPTION REPORT - RISK MANAGEMENT BOARD ASSURANCE

Date submitted	**2nd September 2011**
Name of Risk Workstream	SBSU Objective: Improve health, quality and maintain safety of local services
Description of Risk	Maintaining staff in key positions and ensuring staff capacity to meet Operating Plan requirements e.g. safe services, business intelligence, organisational knowledge. Challenge of expensive cost envelope
Risk Owner	**CFO**
Residual Risk Score	**16**
Target Risk Score	**6**
Date for achievement of Target Risk Score	**Reviewed monthly**

Current Controls	Gaps in Controls / Assurance
▪ Established HR procedures. ▪ Staff turnover reporting to Joint Audit Ctte. ▪ Recruitment panel process in place. ▪ SMT oversight. ▪ Circa 50% management efficiencies made as part of QIPP. ▪ Pay/Non-pay cost review ongoing.	Ongoing London-wide & National budget pressures

ENCLOSURE 14

Action Plan Summary(date / by who)

1) Southwark BSU finance team – ongoing action
2) Monthly reporting from finance team to SBSU CFO
3) …..
4) …..
5) …..
6) …..
7) …..
8) …..
9) …..

South East London

A meeting of the SEL PCT Boards* and Bexley Care Trust 22nd September 2011

ENCLOSURE 15

SHARED OPERATING MODEL FOR CLUSTERS

DIRECTOR RESPONSIBLE: Gill Galliano – Director of Development

AUTHOR: Ben Vinter, Integrated Governance Manager

TO BE CONSIDERED BY: All

SUMMARY:
This briefing provides the Joint Boards with an update on and assurance of the activities undertaken by the management team in order to ensure compliance with and development against the DH issued shared Operating Model for Clusters (issued 28/7/11)

The Joint Boards are also asked to be aware that the NHS London requires each cluster to present to it (for inclusion in their October Board papers) a suite of legacy documentation for cluster operations. NHS London require that the Chair and Chief Executive provide approval of this submission and as such the Boards are asked to provide the Chair and Chief Executive with the authority to approve submission.

KEY ISSUES:
The publication aims to support the development of PCT Clusters to help ensure we (and our peers) deliver our twin objectives of overseeing and accounting for delivery during transition and supporting the development of the new system.

The document sets out the expectation that clusters move towards a more consistent way of operating in some areas as the NHS moves through transition and prepare for the establishment of the NHS Commissioning Board.

The guidance, and our briefing on progress in response to it, is structured around six key business areas (appended). it also sets out where there are processes or functions that all

PCT Clusters will need to perform and where it is important that there is consistency between them.
The areas are;

1. Integrated Finance, Operations and Delivery
2. Commissioning Development
3. Ensuring Quality (Effectiveness, Experience and Safety)
4. Emergency Planning and Resilience
5. The Commissioning Elements of Provider Development
6. Communications and Engagement

Appended
a) DH Shared Operating Model for PCT Clusters (on NHS SEL website)

COMMITTEE INVOLVEMENT:
The Cluster Management Board has considered and discussed the issued document in light of the development of clusters outside of London.

The Boards are being briefed on progress against the stated twin objectives contained within the DH following their approval of the structures established at the time of NHS SEL's creation.

PUBLIC AND USER INVOLVEMENT:
Public and user involvement has not been sought in the development of this briefing for the Boards though public and user involvement is considered to be both standard and best practice in the decision making structures in place within NHS SEL.

IMPACT ASSEESMENT: N/A

RECOMMENDATIONS:
The Board(s) are asked to:

- Note enclosed briefing on NHS SEL progress in implementing the Shared Operating Model for Clusters
- Provide authority to the Chair to take Chairs' Action to approve submission of a map of NHS SEL's legacy documentation to NHS London

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*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.

Shared Operating Model for PCT Clusters
An NHS SEL Briefing to the Joint Boards

1. Introduction

The Operating Framework for 2011/12 announced the creation of PCT Clusters to secure the capacity and flexibility needed for the transition period within which the NHS currently finds itself. PCT Cluster's work as transition vehicles to:

- Oversee and account for delivery; and
- Support the development of the new system.

In January 2011, the Department of Health published PCT Cluster Implementation Guidance to assist the NHS in the identification and development of PCT Clusters. That guidance set out key responsibilities, structures and governance issues for Clusters.

Since then, the Department has agreed with Strategic Health Authorities (SHAs) proposals for 51 PCT Clusters covering England. As a result the DH and NHS published a shared operating model for PCT Clusters in July with this report providing the Joint Boards with a thematic update on progress in respect of the key identified areas for progression within clusters (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_129985.pdf).

2. Progress

a) Integrated Finance, Operations and Delivery

NHS SE London has arrangements in place to cover these responsibilities. We have established a clear performance framework within the Cluster that brings together reporting at a PCT/CCG level for Performance, QIPP and Finance. Within this framework clarity has been achieved on the named prime owner in each borough for each of the performance headline measures and for each of the QIPP initiatives. From an Executive perspective progress or variance against plan in each of the domains is systematically tracked and reported through a cycle of quarterly stocktakes which take place in each borough and which lead to the development of a clear action plan.

The outcome of these Executive stocktakes is reported to :-

- The Local Clinical Commissioning Commitee who will take forward and oversee the local actions pertaining to individual boroughs. The Performance,

ENCLOSURE 15

QIPP and Finance Committee will take forward an in depth review of any cross cutting themes. Such reporting and involvement forms the basis for escalation and action planning. The associated actions rest with the CEO as Accountable Officer.

- In addition a monthly summary Cluster wide report of Performance against the headline measures and a monthly summary Cluster Finance report is produced clarifying the key issues and actions being taken. Responsibility for the leadership of this element of the operating model rests with the Director of Finance and the Director of Operations in conjunction with the Directors/GP leads who are the prime owners of the different elements of the planned delivery.

b) Commissioning Development

Commissioning Development is led across the Cluster by the Director of Development who is supported by four Directors – Director of Corporate Affairs, Director of Strategy and QIPP, Director of Transitional Programmes and Director of Human Resources. There is also a strong working relationship with the Director of Workforce and the Managing Directors of BSUs.

The overall focus is to ensure the successful establishment of the new commissioning architecture through co-production with the Clinical leadership of the Clinical Commissioning Groups, alongside providing support to ensure strong local engagement with Local Authorities and other stakeholders in the development of the Health and Well Being Boards and Public Health transition.

Clinical Commissioning Groups (CCGs)
All practices in South East London are included within the six Borough CCGs. There is a programme in place to support CCGs through stages of delegation to full delegation by 1st April 2012 and onto authorisation by 1st April 2013. As part of this development we are coordinating the allocation of the £2 per head support and the overall development process for CCGs through the London procurement.

BSU are supporting CCGs to ensure they are engaged early in the development of their local health and wellbeing board in shadow form during 2011/12 so that they are able to play a lead role in shaping the joint strategic needs assessment and joint health and wellbeing strategy

Each CCG has ensured that it has the Public Equality duty firmly built into its plans and has an identified lead locally.

Local safeguarding arrangements have been retained with the Director of Nursing providing the overall Corporate leadership.

The strategy team will be providing support to the 2012/13 planning round and with colleagues from the operations team enable CCGs to build up experience in QIPP and the wider commissioning agenda.

Commissioning Support
NHS South East London, along with other London clusters, have begun to develop options for Commissioning Support. One of the options currently being tested is a Commissioning Support Organisation across South London. CCGs have been involved in this process and will be key to testing the options as they become refined to ensure as 'intelligent customers' the proposals meet their needs within the running cost envelope which will be available.

NHS Commissioning Board
The Cluster Director of Finance has begun modelling the running costs of the transitional structures in order to provide a foundation for future decisions. Any decisions taken in the future will be subject to co-production with CCGs and staff, where appropriate.

Primary Care
Co-location of the Clinical Directorate, Primary Care, Finance, Estates and ICT has improved joint working across Directorates and allows for better co-ordinated commissioning of primary care services. This has in the early months produced noticeable improvements in the tackling of Issues of Concern with progress in both resolving long standing issues and completing a number of investigations.

Due diligence is being undertaken to ensure that all contractual arrangements are backed up by signed current contracts and supporting files are available on other areas of expenditure e.g. premises, seniority, enhanced services etc.

Consultation has commenced with local representative committees to create common operating policies across the six PCTs to ensure equal and fair treatment to all contractors. The policies being reviewed include QOF monitoring, locum and premises re-imbursement, list cleansing etc.

The Cluster has three providers of Family Heath Services functions and these services are being reviewed.

At its July meeting the Board received a discussion document covering primary care developments over the next eighteen months. This includes information requirements for peer to peer review by LCCGs, premises developments and delivery of QIPP. The document is being discussed with LCCCs and representative bodies with priorities being brought back to the November Board.

The Directorate is fully engaged with both NHSL and DH forums in the scoping the future of direct commissioning of primary care by the National Commissioning Board (NCB).

Specialised Services
The Acute Contracting Team is working toward the convergence of commissioning arrangements to April 2013 in partnership with the London Specialised Commissioning Group. National guidance is awaited in this area.

Service specifications for commissioned services based upon NICE quality standards are included within local plans subject to and revisions to national guidance

The impact of separating contract activity and timescales for managing such a separation are contained within the team work plan but are currently subject to required clarification of a number of definitions.

Prison Health
Lambeth and Greenwich have commissioning responsibility for health care provision in the two South East London prisons. From 2013, prison health will become the responsibility of the National Commissioning Board, together with health in police custody, and court liaison and diversion. Clinical Commissioning Groups will, however, have responsibility for wider offender health provision, with drug and alcohol being the remit of Public Health. Health & Wellbeing Boards will also have a wider role in offender health. As there is no longer a formal Department of Health offender health unit in London, offender health commissioners in London meet as an informal network to develop London-wide service improvements, and this network is identifying key issues emerging from transition to the NCB.

As every borough has offenders (and not simply those with prisons), the Cluster expects to undertake an offender health needs assessment (HNA), or commission a Cluster-wide HNA.

c) Ensuring Quality (Effectiveness, Experience and Safety)

NHS South East London has appointed a Medical Director and Director of Nursing with clear overall accountability for all three Domains of quality. A quality and safety committee has been established with a systematic reporting structure on all providers including primary care. The Medical Director or the Director of Nursing attends the individual quality meetings for all acute providers and the primary care quality meetings.

Within the Directorate of Workforce Transformation there is an agreed process with local NHS providers and NHSL to establish the overall shape and size of the workforce, which has at its heart the NHS South East London QIPP and ,where appropriate, wider London clinical strategies for 2011-2016.

All trusts in the Cluster use an agreed London wide workforce tool to establish future workforce demand. This directorate is in the process of discussing more

fully with Trusts how they have established their workforce demands in relation to the local QIPP, their risks and challenges and any resulting mitigating action.

Much of the work is used to inform London's overall education and training commissioning for the healthcare workforce. An iterative process, led by NHSL, takes place involving clinicians from a range of staff groups and formal professional scrutiny of all clinical groups is undertaken involving local clinicians and sign off. NHSL seeks local input and SEL participate in it.

Through a web based management benchmarking tool regular workforce indicators such as sickness rates, staff turnover, and use of agency staff are monitored for each Trust. We see future ways of working will increase the emerging collaborative style, where benchmarking and quality would form part of this system wide discussion. Provider Skills Networks are likely to be introduced nationwide during 2012/13 to support further devolution of education and training monies and will also support this model.

The Medical Director and Director of Nursing have led a review of Serious Incident reporting and the management of alerts. Serious Incidents are reported in a common way and collated centrally at the cluster. Alert systems are working locally. The Director of Nursing is responsible for adult and children safeguarding and has reviewed the systems for children and adults. There is a robust work plan in place to ensure that handover to clinical commissioners is done safely.

The Medical Director has put in place robust plans across the cluster for appraisal and revalidation and is the responsible officer for all six PCTs. The medical directorate works closely with the specialist team in primary care to support, investigate and take action on doctors and other clinicians in difficulty.

d) Emergency Planning and Resilience

The Cluster can provide substantial assurance against the Model having taken action in early-2011 to ensure emergency planning and resilience remained a core function of the cluster and that the still-legally extant PCTs maintained their statutory compliance with the Civil Contingencies Act. The action taken was with the full involvement and approval of the NHS London Emergency Planning Managers.

The Executive Lead for EPR, Dr Ann-Marie Connolly chairs the Emergency Planning & Resilience Steering Group (which reports regularly to the Quality & Safety Committee) and whose membership includes Emergency Planning Managers and Leads from all six BSU as well as corporate functions from the Cluster.

A 24/7 response capability has been established through the on-call executive director who is, in turn, supported by a second on-call director. These positions

have all the necessary authority and functions detailed by the model in the Cluster's responsibilities for response.

The Cluster has recently been audited by NHS London. Where further action is required (largely as a consequence of being a relatively new organisation) an Action Plan has been agreed with NHS London which is being implemented under the supervision of the Q&SC.

The Cluster is committed to working with partners and stakeholders across South East London and will be joining the various multi-agency exercises being held in anticipation of the 2012 Olympic Games.

Further clarification has been sought in respect of the reporting requirements to the London-wide Local Resilience Forum (as detailed in the Model) which is currently undertaken by NHS London. The existing Cluster EP policy will be amended when this information is received.

e) The Commissioning Elements of Provider Development

There are two Trusts in the FT pipeline in SE London, Lewisham Healthcare and South London Healthcare Trust. The Cluster has been fully engaged in the FT pipeline processes for each of these. Lewisham Healthcare are currently preparing their business case and there is extensive joint work underway, involving the clinical commissioners in Lewisham to ensure that the commissioner and provider plans align. The financial position at SLHT means that their planned FT achievement date is further out and that work is not as advanced.

The Cluster has already undertaken several AQP processes [in Bromley and Greenwich] and work is in hand to address the requirements to bring forward the further requirements in the non acute service areas by April 2012. We have in house expertise in procurement within the Finance Directorate of the Cluster and, where necessary, we can augment this by securing external support.

f) Communications and Engagement

Summary
Proposals for a nation-wide NHS Communications and Engagement service have been discussed extensively with Communications and Engagement colleagues working across NHS South East London and with key stakeholders including GPs and representatives of patients and the public at the Stakeholder Reference Group. A number of powerful views have been collected that will be fed back to the Department of Health.

A 'prospectus' was expected during August but it remains in draft as, in developing the plans, issues have been identified that will need addressing not only for

communications and engagement, but which will be common for other commissioning support services working in the new NHS system. These include implementation issues around governance, hosting and financing.

A broader based guidance document on commissioning support is due to be published in late September and the detailed proposals for the communications and engagement service are expected at this time. In the meantime we will continue to explain and discuss the vision for the shared service with staff, NHS London, Cluster and clinical commissioning group colleagues as well as partner organisations such as local authorities.

Deliverables and areas of consistency

In respect to the deliverables and areas of consistency listed in the Shared Operating Model, NHS South East London continues to comply fully with the statutory responsibilities for communications and engagement including publishing accounts, holding AGMs, engaging and consulting the public as required under Section 242, engaging with key stakeholders such as LINks and Overview and Scrutiny Committees (undertaken both at borough level and through the Stakeholder Reference Groups), providing information to patients and providing timely responses to FOIs (418 for the 5 PCTs and Bexley Care Trust in the first quarter of 2011/12).

We are continuing to work with the NHS London Director of Communications and the Department of health to influence plans for the National Communications and Engagement Service and are working collaboratively with NHS London and the other five London PCT Clusters on joint campaigns for flu and choose well (using the right NHS service).

Background papers

Shared Operating Model for PCT Clusters

A meeting of the SEL PCT Boards* and Bexley Care Trust
22 September 2011

ENCLOSURE 16

LONDON SPECIALISED COMMISSIONING GROUP

DIRECTOR RESPONSIBLE: Sue McLellen, Chief Operating Officer, London SCG

AUTHOR: Michele Davis, Assistant Director London Specialised Commissioning Group (SCG) based on paper from Ania Slim, Capsticks

TO BE CONSIDERED BY: All

INVOLVEMENT REQUIRED FROM THE BOARDS:
The Joint Boards are asked to agree to the recommendations as outlined below. The consequence of no decision being taken is that the contracts held by London SCG may potentially be void and unenforceable.

SUMMARY:
The Department of Health's lawyers have confirmed that Specialised Commissioning Groups ("**SCG's**") do not have the power to delegate those functions which were delegated to them by PCTs, to another SCG. This means that where SCGs have entered into contracts on behalf of Consortia of SCGs, they were acting outside their powers. London SCG has been advised that this results in all previous and current contracts entered into potentially being void and unenforceable.

In light of this, the paper provides that the PCT delegates authority directly to the Host PCT and the Relevant Lead SCG (as defined in Appendix A and within this Paper) to enter into all contracts noted in Appendix A.

KEY ISSUES:
Section 1.4 Establishment and Delegation outlines what functions are being delegated and these are consistent with current levels of delegation.

There is no risk to individual PCTs in agreeing to the recommendations.

There are no financial implications to this agreement.

The legal advice LSCG have received forms the basis of these proposals and will ensure contracts are not void.

Staffing considerations – *Not applicable*

Equalities – *Not applicable*

Appendices – demonstrate the host PCT and host SCG for each commissioned service.

INVOLVEMENT:
COMMITTEE INVOLVEMENT:
This paper is being presented to the Joint Boards for each London Cluster and South East Coast and East of England SCGs.

PUBLIC AND USER INVOLVEMENT: Not applicable.

IMPACT ASSEESMENT: Not applicable

RECOMMENDATIONS:
The board (s) are asked to **each** agree to the following recommendations:

1. The Primary Care Trust resolves to use its authority under Regulation 10 of the NHS (Functions of SHAs and PCTs and Administration Arrangements) (England) Regulations 2002 to share decision making powers in respect of the contracts referred to in Appendix A, with every PCT in the Relevant SCG area of the Relevant Lead SCG.
2. The Primary Care Trust is content with the establishment of the Relevant Lead SCGs referred to in Appendix A as joint committees, as set out in paragraphs 1.4 and 1.5 above.
3. The Primary Care Trust resolves to delegate authority directly to the Host PCT and the Relevant Lead SCG to enter into and act on its behalf in respect of all contracts listed in Appendix A, as set out in this paper and, in particular, in paragraphs 1.4 and 1.5 above.

4.	To the extent it has the power to do so, the Primary Care Trust resolves that all contracts entered into by the Previous Lead SCG and Relevant Lead SCG shall be deemed valid as if they have been adopted or ratified by the Relevant Lead SCG or retrospectively entered into by the Relevant Lead SCG.

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*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.

The creation of Relevant Lead SCGs as joint committees and the delegation of direct authority from Bexley Care Trust to the Host PCT and Relevant Lead SCG to enter into all contracts previously entered into by the Previous Lead SCG or Relevant Lead SCG

INTERPRETATION

"Consortia of SCGs"	means a group of SCGs which work together to commission services and perform functions;
"Host PCT"	means, for any particular contract, the PCT named in Appendix A, or any successor of its statutory functions;
"PCT SCG"	means **London** PCT's SCG;
"Previous Lead SCG"	means the lead SCG which had been acting to commission services and perform other functions under the authority of the Consortia of SCGs;
" Relevant Lead SCG"	means, for any particular contract, the lead SCG attached to the Host PCT set out in Appendix A;
"Relevant SCGs"	means the SCGs who are part of the Relevant Lead SCG's consortia, as set out in Appendix A.

ACTION

The Board is asked to receive this paper and resolve to accept its recommendations, in accordance with its Standing Orders.

PURPOSE OF PAPER

This paper provides that each Relevant Lead SCG referred to in Appendix A will be established as a joint committee of **Bexley Care Trust** and every other PCT in the Relevant SCG area.

Bexley Care Trust will delegate authority directly to the Host PCT and the Relevant Lead SCG to enter into all contracts which Previous Lead SCGs or Relevant Lead SCGs entered into acting under the authority of Consortia of SCGs. The Host PCT will retain responsibility for entering into legal contracts.

1.1 INTRODUCTION

The Department of Health's lawyers have confirmed that Specialised Commissioning Groups ("**SCG's**") do not have the power to delegate those functions which were delegated to them by PCTs, to another SCG. This means that where Previous Lead SCGs or Relevant Lead SCGs have entered into contracts on behalf of Consortia of SCGs, they were acting outside their powers. **Bexley Care Trust** has been advised that this results in all previous and current contracts entered into by the Previous Lead SCGs or Relevant Lead SCGs potentially being void and unenforceable.

In light of this, the paper provides that the PCT delegates authority directly to the Host PCT and the Relevant Lead SCG (as defined in Appendix A and within this Paper) to enter into all contracts noted in Appendix A and those which the Previous Lead SCG or Relevant Lead SCG entered into. This includes, but is not limited to, the delegation of commissioning functions, contracting, performance management, consultation under sections 242 and 244 NHS Act 2006, and all ancillary functions.

1.2 GEOGRAPHICAL COVERAGE

The PCT SCG will retain its current membership that is comprised of delegates from every PCT in **London** except as amended in the ordinary course of their activity**.**

The Relevant Lead SCGs will retain their current memberships except as amended in the ordinary course of their activity. Each Relevant Lead SCG shall have a Host PCT through which they operate. The Host PCT is as set out in Appendix A to this Paper and will be the body that enters into contracts on behalf of the Relevant Lead SCGs.

1.3 STATUTORY FRAMEWORK

The relevant statute is the National Health Service Act 2006 and specifically sections 1 to 3 which impose a duty on the Secretary of State for Health to provide a comprehensive Health Service. The NHS (Functions of Strategic Health Authorities and Primary Care Trusts and Administrative Arrangements) (England Regulations 2002 SI 2002/2375) (the "**Regulations**") allocate certain functions to Primary Care Trusts. Amongst other provisions, the Regulations authorise PCTs to make arrangements for certain of their functions to be exercisable jointly with other NHS bodies and permits the delegation of the exercise of those functions to committees or sub-committees, including joint committees. The Regulations also permit the delegation of PCT functions to another PCT. If a PCT delegates its relevant functions to a joint committee or another PCT and that committee or PCT reaches a decision, the PCT will be bound by that decision.

1.4 ESTABLISHMENT AND DELEGATION

The Chief Executive of every Primary Care Trust is being asked to obtain approval of the Trust Board to the following decisions:

<u>Establishment of Joint Committees</u>

a) That **Bexley Care Trust** resolves to use its authority under the Regulations to share decision making powers in respect of the contracts referred to in Appendix A with every PCT in the Relevant SCG area.

b) That **Bexley Care Trust** appoint each Relevant Lead SCG referred to in Appendix A as a Joint Committee of the PCT. The Relevant Lead SCGs shall continue to carry out their current functions in respect of the contracts referred to in Appendix A, including (along with the Host PCT) commissioning functions, contracting, performance management, consultation under sections 242 and 244 NHS Act 2006, and all ancillary functions

c) That each Relevant Lead SCG shall comprise of its voting members and be governed by its existing Standing Orders.

Delegation

d) That **Bexley Care Trust** use its authority under the Regulations to delegate authority directly to the Host PCT and Relevant Lead SCGs to act and enter into the contracts noted in Appendix A;

e) This delegation shall, for the contracts and services noted in Appendix A, include the delegation of commissioning functions, contracting, performance management, consultation under sections 242 and 244 NHS Act 2006, and all ancillary functions;

f) That insofar as the PCT has the power to do so, the past or current contracts entered into by the Previous Lead SCG and Relevant Lead SCG shall be deemed to be valid.

1.5 PROCEDURE

Bexley Care Trust is also asked to agree that:

a) The PCT SCG shall, where acting in concert with other SCGs, do so through the Host PCT and Relevant Lead SCGs only under the delegated authority granted by **Bexley Care Trust** and other PCTs in the Relevant SCG area.

b) The Relevant Lead SCG and the Host PCT will act and enter into contracts on behalf of all the PCTs and their SCGs in the Relevant SCG area, in accordance with the delegated power granted by the relevant PCTs.

Recommendations

The PCT Board is asked to pass the following resolutions:

1. The Primary Care Trust resolves to use its authority under Regulation 10 of the NHS (Functions of SHAs and PCTs and Administration Arrangements) (England) Regulations 2002 to share decision making powers in respect of the contracts

referred to in Appendix A, with every PCT in the Relevant SCG area of the Relevant Lead SCG.

2. The Primary Care Trust is content with the establishment of the Relevant Lead SCGs referred to in Appendix A as joint committees, as set out in paragraphs 1.4 and 1.5 above.

3. The Primary Care Trust resolves to delegate authority directly to the Host PCT and the Relevant Lead SCG to enter into and act on its behalf in respect of all contracts listed in Appendix A, as set out in this paper and, in particular, in paragraphs 1.4 and 1.5 above.

4. To the extent it has the power to do so, the Primary Care Trust resolves that all contracts entered into by the Previous Lead SCG and Relevant Lead SCG shall be deemed valid as if they have been adopted or ratified by the Relevant Lead SCG or retrospectively entered into by the Relevant Lead SCG.

[i]

[i] Appendix 2 Compilation of Consortia gives a breakdown of PCTs by Provider

The creation of Relevant Lead SCGs as joint committees and the delegation of direct authority from Bromley PCT to the Host PCT and Relevant Lead SCG to enter into all contracts previously entered into by the Previous Lead SCG or Relevant Lead SCG

INTERPRETATION

"Consortia of SCGs"	means a group of SCGs which work together to commission services and perform functions;
"Host PCT"	means, for any particular contract, the PCT named in Appendix A, or any successor of its statutory functions;
"PCT SCG"	means **London** PCT's SCG;
"Previous Lead SCG"	means the lead SCG which had been acting to commission services and perform other functions under the authority of the Consortia of SCGs;
" Relevant Lead SCG"	means, for any particular contract, the lead SCG attached to the Host PCT set out in Appendix A;
"Relevant SCGs"	means the SCGs who are part of the Relevant Lead SCG's consortia, as set out in Appendix A.

ACTION

The Board is asked to receive this paper and resolve to accept its recommendations, in accordance with its Standing Orders.

PURPOSE OF PAPER

This paper provides that each Relevant Lead SCG referred to in Appendix A will be established as a joint committee of **Bromley PCT** and every other PCT in the Relevant SCG area.

Bromley PCT will delegate authority directly to the Host PCT and the Relevant Lead SCG to enter into all contracts which Previous Lead SCGs or Relevant Lead SCGs entered into acting under the authority of Consortia of SCGs. The Host PCT will retain responsibility for entering into legal contracts.

1.1 INTRODUCTION

The Department of Health's lawyers have confirmed that Specialised Commissioning Groups ("**SCG's**") do not have the power to delegate those functions which were delegated to them by PCTs, to another SCG. This means that where Previous Lead SCGs or Relevant Lead SCGs have entered into contracts on behalf of Consortia of SCGs, they were acting outside their powers. **Bromley PCT** has been advised that this results in all previous and current contracts entered into by the Previous Lead SCGs or Relevant Lead SCGs potentially being void and unenforceable.

In light of this, the paper provides that the PCT delegates authority directly to the Host PCT and the Relevant Lead SCG (as defined in Appendix A and within this Paper) to enter into all contracts noted in Appendix A and those which the Previous Lead SCG or Relevant Lead SCG entered into. This includes, but is not limited to, the delegation of commissioning functions, contracting, performance management, consultation under sections 242 and 244 NHS Act 2006, and all ancillary functions.

1.2 GEOGRAPHICAL COVERAGE

The PCT SCG will retain its current membership that is comprised of delegates from every PCT in **London** except as amended in the ordinary course of their activity**.**

The Relevant Lead SCGs will retain their current memberships except as amended in the ordinary course of their activity. Each Relevant Lead SCG shall have a Host PCT through which they operate. The Host PCT is as set out in Appendix A to this Paper and will be the body that enters into contracts on behalf of the Relevant Lead SCGs.

1.3 STATUTORY FRAMEWORK

The relevant statute is the National Health Service Act 2006 and specifically sections 1 to 3 which impose a duty on the Secretary of State for Health to provide a comprehensive Health Service. The NHS (Functions of Strategic Health Authorities and Primary Care Trusts and Administrative Arrangements) (England Regulations 2002 SI 2002/2375) (the "**Regulations**") allocate certain functions to Primary Care Trusts. Amongst other provisions, the Regulations authorise PCTs to make arrangements for certain of their functions to be exercisable jointly with other NHS bodies and permits the delegation of the exercise of those functions to committees or sub-committees, including joint committees. The Regulations also permit the delegation of PCT functions to another PCT. If a PCT delegates its relevant functions to a joint committee or another PCT and that committee or PCT reaches a decision, the PCT will be bound by that decision.

1.4 ESTABLISHMENT AND DELEGATION

The Chief Executive of every Primary Care Trust is being asked to obtain approval of the Trust Board to the following decisions:

<u>Establishment of Joint Committees</u>

a) That **Bromley PCT** resolves to use its authority under the Regulations to share decision making powers in respect of the contracts referred to in Appendix A with every PCT in the Relevant SCG area.

b) That **Bromley PCT** appoint each Relevant Lead SCG referred to in Appendix A as a Joint Committee of the PCT. The Relevant Lead SCGs shall continue to carry out their current functions in respect of the contracts referred to in Appendix A, including (along with the Host PCT) commissioning functions, contracting, performance management, consultation under sections 242 and 244 NHS Act 2006, and all ancillary functions

c) That each Relevant Lead SCG shall comprise of its voting members and be governed by its existing Standing Orders.

Delegation

d) That **Bromley PCT** use its authority under the Regulations to delegate authority directly to the Host PCT and Relevant Lead SCGs to act and enter into the contracts noted in Appendix A;

e) This delegation shall, for the contracts and services noted in Appendix A, include the delegation of commissioning functions, contracting, performance management, consultation under sections 242 and 244 NHS Act 2006, and all ancillary functions;

f) That insofar as the PCT has the power to do so, the past or current contracts entered into by the Previous Lead SCG and Relevant Lead SCG shall be deemed to be valid.

1.5 PROCEDURE

Bromley PCT is also asked to agree that:

a) The PCT SCG shall, where acting in concert with other SCGs, do so through the Host PCT and Relevant Lead SCGs only under the delegated authority granted by **Bromley PCT** and other PCTs in the Relevant SCG area.

b) The Relevant Lead SCG and the Host PCT will act and enter into contracts on behalf of all the PCTs and their SCGs in the Relevant SCG area, in accordance with the delegated power granted by the relevant PCTs.

Recommendations

The PCT Board is asked to pass the following resolutions:

1. The Primary Care Trust resolves to use its authority under Regulation 10 of the NHS (Functions of SHAs and PCTs and Administration Arrangements) (England) Regulations 2002 to share decision making powers in respect of the contracts

referred to in Appendix A, with every PCT in the Relevant SCG area of the Relevant Lead SCG.

2. The Primary Care Trust is content with the establishment of the Relevant Lead SCGs referred to in Appendix A as joint committees, as set out in paragraphs 1.4 and 1.5 above.

3. The Primary Care Trust resolves to delegate authority directly to the Host PCT and the Relevant Lead SCG to enter into and act on its behalf in respect of all contracts listed in Appendix A, as set out in this paper and, in particular, in paragraphs 1.4 and 1.5 above.

4. To the extent it has the power to do so, the Primary Care Trust resolves that all contracts entered into by the Previous Lead SCG and Relevant Lead SCG shall be deemed valid as if they have been adopted or ratified by the Relevant Lead SCG or retrospectively entered into by the Relevant Lead SCG.

[i]

[i] Appendix 2 Compilation of Consortia gives a breakdown of PCTs by Provider

The creation of Relevant Lead SCGs as joint committees and the delegation of direct authority from Greenwich Teaching PCT to the Host PCT and Relevant Lead SCG to enter into all contracts previously entered into by the Previous Lead SCG or Relevant Lead SCG

INTERPRETATION

"Consortia of SCGs"	means a group of SCGs which work together to commission services and perform functions;
"Host PCT"	means, for any particular contract, the PCT named in Appendix A, or any successor of its statutory functions;
"PCT SCG"	means **London** PCT's SCG;
"Previous Lead SCG"	means the lead SCG which had been acting to commission services and perform other functions under the authority of the Consortia of SCGs;
" Relevant Lead SCG"	means, for any particular contract, the lead SCG attached to the Host PCT set out in Appendix A;
"Relevant SCGs"	means the SCGs who are part of the Relevant Lead SCG's consortia, as set out in Appendix A.

ACTION

The Board is asked to receive this paper and resolve to accept its recommendations, in accordance with its Standing Orders.

PURPOSE OF PAPER

This paper provides that each Relevant Lead SCG referred to in Appendix A will be established as a joint committee of **Greenwich Teaching PCT** and every other PCT in the Relevant SCG area.

Greenwich Teaching PCT will delegate authority directly to the Host PCT and the Relevant Lead SCG to enter into all contracts which Previous Lead SCGs or Relevant Lead SCGs entered into acting under the authority of Consortia of SCGs. The Host PCT will retain responsibility for entering into legal contracts.

1.1 INTRODUCTION

The Department of Health's lawyers have confirmed that Specialised Commissioning Groups ("**SCG's**") do not have the power to delegate those functions which were delegated to them by PCTs, to another SCG. This means that where Previous Lead SCGs or Relevant Lead SCGs have entered into contracts on behalf of Consortia of SCGs, they were acting outside their powers. **Greenwich Teaching PCT** has been advised that this results in all previous and current contracts entered into by the Previous Lead SCGs or Relevant Lead SCGs potentially being void and unenforceable.

In light of this, the paper provides that the PCT delegates authority directly to the Host PCT and the Relevant Lead SCG (as defined in Appendix A and within this Paper) to enter into all contracts noted in Appendix A and those which the Previous Lead SCG or Relevant Lead SCG entered into. This includes, but is not limited to, the delegation of commissioning functions, contracting, performance management, consultation under sections 242 and 244 NHS Act 2006, and all ancillary functions.

1.2 GEOGRAPHICAL COVERAGE

The PCT SCG will retain its current membership that is comprised of delegates from every PCT in **London** except as amended in the ordinary course of their activity**.**

The Relevant Lead SCGs will retain their current memberships except as amended in the ordinary course of their activity. Each Relevant Lead SCG shall have a Host PCT through which they operate. The Host PCT is as set out in Appendix A to this Paper and will be the body that enters into contracts on behalf of the Relevant Lead SCGs.

1.3 STATUTORY FRAMEWORK

The relevant statute is the National Health Service Act 2006 and specifically sections 1 to 3 which impose a duty on the Secretary of State for Health to provide a comprehensive Health Service. The NHS (Functions of Strategic Health Authorities and Primary Care Trusts and Administrative Arrangements) (England Regulations 2002 SI 2002/2375) (the "**Regulations**") allocate certain functions to Primary Care Trusts. Amongst other provisions, the Regulations authorise PCTs to make arrangements for certain of their functions to be exercisable jointly with other NHS bodies and permits the delegation of the exercise of those functions to committees or sub-committees, including joint committees. The Regulations also permit the delegation of PCT functions to another PCT. If a PCT delegates its relevant functions to a joint committee or another PCT and that committee or PCT reaches a decision, the PCT will be bound by that decision.

1.4 ESTABLISHMENT AND DELEGATION

The Chief Executive of every Primary Care Trust is being asked to obtain approval of the Trust Board to the following decisions:

<u>Establishment of Joint Committees</u>

a) That **Greenwich Teaching PCT** resolves to use its authority under the Regulations to share decision making powers in respect of the contracts referred to in Appendix A with every PCT in the Relevant SCG area.

b) That **Greenwich Teaching PCT** appoint each Relevant Lead SCG referred to in Appendix A as a Joint Committee of the PCT. The Relevant Lead SCGs shall continue to carry out their current functions in respect of the contracts referred to in Appendix A, including (along with the Host PCT) commissioning functions, contracting, performance management, consultation under sections 242 and 244 NHS Act 2006, and all ancillary functions

c) That each Relevant Lead SCG shall comprise of its voting members and be governed by its existing Standing Orders.

Delegation

d) That **Greenwich Teaching PCT** use its authority under the Regulations to delegate authority directly to the Host PCT and Relevant Lead SCGs to act and enter into the contracts noted in Appendix A;

e) This delegation shall, for the contracts and services noted in Appendix A, include the delegation of commissioning functions, contracting, performance management, consultation under sections 242 and 244 NHS Act 2006, and all ancillary functions;

f) That insofar as the PCT has the power to do so, the past or current contracts entered into by the Previous Lead SCG and Relevant Lead SCG shall be deemed to be valid.

1.5 PROCEDURE

Greenwich Teaching PCT is also asked to agree that:

a) The PCT SCG shall, where acting in concert with other SCGs, do so through the Host PCT and Relevant Lead SCGs only under the delegated authority granted by **Greenwich Teaching PCT** and other PCTs in the Relevant SCG area.

b) The Relevant Lead SCG and the Host PCT will act and enter into contracts on behalf of all the PCTs and their SCGs in the Relevant SCG area, in accordance with the delegated power granted by the relevant PCTs.

Recommendations

The PCT Board is asked to pass the following resolutions:

1. The Primary Care Trust resolves to use its authority under Regulation 10 of the NHS (Functions of SHAs and PCTs and Administration Arrangements) (England) Regulations 2002 to share decision making powers in respect of the contracts

referred to in Appendix A, with every PCT in the Relevant SCG area of the Relevant Lead SCG.

2. The Primary Care Trust is content with the establishment of the Relevant Lead SCGs referred to in Appendix A as joint committees, as set out in paragraphs 1.4 and 1.5 above.

3. The Primary Care Trust resolves to delegate authority directly to the Host PCT and the Relevant Lead SCG to enter into and act on its behalf in respect of all contracts listed in Appendix A, as set out in this paper and, in particular, in paragraphs 1.4 and 1.5 above.

4. To the extent it has the power to do so, the Primary Care Trust resolves that all contracts entered into by the Previous Lead SCG and Relevant Lead SCG shall be deemed valid as if they have been adopted or ratified by the Relevant Lead SCG or retrospectively entered into by the Relevant Lead SCG.

[i]

[i] Appendix 2 Compilation of Consortia gives a breakdown of PCTs by Provider

The creation of Relevant Lead SCGs as joint committees and the delegation of direct authority from Lambeth PCT to the Host PCT and Relevant Lead SCG to enter into all contracts previously entered into by the Previous Lead SCG or Relevant Lead SCG

INTERPRETATION

"Consortia of SCGs"	means a group of SCGs which work together to commission services and perform functions;
"Host PCT"	means, for any particular contract, the PCT named in Appendix A, or any successor of its statutory functions;
"PCT SCG"	means **London** PCT's SCG;
"Previous Lead SCG"	means the lead SCG which had been acting to commission services and perform other functions under the authority of the Consortia of SCGs;
" Relevant Lead SCG"	means, for any particular contract, the lead SCG attached to the Host PCT set out in Appendix A;
"Relevant SCGs"	means the SCGs who are part of the Relevant Lead SCG's consortia, as set out in Appendix A.

ACTION

The Board is asked to receive this paper and resolve to accept its recommendations, in accordance with its Standing Orders.

PURPOSE OF PAPER

This paper provides that each Relevant Lead SCG referred to in Appendix A will be established as a joint committee of **Lambeth PCT** and every other PCT in the Relevant SCG area.

Lambeth PCT will delegate authority directly to the Host PCT and the Relevant Lead SCG to enter into all contracts which Previous Lead SCGs or Relevant Lead SCGs entered into acting under the authority of Consortia of SCGs. The Host PCT will retain responsibility for entering into legal contracts.

1.1 INTRODUCTION

The Department of Health's lawyers have confirmed that Specialised Commissioning Groups ("**SCG's**") do not have the power to delegate those functions which were delegated to them by PCTs, to another SCG. This means that where Previous Lead SCGs or Relevant Lead SCGs have entered into contracts on behalf of Consortia of SCGs, they were acting outside their powers. **Lambeth PCT** has been advised that this results in all previous and current contracts entered into by the Previous Lead SCGs or Relevant Lead SCGs potentially being void and unenforceable.

In light of this, the paper provides that the PCT delegates authority directly to the Host PCT and the Relevant Lead SCG (as defined in Appendix A and within this Paper) to enter into all contracts noted in Appendix A and those which the Previous Lead SCG or Relevant Lead SCG entered into. This includes, but is not limited to, the delegation of commissioning functions, contracting, performance management, consultation under sections 242 and 244 NHS Act 2006, and all ancillary functions.

1.2 GEOGRAPHICAL COVERAGE

The PCT SCG will retain its current membership that is comprised of delegates from every PCT in **London** except as amended in the ordinary course of their activity**.**

The Relevant Lead SCGs will retain their current memberships except as amended in the ordinary course of their activity. Each Relevant Lead SCG shall have a Host PCT through which they operate. The Host PCT is as set out in Appendix A to this Paper and will be the body that enters into contracts on behalf of the Relevant Lead SCGs.

1.3 STATUTORY FRAMEWORK

The relevant statute is the National Health Service Act 2006 and specifically sections 1 to 3 which impose a duty on the Secretary of State for Health to provide a comprehensive Health Service. The NHS (Functions of Strategic Health Authorities and Primary Care Trusts and Administrative Arrangements) (England Regulations 2002 SI 2002/2375) (the "**Regulations**") allocate certain functions to Primary Care Trusts. Amongst other provisions, the Regulations authorise PCTs to make arrangements for certain of their functions to be exercisable jointly with other NHS bodies and permits the delegation of the exercise of those functions to committees or sub-committees, including joint committees. The Regulations also permit the delegation of PCT functions to another PCT. If a PCT delegates its relevant functions to a joint committee or another PCT and that committee or PCT reaches a decision, the PCT will be bound by that decision.

1.4 ESTABLISHMENT AND DELEGATION

The Chief Executive of every Primary Care Trust is being asked to obtain approval of the Trust Board to the following decisions:

<u>Establishment of Joint Committees</u>

a) That **Lambeth PCT** resolves to use its authority under the Regulations to share decision making powers in respect of the contracts referred to in Appendix A with every PCT in the Relevant SCG area.

b) That **Lambeth PCT** appoint each Relevant Lead SCG referred to in Appendix A as a Joint Committee of the PCT. The Relevant Lead SCGs shall continue to carry out their current functions in respect of the contracts referred to in Appendix A, including (along with the Host PCT) commissioning functions, contracting, performance management, consultation under sections 242 and 244 NHS Act 2006, and all ancillary functions

c) That each Relevant Lead SCG shall comprise of its voting members and be governed by its existing Standing Orders.

Delegation

d) That **Lambeth PCT** use its authority under the Regulations to delegate authority directly to the Host PCT and Relevant Lead SCGs to act and enter into the contracts noted in Appendix A;

e) This delegation shall, for the contracts and services noted in Appendix A, include the delegation of commissioning functions, contracting, performance management, consultation under sections 242 and 244 NHS Act 2006, and all ancillary functions;

f) That insofar as the PCT has the power to do so, the past or current contracts entered into by the Previous Lead SCG and Relevant Lead SCG shall be deemed to be valid.

1.5 PROCEDURE

Lambeth PCT is also asked to agree that:

a) The PCT SCG shall, where acting in concert with other SCGs, do so through the Host PCT and Relevant Lead SCGs only under the delegated authority granted by **Lambeth PCT** and other PCTs in the Relevant SCG area.

b) The Relevant Lead SCG and the Host PCT will act and enter into contracts on behalf of all the PCTs and their SCGs in the Relevant SCG area, in accordance with the delegated power granted by the relevant PCTs.

Recommendations

The PCT Board is asked to pass the following resolutions:

1. The Primary Care Trust resolves to use its authority under Regulation 10 of the NHS (Functions of SHAs and PCTs and Administration Arrangements) (England) Regulations 2002 to share decision making powers in respect of the contracts

referred to in Appendix A, with every PCT in the Relevant SCG area of the Relevant Lead SCG.

2. The Primary Care Trust is content with the establishment of the Relevant Lead SCGs referred to in Appendix A as joint committees, as set out in paragraphs 1.4 and 1.5 above.

3. The Primary Care Trust resolves to delegate authority directly to the Host PCT and the Relevant Lead SCG to enter into and act on its behalf in respect of all contracts listed in Appendix A, as set out in this paper and, in particular, in paragraphs 1.4 and 1.5 above.

4. To the extent it has the power to do so, the Primary Care Trust resolves that all contracts entered into by the Previous Lead SCG and Relevant Lead SCG shall be deemed valid as if they have been adopted or ratified by the Relevant Lead SCG or retrospectively entered into by the Relevant Lead SCG.

[i]

[i] Appendix 2 Compilation of Consortia gives a breakdown of PCTs by Provider

The creation of Relevant Lead SCGs as joint committees and the delegation of direct authority from Lewisham PCT to the Host PCT and Relevant Lead SCG to enter into all contracts previously entered into by the Previous Lead SCG or Relevant Lead SCG

INTERPRETATION

"Consortia of SCGs"	means a group of SCGs which work together to commission services and perform functions;
"Host PCT"	means, for any particular contract, the PCT named in Appendix A, or any successor of its statutory functions;
"PCT SCG"	means **London** PCT's SCG;
"Previous Lead SCG"	means the lead SCG which had been acting to commission services and perform other functions under the authority of the Consortia of SCGs;
" Relevant Lead SCG"	means, for any particular contract, the lead SCG attached to the Host PCT set out in Appendix A;
"Relevant SCGs"	means the SCGs who are part of the Relevant Lead SCG's consortia, as set out in Appendix A.

ACTION

The Board is asked to receive this paper and resolve to accept its recommendations, in accordance with its Standing Orders.

PURPOSE OF PAPER

This paper provides that each Relevant Lead SCG referred to in Appendix A will be established as a joint committee of **Lewisham PCT** and every other PCT in the Relevant SCG area.

Lewisham PCT will delegate authority directly to the Host PCT and the Relevant Lead SCG to enter into all contracts which Previous Lead SCGs or Relevant Lead SCGs entered into acting under the authority of Consortia of SCGs. The Host PCT will retain responsibility for entering into legal contracts.

1.1 INTRODUCTION

The Department of Health's lawyers have confirmed that Specialised Commissioning Groups ("**SCG's**") do not have the power to delegate those functions which were delegated to them by PCTs, to another SCG. This means that where Previous Lead SCGs or Relevant Lead SCGs have entered into contracts on behalf of Consortia of SCGs, they were acting outside their powers. **Lewisham PCT** has been advised that this results in all previous and current contracts entered into by the Previous Lead SCGs or Relevant Lead SCGs potentially being void and unenforceable.

In light of this, the paper provides that the PCT delegates authority directly to the Host PCT and the Relevant Lead SCG (as defined in Appendix A and within this Paper) to enter into all contracts noted in Appendix A and those which the Previous Lead SCG or Relevant Lead SCG entered into. This includes, but is not limited to, the delegation of commissioning functions, contracting, performance management, consultation under sections 242 and 244 NHS Act 2006, and all ancillary functions.

1.2 GEOGRAPHICAL COVERAGE

The PCT SCG will retain its current membership that is comprised of delegates from every PCT in **London** except as amended in the ordinary course of their activity**.**

The Relevant Lead SCGs will retain their current memberships except as amended in the ordinary course of their activity. Each Relevant Lead SCG shall have a Host PCT through which they operate. The Host PCT is as set out in Appendix A to this Paper and will be the body that enters into contracts on behalf of the Relevant Lead SCGs.

1.3 STATUTORY FRAMEWORK

The relevant statute is the National Health Service Act 2006 and specifically sections 1 to 3 which impose a duty on the Secretary of State for Health to provide a comprehensive Health Service. The NHS (Functions of Strategic Health Authorities and Primary Care Trusts and Administrative Arrangements) (England Regulations 2002 SI 2002/2375) (the "**Regulations**") allocate certain functions to Primary Care Trusts. Amongst other provisions, the Regulations authorise PCTs to make arrangements for certain of their functions to be exercisable jointly with other NHS bodies and permits the delegation of the exercise of those functions to committees or sub-committees, including joint committees. The Regulations also permit the delegation of PCT functions to another PCT. If a PCT delegates its relevant functions to a joint committee or another PCT and that committee or PCT reaches a decision, the PCT will be bound by that decision.

1.4 ESTABLISHMENT AND DELEGATION

The Chief Executive of every Primary Care Trust is being asked to obtain approval of the Trust Board to the following decisions:

<u>Establishment of Joint Committees</u>

a) That **Lewisham PCT** resolves to use its authority under the Regulations to share decision making powers in respect of the contracts referred to in Appendix A with every PCT in the Relevant SCG area.

b) That **Lewisham PCT** appoint each Relevant Lead SCG referred to in Appendix A as a Joint Committee of the PCT. The Relevant Lead SCGs shall continue to carry out their current functions in respect of the contracts referred to in Appendix A, including (along with the Host PCT) commissioning functions, contracting, performance management, consultation under sections 242 and 244 NHS Act 2006, and all ancillary functions

c) That each Relevant Lead SCG shall comprise of its voting members and be governed by its existing Standing Orders.

Delegation

d) That **Lewisham PCT** use its authority under the Regulations to delegate authority directly to the Host PCT and Relevant Lead SCGs to act and enter into the contracts noted in Appendix A;

e) This delegation shall, for the contracts and services noted in Appendix A, include the delegation of commissioning functions, contracting, performance management, consultation under sections 242 and 244 NHS Act 2006, and all ancillary functions;

f) That insofar as the PCT has the power to do so, the past or current contracts entered into by the Previous Lead SCG and Relevant Lead SCG shall be deemed to be valid.

1.5 PROCEDURE

Lewisham PCT is also asked to agree that:

a) The PCT SCG shall, where acting in concert with other SCGs, do so through the Host PCT and Relevant Lead SCGs only under the delegated authority granted by **Lewisham PCT** and other PCTs in the Relevant SCG area.

b) The Relevant Lead SCG and the Host PCT will act and enter into contracts on behalf of all the PCTs and their SCGs in the Relevant SCG area, in accordance with the delegated power granted by the relevant PCTs.

Recommendations

The PCT Board is asked to pass the following resolutions:

1. The Primary Care Trust resolves to use its authority under Regulation 10 of the NHS (Functions of SHAs and PCTs and Administration Arrangements) (England) Regulations 2002 to share decision making powers in respect of the contracts

referred to in Appendix A, with every PCT in the Relevant SCG area of the Relevant Lead SCG.

2. The Primary Care Trust is content with the establishment of the Relevant Lead SCGs referred to in Appendix A as joint committees, as set out in paragraphs 1.4 and 1.5 above.

3. The Primary Care Trust resolves to delegate authority directly to the Host PCT and the Relevant Lead SCG to enter into and act on its behalf in respect of all contracts listed in Appendix A, as set out in this paper and, in particular, in paragraphs 1.4 and 1.5 above.

4. To the extent it has the power to do so, the Primary Care Trust resolves that all contracts entered into by the Previous Lead SCG and Relevant Lead SCG shall be deemed valid as if they have been adopted or ratified by the Relevant Lead SCG or retrospectively entered into by the Relevant Lead SCG.

[i]

[i] Appendix 2 Compilation of Consortia gives a breakdown of PCTs by Provider

The creation of Relevant Lead SCGs as joint committees and the delegation of direct authority from Southwark PCT to the Host PCT and Relevant Lead SCG to enter into all contracts previously entered into by the Previous Lead SCG or Relevant Lead SCG

INTERPRETATION

"Consortia of SCGs"	means a group of SCGs which work together to commission services and perform functions;
"Host PCT"	means, for any particular contract, the PCT named in Appendix A, or any successor of its statutory functions;
"PCT SCG"	means **London** PCT's SCG;
"Previous Lead SCG"	means the lead SCG which had been acting to commission services and perform other functions under the authority of the Consortia of SCGs;
" Relevant Lead SCG"	means, for any particular contract, the lead SCG attached to the Host PCT set out in Appendix A;
"Relevant SCGs"	means the SCGs who are part of the Relevant Lead SCG's consortia, as set out in Appendix A.

ACTION

The Board is asked to receive this paper and resolve to accept its recommendations, in accordance with its Standing Orders.

PURPOSE OF PAPER

This paper provides that each Relevant Lead SCG referred to in Appendix A will be established as a joint committee of **Southwark PCT** and every other PCT in the Relevant SCG area.

Southwark PCT will delegate authority directly to the Host PCT and the Relevant Lead SCG to enter into all contracts which Previous Lead SCGs or Relevant Lead SCGs entered into acting under the authority of Consortia of SCGs. The Host PCT will retain responsibility for entering into legal contracts.

1.1 INTRODUCTION

The Department of Health's lawyers have confirmed that Specialised Commissioning Groups ("**SCG's**") do not have the power to delegate those functions which were delegated to them by PCTs, to another SCG. This means that where Previous Lead SCGs or Relevant Lead SCGs have entered into contracts on behalf of Consortia of SCGs, they were acting outside their powers. **Southwark PCT** has been advised that this results in all previous and current contracts entered into by the Previous Lead SCGs or Relevant Lead SCGs potentially being void and unenforceable.

In light of this, the paper provides that the PCT delegates authority directly to the Host PCT and the Relevant Lead SCG (as defined in Appendix A and within this Paper) to enter into all contracts noted in Appendix A and those which the Previous Lead SCG or Relevant Lead SCG entered into. This includes, but is not limited to, the delegation of commissioning functions, contracting, performance management, consultation under sections 242 and 244 NHS Act 2006, and all ancillary functions.

1.2 GEOGRAPHICAL COVERAGE

The PCT SCG will retain its current membership that is comprised of delegates from every PCT in **London** except as amended in the ordinary course of their activity**.**

The Relevant Lead SCGs will retain their current memberships except as amended in the ordinary course of their activity. Each Relevant Lead SCG shall have a Host PCT through which they operate. The Host PCT is as set out in Appendix A to this Paper and will be the body that enters into contracts on behalf of the Relevant Lead SCGs.

1.3 STATUTORY FRAMEWORK

The relevant statute is the National Health Service Act 2006 and specifically sections 1 to 3 which impose a duty on the Secretary of State for Health to provide a comprehensive Health Service. The NHS (Functions of Strategic Health Authorities and Primary Care Trusts and Administrative Arrangements) (England Regulations 2002 SI 2002/2375) (the "**Regulations**") allocate certain functions to Primary Care Trusts. Amongst other provisions, the Regulations authorise PCTs to make arrangements for certain of their functions to be exercisable jointly with other NHS bodies and permits the delegation of the exercise of those functions to committees or sub-committees, including joint committees. The Regulations also permit the delegation of PCT functions to another PCT. If a PCT delegates its relevant functions to a joint committee or another PCT and that committee or PCT reaches a decision, the PCT will be bound by that decision.

1.4 ESTABLISHMENT AND DELEGATION

The Chief Executive of every Primary Care Trust is being asked to obtain approval of the Trust Board to the following decisions:

<u>Establishment of Joint Committees</u>

a) That **Southwark PCT** resolves to use its authority under the Regulations to share decision making powers in respect of the contracts referred to in Appendix A with every PCT in the Relevant SCG area.

b) That **Southwark PCT** appoint each Relevant Lead SCG referred to in Appendix A as a Joint Committee of the PCT. The Relevant Lead SCGs shall continue to carry out their current functions in respect of the contracts referred to in Appendix A, including (along with the Host PCT) commissioning functions, contracting, performance management, consultation under sections 242 and 244 NHS Act 2006, and all ancillary functions

c) That each Relevant Lead SCG shall comprise of its voting members and be governed by its existing Standing Orders.

Delegation

d) That **Southwark PCT** use its authority under the Regulations to delegate authority directly to the Host PCT and Relevant Lead SCGs to act and enter into the contracts noted in Appendix A;

e) This delegation shall, for the contracts and services noted in Appendix A, include the delegation of commissioning functions, contracting, performance management, consultation under sections 242 and 244 NHS Act 2006, and all ancillary functions;

f) That insofar as the PCT has the power to do so, the past or current contracts entered into by the Previous Lead SCG and Relevant Lead SCG shall be deemed to be valid.

1.5 PROCEDURE

Southwark PCT is also asked to agree that:

a) The PCT SCG shall, where acting in concert with other SCGs, do so through the Host PCT and Relevant Lead SCGs only under the delegated authority granted by **Southwark PCT** and other PCTs in the Relevant SCG area.

b) The Relevant Lead SCG and the Host PCT will act and enter into contracts on behalf of all the PCTs and their SCGs in the Relevant SCG area, in accordance with the delegated power granted by the relevant PCTs.

Recommendations

The PCT Board is asked to pass the following resolutions:

1. The Primary Care Trust resolves to use its authority under Regulation 10 of the NHS (Functions of SHAs and PCTs and Administration Arrangements) (England) Regulations 2002 to share decision making powers in respect of the contracts

referred to in Appendix A, with every PCT in the Relevant SCG area of the Relevant Lead SCG.

2. The Primary Care Trust is content with the establishment of the Relevant Lead SCGs referred to in Appendix A as joint committees, as set out in paragraphs 1.4 and 1.5 above.

3. The Primary Care Trust resolves to delegate authority directly to the Host PCT and the Relevant Lead SCG to enter into and act on its behalf in respect of all contracts listed in Appendix A, as set out in this paper and, in particular, in paragraphs 1.4 and 1.5 above.

4. To the extent it has the power to do so, the Primary Care Trust resolves that all contracts entered into by the Previous Lead SCG and Relevant Lead SCG shall be deemed valid as if they have been adopted or ratified by the Relevant Lead SCG or retrospectively entered into by the Relevant Lead SCG.

[i]

[i] Appendix 2 Compilation of Consortia gives a breakdown of PCTs by Provider

APPENDIX A

Contract	Host PCT	Relevant Lead SCG	Relevant SCGs
Barnet and Chase Farm Hospitals NHS Trust	NHS Croydon	London SCG	East of England SCG
Barts and The London NHS Trust	NHS Croydon	London SCG	South East Coast SCG East of England SCG
Barking, Havering and Redbridge Hospitals NHS Trust	NHS Croydon	London SCG	East of England SCG
Cambridge University Hospitals NHS Foundation Trust	NHS Croydon	London SCG	South East Coast SCG East of England SCG
Chelsea and Westminster Hospital NHS Foundation Trust	NHS Croydon	London SCG	East of England
East Kent Hospitals University NHS Foundation Trust	NHS Croydon	London SCG	South East Coast SCG East of England SCG
Epsom and St Helier University Hospitals NHS Trust	NHS Croydon	London SCG	East of England SCG
Great Ormond Street Hospital For Children NHS Trust	NHS Croydon	London SCG	South East Coast SCG East of England SCG
Guy's and St Thomas' Hospital NHS Foundation Trust	NHS Croydon	London SCG	South East Coast SCG East of England SCG
Hillingdon Hospital NHS Trust	NHS Croydon	London SCG	East of England SCG
Homerton University Hospital NHS Foundation Trust	NHS Croydon	London SCG	South East Coast SCG East of England SCG
Imperial College Healthcare NHS Trust	NHS Croydon	London SCG	South East Coast SCG East of England SCG
King’s College Hospital NHS Foundation Trust	NHS Croydon	London SCG	South East Coast SCG East of England SCG

Kingston Hospital NHS Trust	NHS Croydon	London SCG	East of England SCG
Lewisham Hospital NHS Trust	NHS Croydon	London SCG	East of England SCG
Croydon Health Services NHS Trust	NHS Croydon	London SCG	East of England SCG
Medway NHS Foundation Trust	NHS Croydon	London SCG	East of England SCG
Newham University Hospital NHS Trust	NHS Croydon	London SCG	East of England SCG
Basingstoke and North Hampshire NHS Foundation Trust	NHS Croydon	London SCG	East of England SCG
North Middlesex University Hospital NHS Trust	NHS Croydon	London SCG	East of England SCG
North West London Hospitals NHS Trust	NHS Croydon	London SCG	East of England SCG
Royal Brompton & Harefield Foundation NHS Trust	NHS Croydon	London SCG	South East Coast East of England SCG
Royal Free Hampstead NHS Trust	NHS Croydon	London SCG	South East Coast East of England SCG
The Royal Marsden NHS Foundation Trust	NHS Croydon	London SCG	South East Coast East of England SCG
St George's Healthcare NHS Trust	NHS Croydon	London SCG	South East Coast East of England SCG
South London Healthcare NHS Trust	NHS Croydon	London SCG	East of England SCG
The Whittington Hospital NHS Trust	NHS Croydon	London SCG	East of England SCG

University College London Hospital NHS Foundation Trust	NHS Croydon	London SCG	South East Coast East of England SCG
Whipps Cross University Hospital NHS Trust	NHS Croydon	London SCG	East of England SCG
Royal National Orthopaedic Hospital NHS Trust	NHS West Kent	South East Coast SCG	South East Coast SCG London SCG South Central SCG East of England SCG East Midlands SCG
Salisbury NHS Foundation Trust	NHS West Kent	South East Coast SCG	South East Coast SCG London SCG South Central SCG East of England SCG East Midlands SCG
Buckinghamshire Healthcare NHS Trust	NHS West Kent	South East Coast SCG	South East Coast SCG London SCG South Central SCG East of England SCG East Midlands SCG

Appendix B: Commissioning across SCG boundaries – Governance

Compilation of Consortia

Host SCG	Provider	Services commissioned	PCTs commissioned for (outside host SCG)
London	Guy's & St Thomas' NHS Foundation Trust	• Adult BMT • Cleft Lip & Palate • Genetics • Haemophilia • Newborn Screening • NICU • PICU	**East of England SCG** Bedfordshire East of England NIC Network Hertfordshire Luton Teaching Mid Essex North East Essex South East Essex South West Essex Teaching West Essex **South East Coast** Brighton and Hove City Teaching East Sussex Downs & Weald Eastern & Coastal Kent Teaching Hastings & Rother Medway Teaching Surrey West Kent West Sussex Teaching
	Barnet and Chase Farm Hospitals NHS Trust	• NICU	**East of England SCG** East of England NIC Network Hertfordshire Mid Essex

			North East Essex South East Essex South West Essex Teaching West Essex
	Barts and The London NHS Trust	• BMT Adult • Haemophilia • NICU • PICU	**East of England SCG** Bedfordshire East of England NIC Network Hertfordshire Luton Teaching Mid Essex North East Essex South East Essex South West Essex Teaching West Essex **South East Coast SCG** Brighton and Hove City Teaching East Sussex Downs & Weald Eastern & Coastal Kent Teaching Hastings & Rother Medway Teaching Surrey West Kent West Sussex Teaching
	Barking, Havering and Redbridge Hospitals NHS Trust	• NICU	**East of England SCG** East of England NIC Network Hertfordshire Mid Essex North East Essex South East Essex South West Essex Teaching West Essex

	Chelsea and Westminster Hospital NHS Foundation Trust	• NICU • Burns	**East of England SCG** Bedfordshire Cambridgeshire East of England NIC Network Great Yarmouth & Waveney Hertfordshire Luton Teaching Mid Essex Norfolk North East Essex Peterborough South East Essex South West Essex Teaching Suffolk West Essex **South East Coast SCG** Brighton and Hove City Teaching East Sussex Downs & Weald Eastern & Coastal Kent Teaching Hastings & Rother Medway Teaching Surrey West Kent West Sussex Teaching
	East Kent Hospitals University NHS Foundation Trust	• Haemophilia	**East of England SCG** Bedfordshire Hertfordshire Luton Teaching Mid Essex North East Essex South East Essex

			South West Essex Teaching West Essex **South East Coast SCG** Brighton and Hove City Teaching East Sussex Downs & Weald Eastern & Coastal Kent Teaching Hastings & Rother Medway Teaching Surrey West Kent West Sussex Teaching
	Epsom and St Helier University Hospitals NHS Trust	• NICU • Newborn Screening	**East of England SCG** East of England NIC Network Hertfordshire Mid Essex North East Essex South East Essex South West Essex Teaching West Essex
	Great Ormond Street Hospital For Children NHS Trust	• Children & Young People Oncology & BMT • Cleft Lip & Palate • Genetics • Haemophilia • Newborn Screening • PICU	**East of England SCG** Bedfordshire Hertfordshire Luton Teaching Mid Essex North East Essex South East Essex South West Essex Teaching West Essex **South East Coast SCG** Brighton and Hove City Teaching East Sussex Downs & Weald

			Eastern & Coastal Kent Teaching Hastings & Rother Medway Teaching Surrey West Kent West Sussex Teaching
	Hillingdon Hospital NHS Trust	• NICU	**East of England SCG** East of England NIC Network Hertfordshire Mid Essex North East Essex South East Essex South West Essex Teaching West Essex
	Homerton University Hospital NHS Foundation Trust	• NICU	**East of England SCG** East of England NIC Network Hertfordshire Mid Essex North East Essex South East Essex South West Essex Teaching West Essex
	Imperial College Healthcare NHS Trust	• BMT Adult • Children & Young People Oncology & BMT • Haemophilia • NICU • PICU	**East of England SCG** Bedfordshire East of England NIC Network Hertfordshire Luton Teaching Mid Essex North East Essex South East Essex South West Essex Teaching

			West Essex **South East Coast SCG** Brighton and Hove City Teaching East Sussex Downs & Weald Eastern & Coastal Kent Teaching Hastings & Rother Medway Teaching Surrey West Kent West Sussex Teaching
	King's College Hospital NHS Foundation Trust	• BMT Adult • Newborn Screening • NICU • PICU	**East of England SCG** Bedfordshire East of England NIC Network Hertfordshire Luton Teaching Mid Essex North East Essex South East Essex South West Essex Teaching West Essex **South East Coast SCG** Brighton and Hove City Teaching East Sussex Downs & Weald Eastern & Coastal Kent Teaching Hastings & Rother Medway Teaching Surrey West Kent West Sussex Teaching
	Kingston Hospital NHS Trust	• NICU	**East of England SCG** East of England NIC Network

			Hertfordshire Mid Essex North East Essex South East Essex South West Essex Teaching West Essex
	Lewisham Hospital NHS Trust	• NICU • Haemophilia • PICU	**East of England SCG** Bedfordshire East of England NIC Network Hertfordshire Luton Teaching Mid Essex North East Essex South East Essex South West Essex Teaching West Essex **South East Coast SCG** Brighton and Hove City Teaching East Sussex Downs & Weald Eastern & Coastal Kent Teaching Hastings & Rother Medway Teaching Surrey West Kent West Sussex Teaching
	Croydon Health Services NHS Trust	• NICU	**East of England SCG** East of England NIC Network Hertfordshire Mid Essex North East Essex South East Essex

			South West Essex Teaching West Essex
	Medway NHS Foundation Trust	• NICU	**East of England SCG** East of England NIC Network Hertfordshire Mid Essex North East Essex South East Essex South West Essex Teaching West Essex
	Newham University Hospital NHS Trust	• NICU	**East of England SCG** East of England NIC Network Hertfordshire Mid Essex North East Essex South East Essex South West Essex Teaching West Essex
	Basingstoke and North Hampshire NHS Foundation Trust	• Haemophilia	**East of England SCG** Bedfordshire Hertfordshire Luton Teaching Mid Essex North East Essex South East Essex South West Essex Teaching West Essex **South East Coast SCG** Brighton and Hove City Teaching East Sussex Downs & Weald Eastern & Coastal Kent Teaching

			Hastings & Rother Medway Teaching Surrey West Kent West Sussex Teaching
	North Middlesex University Hospital NHS Trust	• NICU	**East of England SCG** East of England NIC Network Hertfordshire Mid Essex North East Essex South East Essex South West Essex Teaching West Essex
	Royal Brompton & Harefield Foundation NHS Trust	• PICU	**East of England SCG** Bedfordshire Hertfordshire Luton Teaching Mid Essex North East Essex South East Essex South West Essex Teaching West Essex **South East Coast SCG** Brighton and Hove City Teaching East Sussex Downs & Weald Eastern & Coastal Kent Teaching Hastings & Rother Medway Teaching Surrey West Kent West Sussex Teaching

	Royal Free Hampstead NHS Trust	• BMT Adult • Haemophilia • NICU	**East of England SCG** Bedfordshire East of England NIC Network Hertfordshire Luton Teaching Mid Essex North East Essex South East Essex South West Essex Teaching West Essex **South East Coast SCG** Brighton and Hove City Teaching East Sussex Downs & Weald Eastern & Coastal Kent Teaching Hastings & Rother Medway Teaching Surrey West Kent West Sussex Teaching
	The Royal Marsden NHS Foundation Trust	• BMT Adult • Children & Young People Oncology & BMT	**East of England SCG** Hertfordshire Mid Essex North East Essex South East Essex South West Essex Teaching West Essex **South East Coast** Brighton and Hove City Teaching East Sussex Downs & Weald Eastern & Coastal Kent Teaching Hastings & Rother

			Medway Teaching Surrey West Kent West Sussex Teaching
	Southampton University Hospitals NHS Trust	• BMT Adult	**East of England SCG** Hertfordshire Mid Essex North East Essex South East Essex South West Essex Teaching West Essex **South East Coast** Brighton and Hove City Teaching East Sussex Downs & Weald Eastern & Coastal Kent Teaching Hastings & Rother Medway Teaching Surrey West Kent West Sussex Teaching
	St George's Healthcare NHS Trust	• Haemophilia • BMT Adult • BMT Paediatric • Children & Young People Oncology & BMT • PICU • NICU • Genetics	**East of England SCG** Bedfordshire East of England NIC Network Hertfordshire Luton Teaching Mid Essex North East Essex South East Essex South West Essex Teaching West Essex **South East Coast SCG**

			Brighton and Hove City Teaching East Sussex Downs & Weald Eastern & Coastal Kent Teaching Hastings & Rother Medway Teaching Surrey West Kent West Sussex Teaching
South East Coast	Royal National Orthopaedic Hospital NHS Trust	• Spinal Cord Injury Services	**London SCG** Bexley Bromley Greenwich Lambeth Lewisham Southwark Croydon Kingston Richmond & Twickenham Sutton & Merton Wandsworth Brent Ealing Hammersmith & Fulham Harrow Hillingdon Hounslow Kensington & Chelsea Westminster

			Barnet Camden Enfield Haringey Islington Barking & Dagenham City & Hackney Havering Newham Redbridge Tower Hamlets Waltham Forest **East of England SCG** NHS Hertfordshire Mid Essex West Essex North East Essex South East Essex South West Essex Norfolk Great Yarmouth & Waveney Cambridgeshire Peterborough Suffolk Bedfordshire Luton **South Central SCG** Buckinghamshire Milton Keynes

			Oxfordshire Berkshire West Berkshire East Hampshire Isle of Wight Portsmouth City Teaching Southampton City **East Midlands SCG** Leicestershire County and Rutland Leicester City Northamptonshire
	Salisbury NHS Foundation Trust	• Spinal Cord Injury Services	**London SCG** Bexley Bromley Greenwich Lambeth Lewisham Southwark Croydon Kingston Richmond & Twickenham Sutton & Merton Wandsworth Brent Ealing Hammersmith & Fulham Harrow

			Hillingdon Hounslow Kensington & Chelsea Westminster Barnet Camden Enfield Haringey Islington Barking & Dagenham City & Hackney Havering Newham Redbridge Tower Hamlets Waltham Forest **East of England SCG** NHS Hertfordshire Mid Essex West Essex North East Essex South East Essex South West Essex Norfolk Great Yarmouth & Waveney Cambridgeshire Peterborough Suffolk Bedfordshire

			Luton **South Central SCG** Buckinghamshire Milton Keynes Oxfordshire Berkshire West Berkshire East Hampshire Isle of Wight Portsmouth City Teaching Southampton City **East Midlands SCG** Leicestershire County and Rutland Leicester City Northamptonshire
	Buckinghamshire Healthcare NHS Trust	• Spinal Cord Injury Services	**London SCG** Bexley Bromley Greenwich Lambeth Lewisham Southwark Croydon Kingston Richmond & Twickenham Sutton & Merton Wandsworth Brent Ealing

			Hammersmith & Fulham Harrow Hillingdon Hounslow Kensington & Chelsea Westminster Barnet Camden Enfield Haringey Islington Barking & Dagenham City & Hackney Havering Newham Redbridge Tower Hamlets Waltham Forest **East of England SCG** NHS Hertfordshire Mid Essex West Essex North East Essex South East Essex South West Essex Norfolk Great Yarmouth & Waveney Cambridgeshire

			Peterborough Suffolk Bedfordshire Luton **South Central SCG** Buckinghamshire Milton Keynes Oxfordshire Berkshire West Berkshire East Hampshire Isle of Wight Portsmouth City Teaching Southampton City **East Midlands SCG** Leicestershire County and Rutland Leicester City Northamptonshire

South East London

A meeting of the SEL PCT Boards* and Bexley Care Trust
22 September 2011

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CHAIR'S REPORT

Interim Chief Executive Arrangements

Between 1st September 2011 and 30th September 2011, Gill Galliano, Executive Director of Development and Jane Schofield, Executive Director of Operations, will be the joint interim Chief Executive. Jane Schofield will be the Accountable Officer.

Andrew Kenworthy, our new Chief Executive will be taking up his position on 1 October 2011

Information for management and assurance purposes

I have asked executive colleagues to set out for NEDs the sources of information that they use to review finance, performance and quality and demonstrate how this information is collated and interpreted and used to report to board committees (including the Local Clinical Commissioning Committees, Board committees and Joint Boards). I have also requested executive colleagues for a map of commissioned services to give an overview of where responsibility sits for commissioning services and when LCCC chairs assume responsibility for different portfolios of these services.

Implementation of Borough Days

In the first few months of the new cluster much of my time was focused on embedding the new governance structure and recruitment of our Chief Executive.

Since July I have begun to spend more time out in the boroughs. This has been an opportunity to meet key partners in each borough and gain further understanding on successes and key issues. It has also enabled me to identify common themes and opportunities for cross learning. Thank you in particular to the support staff on the

Business Support Units for sorting out the arrangements and looking after me from October. I will also be reintroducing visits to provider services in my calendar.

AGMs

This month I am attending the Annual General Meetings in each PCT/Care Trust. We have had two excellent events to date, with the remaining four in the last week of September.

The Southwark AGM was more of a traditional event which also launched the Annual Public Health Report for 2011. The gauntlet thrown down by a local MP to make it attractive to local people was certainly picked up at the Lambeth AGM which highlighted the Living Well Collaborative and the changes to Mental Health services being brought about by a co-production approach to commissioning. The room was packed out with many local residents in attendance.

Board meeting and Committee Dates until April 2013

Dates for Joint Boards and Joint committees meetings have been set until April 2013 and are available on the website.

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South East London

A meeting of the SEL PCT Boards* and Bexley Care Trust
22 September 2011

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CHIEF EXECUTIVE'S REPORT

2011/12 Planning
In a letter to the Chief Executive dated 22 August 2011, NHS London confirmed that no further reiteration of the cluster's 2011/12 to 2014/15 QIPP plan is required and that delivery will continue to be monitored through the NHS London performance regime.

2012/13 Planning
NHS London's planning principles for 2012/13 onwards were agreed at the Strategy and Innovation PLG on 2 September 2011. A refresh of current 4 year plans will form the basis of new 3 year plans, to coincide with the 3 year planning cycle of the new NHS Commissioning Board. There will be significant emphasis on cluster recurring financial balance, improved clarity on transformational change including activity and demand controls and associated impacts on providers, energising providers to work collaboratively and increased activity analysis to demonstrate the impact of current and future plans. It is anticipated that CCG level plans will form part of the CCG authorisation process in 2012 and consequently plans will need to demonstrate a coherent cluster wide approach that addresses local borough level priorities. Local south east London planning guidelines are in place and have been shared with the Performance, Finance and QIPP committee. The Board/s will be kept informed of progress ahead of finalisation in December.

Development of an estates strategy
Estates developments, such as new LIFT schemes or disposal of unneeded sites, needs to fit within a wider Estates Strategic Plan. This is to ensure organisational goals are achieved, including QIPP savings. The Estates Strategic Plan will need to take into account the August 2011 Department of Health guidance on the future of the PCT estate which directs PCTs to offer much of its estate to community service providers where they are NHS Trusts or Foundation NHS Trusts. One of the issues for development in the Estates Strategic Plan is the future office requirements for cluster and Business Support Unit commissioning functions. External support is being

procured to develop the Estates Strategic Plan and an appointment is anticipated in the near future.

Memorandums of Understanding
The purpose of the Memorandums of Understanding (MoU) is to bring together Local Authorities and Clusters to discuss and agree how joint working arrangements can be strengthened locally.

The Memorandum of Understanding sets out:

- A commitment by all organisations to working together
- The areas in which joint working arrangements exist and where they could be put in place
- The role of each organisation participating in the MOU

The MoU should address and build on the areas for collaborative working identified in the 2011/12 NHS Operating Framework, including themes of:

- Strategy and planning
- Organisational structures
- Shared resources
- Information management
- Safeguarding
- Public health and health improvement

The Business Support Units (BSUs) on behalf of NHS South East London Cluster are making good progress on negotiating and agreeing these MoUs with their respective Local Authorities, with Southwark and Lewisham BSUs having agreed and signed their MoU.

London Cardiovascular Project
The cardiovascular review carried out by Commissioning Support for London looked at how to improve outcomes for patients undergoing interventional procedures for acute, complex and emergency aspects of care in three areas: vascular surgery, cardiac surgery and cardiology.

The recommendations in the model of care will improve patient outcomes and the patient experience and will save thousands of bed days across the capital. The London Cardiac Networks were directed by NHS London to support local implementation of the London Cardiovascular Project across the capital, which has begun this year with full implementation planned for March 2012.

A report providing a stocktake on progress for implementation of the project to date as well as highlighting future milestones, governance arrangements and key risks has been circulated to board members for information.

Civil Disorder

Between the 6th and 12th of August London experienced civil unrest and riots on a number of evenings that were disturbing and damaging to local areas. A number of areas in South East London were affected e.g. Peckham, Brixton, Bromley. The main impact related to damage to business premises and looting of property. There was however some impact on the health services, mainly because of the need to close primary care premises as there was a threat or a perceived threat to primary care premises such as GP surgeries or high street pharmacies. SEL NHS Cluster on–call responded through a series of daily teleconference calls across the cluster with MDs of BSUs to assess the situation and identify if further action was required. The Director on-call also liaised with NHS London for a daily call about issues. A major incident was not called for health services as the impact on health and health services did not seem to warrant it.

In follow up of the riots there was a debrief conducted of the lessons learned from the events. This identified what went well, such as the on-call response, daily meeting/teleconference about issues, good communications between BSUs and cluster and between BSUs and providers. There was a good responsiveness from services. The incidents provided an opportunity to test the on-call systems, Major Incident Plan and also the use of the Emergency Control Rooms. Where there were lessons about what could be done better these are being fed back through the Emergency Planning and Resilience Steering Group for further review e.g some technical issues about the ECR(s), some further communication issues, lessons about buildings from which a number of services work, and ensuring that there is a single point of contact and decision making in relation to the closure of primary care premises.

111

The National 111 programme is a joint NHS and DH initiative to deliver a better integrated 24/7 emergency and urgent care system and is a key element of the QIPP for Urgent and Emergency Care work stream. The Department of Health has set a target of universal coverage by the NHS 111 number for unscheduled care by April 2013 and extended an invitation for further NHS 111 service pilots. NHS London responded by expressing an interest in developing a pan-London 111 pilot with a staged implementation approach through: i) developing a pan-London (CMS) Directory of Services (DoS) and ii) supporting London 111 pilots. A London Improving Unscheduled Care Programme Board has been established, chaired by Dr Tom Coffey, as Medical Director, and has overseen the development of the London wide '111' business case.

The 111 service will provide consistent clinical assessment at the first point of contact and direct people to the right NHS service, first time, including an emergency 999 disposition if required, without the need for the caller to repeat information. The principle of the 111 operating model is that it will support the objectives of better access, simplified systems and more appropriate treatment for patients through a single point of access for both patients and care professionals for unscheduled care and will be staffed with suitably trained and experienced call handling staff and nurse advisors operating NHS Pathways. It is underpinned by a Directory of Services (DoS) on the Adastra

system that lists primary care, dentistry, optometry, walk in centres, urgent care centres, mental health crisis services, community health services and emergency departments that the call handlers can sign post the caller to, or where agreed, make appointments.

London is a pilot for implementing 111 and each cluster is required to submit a plan that sets out how it will be implementing 111. The Clinical Strategy Group and Southwark Clinical Cabinet have considered the south east London approach to the implementation of the 111 service. The approach being suggested is a dual approach encompassing working concurrently with the current GP out-of-hours providers to form a consortium to pilot the implementation of 111 across SEL and a limited procurement process with a start date of November 2011. Engagement with CCG's continues until the end of October. Clinical commissioners have agreed to identify a cluster 111 clinical champion. The project will be supported by the cluster Darzi Fellow.

There are a separate series of events called 'Break the System' which allow participants to view the directory and play with the decision making software (NHS Pathways).

A cluster-wide business case will be developed and submitted for November.

Primary Care Strategy Update
Following the presentation of the Primary Care Improvement Plan to the July Board, discussions have commenced with local clinical commissioning groups and the LMC. Formal engagement is planned for September and October. Presentations to other professional groups and LiNKS will take place during this period. A prioritised plan with associated financial costs will be presented to the November board.

EDS national launch
Following the approval by the Cluster Joint Boards to adopt the Equality Delivery System (EDS) on 21 July, EDS guidance documents were published on 29 July 2011. The guidance documents can be viewed at http://www.eastmidlands.nhs.uk/about-us/inclusion/eds/.

The EDS Programme Office has requested all London Clusters to hold an EDS Launch event and the SEL event will take place on Monday, 14 November 2011. The event will be an opportunity for us to have a conversation with local interests about the new EDS assessment tool and how they can help us to assess our equality performance and set equality objectives for the next four years.

Pathfinder development support
The six Pathfinders in South East London have been involved in a mini tender process to appoint one of the following Providers on a framework to support their leaning and development towards delegation and authorisation.

- The RCGP Centre for Commissioning, McKinsey and Ashridge Alliance for Clinical Commissioning (McKinsey)

- KPMG Partnership for commissioning
- PriceWaterhouseCoopers LLP
- Entrusted Health Partnership (ANODOS I.S. Strategy Ltd)
- BDO LLP
- Capsticks Solicitors LLP
- Capita Business Services
- Ernest & Young LLP

Providers on the framework were appointed by NHSL and hold the overall contract but each Pathfinder was able to produce a Statement of Works outlining their specific learning and development requirements and select a provider to work with from the framework. A full list of which Provider is working with individual Pathfinders will be available by the end of September.

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South East London

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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 issues during the second quarter of 2011.

KEY ISSUES:

1. **Staff Survey 2010/2011**
   We are currently establishing arrangements to carry out the annual staff survey for 2011, a requirement for all NHS organisations. Staff across the Cluster will receive a copy of the survey for completion in October. This information provides us with important information on our employees' perspective of working in NHS South East London. Details of the results of the surveys will be presented to a group of Board members and staff in early 2012.

2. **Organisational Change Policy.** We currently have six separate organisational change policies in operation within the PCTs in SEL Cluster. We are currently developing a single Organisational Change policy for SEL, incorporating key elements of these policies and recent guidance from the Department of Health and NHS London on how further change will be managed during the transition period. We will also incorporate comments received from staff on the review of the management cost savings change process earlier this year. The new policy will be discussed with staff side colleagues in early October and will be presented to the Board for approval as soon as possible.

3. **Vacancies in the current structure.** The Cluster vacancy panel continues to review all requests to fill vacant posts or to make any change to the payroll (changes to grades). This panel meets on a fortnightly basis and includes the

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following membership:

a. Gill Galliano, Director of Development (Chair)
b. Andrew Eyres, Managing Director, Lambeth
c. Marie Farrell, Director of Finance, IT and Estates
d. Una Dalton, Director of Human Resources

The Management Team have agreed revised criteria for the panel to use when deciding to fill posts and we are maximising the use of interim and agency workers where possible.

4. Staff absence

We will present an update on staff absence rates and turnover figures to the meeting of the Employment and Remuneration Committee to be held on 26th September. If Board members would like to receive any other regular workforce information in public please email Una Dalton at una.dalton@lambethpct.nhs.uk

5. Staff Engagement

We held our first Cluster wide Staff Partnership Forum meeting on 2nd August 2011 to take forward our ongoing discussions with staff and their trade unions. The forum will report into the Cluster Employment and Remuneration Committee and will be fundamental to our discussions with staff side regarding organisational change during this transition period.

6. 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 95% of staff have completed and submitted a copy of their agreed personal development plan following the annual appraisal meeting. The Human Resources team are using 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 due to be launched by end September 2011.

7. Employment and Remuneration Committee

The Cluster Employment and Remuneration Committee will meet on 26th September and will focus on the following items for consideration:

a. Remuneration for Clinical engagement across the Cluster
b. Staffing structure costings
c. Staff absence

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

8. Flu Vaccination (Staff).

Over the next few weeks we will work with Occupational health to get our annual staff flu campaign underway. Following a discussion with Public Health we propose to target the following staff groups:

- any front line staff
- pregnant workers
- staff participating on on-call rotas

We will encourage all other staff to go to their GP for jabs.

COMMITTEE INVOLVEMENT: Employment and Remuneration Committee – July 2010.

PUBLIC AND USER INVOLVEMENT: Not applicable.

IMPACT ASSEESMENT: A review of the overall impact of organisation change on staffing structures is planned.

RECOMMENDATIONS:
The board (s) is asked to:-

- Note the report

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*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.

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22 September 2011

ENCLOSURE 20

PERFORMANCE, FINANCE & QIPP COMMITTEE - SUMMARY

NAME OF COMMITTEE: Performance, Finance and QIPP

DATE OF COMMITTEE: 8 September 2011

PRINCIPLE FOCUS:

1. To consider the outcome of the first quarter executive stocktake meetings assessing delivery against plan in each of the 6 boroughs.
2. Review of month four performance and month three finance data and identification of initial areas of concern.
3. To consider a business case for the migration to one common ledger system.

ISSUES ARISING:

1. The committee received assurance following the series of Q1 stocktake meetings with each of the 6 boroughs and noted the actions agreed to further analyse the issues and mitigate the risks.
2. The committee noted that the main financial risks identified related to acute contract over performance which in many cases arise in areas not subject to QIPP initiatives. This would be reviewed at the next meeting.
3. The committee agreed to the implementation of a standardised ledger and reporting system, NHS SBS, across the cluster.

RECOMMENDATIONS MADE:
No specific recommendations for the Board were made.

COMMITTEE CHAIR:
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LEAD DIRECTOR:
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*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.

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A meeting of the SEL PCT Boards* and Bexley Care Trust 22nd September 2011

ENCLOSURE 21 **USE OF NHS SEL PCT / CARE TRUST SEALS**
DIRECTOR RESPONSIBLE: Jane Schofield, Director of Operations
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.
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.

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*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.

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REGISTER OF SEALED DOCUMENTS

Reported since last meeting of the Joint Boards on 21th July 2011

DATE	DOCUMENT	SIGNATORIES	PCT / Care Trust
No Use of seal			Bexley
28/7/11	TR1 for Angus House From Bromley PCT to Robert Porritt	Simon Robbins Marie Farrell	Bromley
28/7/11	Overidge Agreement for Angus House between Bromley PCT and Robert Porritt	Simon Robbins Marie Farrell	Bromley
10/8/11	Agreement of sale and transfer document for 103 Bourne Way	Simon Robbins Marie Farrell	Bromley
No Use of seal			Greenwich
7/9/11	Consent for alterations to 1 Lower Marsh	Marie Farrell Jane Schofield	Lambeth
No Use of seal			Lewisham
			Southwark

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PAEDIATRIC CONGENITAL CARDIAC SURGERY: UPDATE ON PROGRESS AND JUDICIAL REVIEW

DIRECTOR RESPONSIBLE: Gill Galliano, Director of Development

AUTHOR: Simon Williams, Divisional Director NWL, London SCG

TO BE CONSIDERED BY: All

SUMMARY:
This paper seeks to update Members on progress with the Paediatric Congenital Cardiac Surgery (PCCS) review.

Although the public consultation closed on 1st July 2011 a number of supporting work streams have been under way and a few have already issued interim reports. These include:

- Data validation – reporting on 2010/11 activity.
- Health Impact Assessment
- Public consultation findings
- Capacity review
- Patient flows
- Independent Review of paediatric respiratory services at Royal Brompton (RBH)

The report covers the latest position on these work streams and any preliminary findings.

On 15th July RBH was granted a judicial review of the consultation process. This will be heard the week of the 26th September.

KEY ISSUES: As above.
INVOLVEMENT: Not Applicable.
RECOMMENDATIONS: The Boards are asked to:- 1. NOTE the content of the report.
DIRECTORS CONTACT: Name: Gill Galliano E-Mail: g.galliano@nhs.net Telephone: 020 7206 3332

Paediatric Congenital Cardiac Surgery: Update on progress and Judicial Review

1. Introduction

The April report on PCCS to PCTs in London gave a background to the origins and process of the current PCCS review. It is the intention of this report to give an update on the work since the last report.

The public consultation was from the 1st March 2011 to 1st July 2011. Overview and Scrutiny Committees have a longer consultation period which will last until 5th October in order that they can consider interim reports on the public consultation and Health Impact Assessment.

The consultation document set out four preferred options. Each of the preferred options assumed that two of the present three PCCS units in London would continue to provide a service. The options further suggested that the two units should be Great Ormond Street Hospital (GOSH) and Evelina Children's Hospital (ECH – part of Guy's and St Thomas').

A number of processes are underway related to the review. While some of these work streams were built into the original plan a number of other work streams have been initiated in order to address important concerns raised during the consultation process. This report will outline these processes.

The Royal Brompton and Harefield FT (RBH) has engaged in a legal challenge to the process that names the JCPCT and Croydon PCT (on its own behalf and as a representative of all PCTs in England) as defendants in their challenge. This report will update members of the parties' outline cases, the current position and with the legal challenge.

2. PCCS work progress

A number of work streams are under way to ensure that when the JCPCT meets in November to consider final recommendations to Ministers all possible factors and issues are taken into account. There are six work streams, four of which were on the original schedule and two that have been added following issues raised during the consultation period.

The planned work streams are as follows with their reporting dates (all reports will be released into the public domain):

- Data validation – this work related to the PCCS activity in the current providers during the financial year 2010/11 in order to test planning assumptions made on previous years' data on activity. This reported on 5th August 2011. Nationally there were 143 additional cases with 96 of those in London. All three London providers saw an increase in their activity (GOSH – 25, RBH – 36, ECH – 35).
- Health Impact Assessment – this work was carried out independently by Mott MacDonald to assess the impact on other services and hard to reach

patient groups. The interim report was released in the first week of August with the final report due towards the end of October 2011.

- Public consultation report – this reports the findings from the public consultation carried out by Ipsos MORI. An interim report is expected around the 23rd August 2011 with a final report available towards the end of October.
- Capacity review – this is a piece of work being carried out by the Safe & Sustainable Team to assess the capacity of Trusts to deliver the potential workloads identified for those organisations within the consultation options. This is expected to be completed by the beginning of October.

The two additional work streams are as follows:

- Patient flows – An independent review of patient flow assumptions built into the consultation options. This work arose as a result of a number of concerns that the planning assumptions did not take account of local issues that might result in patient flows contrary to those assumed. This is due to report in the middle of October.
- Paediatric services at RBH – RBH raised concerns about the potential effect on diagnostic bronchoscopy and children's respiratory services. If they were to cease to be a provider of PCCS services and could then no longer support a PICU. An Independent Review Panel chaired by Adrian Pollitt with professional experts from across the UK and Toronto (independent of PCCS) will assess the position through the week of 5th September 2011 and possibly report by the end of the month.

3. The legal challenge

Whilst the work continues to ensure the JCPCT can make a fully considered decision on the future configuration of PCCS throughout England the legal case brought by RBH continues to run in parallel.

The RBH case is outlined below:

- The consultation document gives two London centres as a preferred option, with GOSH and ECH as the preferred two. RBH say there was no meaningful opportunity in the consultation to put forward three London centres.
- RBH allege that the decision that RBH would be the loser if only two centres were chosen was made months before the consultation started.

RBH put their arguments about unlawfulness into five strands.

- There was a failure to consult on all viable options.
- The consultation was not taking place whilst the proposals were at a formative stage.
- To exclude RBH from any other recommended options was irrational.
- The process leading up to the choice of preferred options was biased and pre-determined.

- The breach of legitimate expectation/abuse of power.

The defendants do not accept the allegations stating that the law on bias on which the Claimant relies only relates to the decision making body and there is no suggestion that any JCPCT members were biased. There is no legal authority to support the claim that this legal test should be applied to the Steering Group. The Steering Group was simply an advisory body comprised of professionals selected by their professional associations, not as representatives of their employing Trust. RBH was not the only Trust that did not have an employee on the group. Whilst the Steering Group did, at the request of the JCPCT, express a clinical view about whether two or three centres was better for London, it did not consider the issue of which sites were preferable.

On the 14th and 15th July 2011 the application for a judicial review was heard by a judge. The judge concluded that there was an arguable case "with some hesitation". The threshold for this is very low requiring the defendants to have demolished each of the claimant's arguments. In allowing a judicial review the judge:

- Did not support the RBH request to halt the consultation process.
- Ruled that it was important that the JCPCT continue its work.
- Recognised the importance and urgency of the case.

The judicial review will be heard in the week commencing 26th September 2011 which will allow the JCPCT to conclude its work within the existing timescale. The 17th November 2011 is the timetabled JCPCT meeting for reaching a decision on the outcome of consultation.

4. Recommendation

Members are asked to note the report.