NHS
Lewisham
Clinical Commissioning Group

Annual Report & Accounts 2013/14

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Member Practices Introduction

Reflections on the year 2013-14

Our Annual Report and Accounts provides us with the opportunity to look back at the year that has passed and to consider how well we have progressed in delivering our strategic aims, as set out in the CCG's constitution, and to address the key challenges facing the CCG. In this first Annual Report and Accounts, I would like to reflect on some of the key themes of our first year, assess the impact we have had and draw some conclusions for the year ahead.

The first year of any new organisation is a relatively challenging period and for the CCG this has involved establishing new structures and systems and managing resources, in a period of unprecedented change for the NHS as a whole, as well as ensuring continued commissioning support for our membership practices.

Our first priority was to ensure that NHS Lewisham CCG was able to operate effectively following its launch as a legal entity in April 2013. We ensured that the CCG had:

- strong governance arrangements so that the Governing Body's decisions, informed by members' views – and the process by which it makes those decisions – are clear to the wider membership and the public
- internal controls to manage the CCG's resources and risks efficiently
- met its legal and statutory duties
- robust contracting arrangements, including with the new provider, Lewisham and Greenwich NHS Trust, supported by the South London Commissioning Unit, to ensure best value in the way resources were spent
- open and accessible engagement with stakeholders, especially with the public, patients and carers
- strong collaborative relationships with our commissioning partners in the new health and care landscape, particularly with the London Borough of Lewisham and the Health and Wellbeing Board, NHS England, and our neighbouring CCGs across South East London.

Members were able to confirm the strength and sustainability of these new systems through the Governing Body self- assessment, which took place in April 2014 and allowed the Governing Body to review their collective and individual contributions as leaders of the organisation in strategy, accountability, shaping the CCG's culture and identifying those areas which required improvement to be included within our revised Organisational Development Plan for 2014/15.

Our second priority was to ensure clarity about the new CCG's purpose, especially about the specific priorities needed to improve the health of people in Lewisham. Like many organisations in the NHS, the CCG faces many challenges with finite resources, so it was essential that we were clear about where we needed to focus our collective efforts in order to achieve the best for people in Lewisham.

The organisation has a clear vision – to deliver better health, best care and best value for everybody in Lewisham – and has developed three strategic themes:

- Healthy living for all – we will help people to live healthy lifestyles, have healthy families and make healthy choices, while at the same time tackling health inequalities in the borough.

- Frail and vulnerable people – ensuring that they are supported and cared for at all times with dignity, compassion and respect.

- People with long-term conditions, such as diabetes or heart disease – empowering them to have greater control over managing their condition.

Commissioning Intentions have been agreed to deliver this vision for the next two years, and work is under way with the other south east London CCGs to develop a five-year plan for the whole of south east London, to benefit from the advantages of scale and make the best use of opportunities where a wider approach can add value.

In every case, our five year strategic plan, our two year commissioning intentions and our Operating Plan have been developed through dialogue and active engagement with the public, to ensure that the CCG's priorities are aligned with the needs of local people. Members have been well-placed to add value here, as our grouping into four neighbourhoods ensures that we can feed a local perspective and local expertise into Governing Body decisions.

The impact of our commissioning
With our structures in place, and our priorities agreed, we can point to some significant achievements in each of the three areas of our vision for better health, best care and best value. However there remain significant commissioning challenges and risks for Lewisham CCG to address in the forthcoming year. There will be greater demand for health and care services, and we need to find ways of achieving more, with the same or diminishing resources by working differently in partnership with Lewisham people and collaboratively with local providers. This is our key strategic challenge.

Best care
NHS Lewisham CCG recognises the need to respond creatively to the significant risks facing the NHS and to do things differently, so allowing us to improve the quality of care. As a clinician-led organisation, the CCG is well placed to promote innovation in health care and use the opportunities available as part of the new NHS and social care arrangements to respond to these challenges.

Through our public and members engagement during 2013/14, we have heard many concerns about the quality of local service, most recently at the Members Event (March 2014) and the Quality Summit (March 2014). Particular concerns voiced included:

- The experience of users of district nursing services and inpatient hospital care;
- The continued high numbers of pressure ulcers
- The wide variation in the quality of services delivered by different providers, for example primary care and access to primary care;
- The poor communication across health and social care professionals, for example communications to co-ordinate the discharge and follow up care of patients.

In response to this the CCG has been piloting and evaluating a number of new approaches - to improve the quality of care, which are described in greater detail in the report. They include:

- the team around the mother, focusing on the mother's experience, wishes and outcomes from maternity services
- improving access to primary care, where the GP practice proactively contacts a patient to support them to manage their own care better.

- work across south east London to improve the management of patients to prevent pressure ulcers forming and to improve the skills and knowledge of healthcare professionals in all care settings so that they are able to provide more effective care to patients that have acquired pressure ulcers, not all of which are preventable.
- additional support to all care homes, to improve and reduce variation in the quality of care, such as the scheme to prevent falls, which can have such a catastrophic impact on the health and independence of frail elderly people;
- ways to deliver better care and self-management, and fewer emergency admissions for people with long-term conditions, such as the risk profiling project for GPs and collaborative care planning, where the GP and the wider health and social care team work in partnership with the patient and carers on what best meets their individual needs.
- an active review, currently underway, of the district nursing service.

These approaches are evidence-based; pilot schemes are monitored so that what works best for the people of Lewisham can be rolled out across healthcare in the Borough, and as many people as possible can benefit from the new ways of working.

Some examples of how pilot projects have already been mainstreamed across Lewisham include:

- The diabetes champions, who take the message of the benefits of health care and self-management into communities to improve access to services and early diagnosis.
- The 'Three Rs' approach to diabetes, whereby GP practices actively pursue an approach of 'register, recall and review' to improve early diagnosis and therefore better treatment for people with diabetes.
- A complete redesign of services for people with dementia, following consultation with patients, carers and other key stakeholders and then re-commissioning the service;
- A named key worker in every GP practice to promote early diagnosis and self-management for people with COPD.
- Discussions are underway between member practices about the benefits of working together in order to offer alternative ways of working.

We believe that this new clinician-led approach to commissioning is improving the quality and safety of health care in Lewisham. Underpinning everything we do is the drive for quality, so we have implemented a more systematic approach to monitoring and escalating concerns as they arise. We believe we are seeing some improvements already in the three key areas that define quality for patients:

- Safety – we have improved our infection control and child and adult safeguarding arrangements;
- Patient experience – we have improved the experience for patients with long-term conditions and in primary care;
- Effectiveness – our work is based on evidence and, where new or different approaches are taken, on robust evaluation to learn the lessons of what works.

However we know that there is more work to do on improving patient experience particularly in our nursing workforce, maternity and inpatient care – especially around discharge of patients from hospital – and variation in quality and access to primary care services.

Better health

Lewisham faces significant health challenges, as set out in this report. Our population is overall increasing, with high levels of deprivation and significant health inequalities. Overall the trend in life expectancy is improving, however for people living in Lewisham it is shorter than for the London and England. There are higher than average rates of mental health problems in Lewisham. There are increasing numbers of people with long term conditions, in common with other CCGs. Together, these factors will inevitably mean a greater demand for health and care services.

After just one year in operation, it is difficult to assess the impact of the different ways we have commissioned services, especially on the long term health outcomes of Lewisham people. However Lewisham CCG is committed to supporting health promotion interventions which should have a significant impact on improving the long term health of Lewisham people. Also the CCG is committed to working with the Health and Wellbeing Board and public health colleagues to address the wider issues that have an impact on health, such as housing, lack of education and finding ways to promote good health and reduce or prevent ill health in both primary and community care. Examples of where this approach is already having an effect, include:

- improving mumps, measles and rubella immunisation at year 2. This was an early clinical priority identified with members. With huge effort we improved vaccination rates by 10% in a 12 month period, making us one of the most improved CCGs in London on this measure. We are looking to sustain and improve other vaccination levels.
- developing a network of clinical commissioning facilitators who link up with particular practices, to share good practice and to promote health checks, immunisations and to stop smoking;
- encouraging the uptake of vitamin D, by bringing together various parts of the health economy, including the CCG, public health and pharmacies, to launch a campaign to improve access to vitamin D for young children.
- promoting flu vaccinations – working to support GP practices to improve uptake for the over 65s.

Best value

The CCG was able to start 2013/14 by setting a balanced budget, and by the end of the financial year:

- We met all our statutory financial duties, including the need for a 1% surplus.
- We delivered our Quality Innovation, Prevention and Productivity (QIPP) programme savings of £12.1 million, but we were not successful in meeting our plans to reduce significantly the numbers of emergency admissions that should not usually require a hospital admission and the level of new outpatient referrals. The QIPP programme for 2014/15 will focus on reducing unnecessary or inappropriate activity in these areas.

Looking ahead, there are challenges, but our belief is that we can meet these challenges and achieve our goals for the people of Lewisham through working together.

We will do this through delivering our strategic model of care. This is based on shifting the balance of care from emergency responses to care that is proactive and planned. It means developing local neighbourhoods and communities so that services respond to those local needs of these communities, and we are better placed to tackle inequalities in the borough.

Above all it means always putting the individual patient at the centre of care, seeing the whole person and empowering them to act as a partner in improving health.

Dr Marc Rowland
Chair of the Governing Body, NHS Lewisham Clinical Commissioning Group
June 5th 2014

Strategic Report

Lewisham Context

Who we are

NHS Lewisham Clinical Commissioning Group is the organisation responsible for planning, monitoring and buying most of the health services needed in Lewisham, including:

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

Some health services in the borough, including GPs themselves, pharmacies, dentists, opticians and some specialist services, are commissioned by NHS England.

We were established in April 2013 as part of the changes to the NHS which put GPs in charge of making decisions about what health services should be available for their patients. Lewisham GPs lead the CCG and every GP practice in Lewisham is a member and able to have a say on the decisions that are made.

We had an allocation of £365 million in 2013-14 to secure the best possible health and care services for Lewisham residents in order to reduce health inequalities and improve health outcomes.

To achieve our vision and tackle the health challenges in Lewisham, we work in partnership with the public, patients and carers, through specially organised public events and through specially-created fora such as our Patient Engagement Group, to ensure that our services will meet the needs of people in Lewisham. Also we work in collaboration with other commissioners, including London Borough of Lewisham, NHS England and neighbouring CCGs to meet our goals and ensure efficient and effective working. .

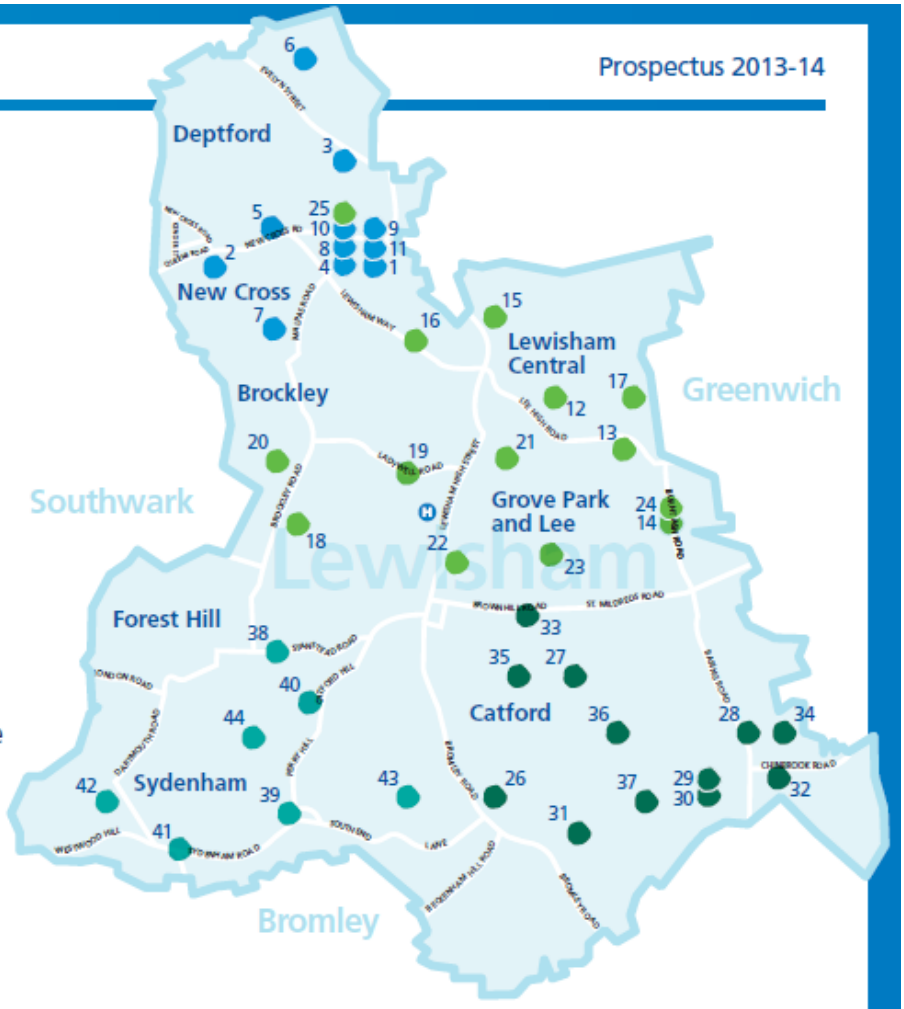
Our Borough

Lewisham CCG is coterminous with the London Borough of Lewisham**.**

Lewisham is a diverse borough with a population estimated at 284,325 people in 2013, 49% male, 51% female. It is a young population, with a quarter (25.4%) under the age of 20. It is also highly mobile, with as many as a fifth of residents moving in and out of the borough every year. This mobility places an additional strain on health services. For example, people who are not registered with a GP are more likely to have to use unplanned, and more expensive, urgent care services. It is also harder to ensure that people take up health screening services, and so miss out on their preventative health benefits.

To assist us in delivering local responsive health and social care services, Lewisham Borough is divided into four neighbourhoods:

GP Practices in Lewisham



Neighbourhood 1 Practices

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

Neighbourhood 2 Practices

12 Belmont Hill
13 Lewisham Medical Centre
14 Lee Health Centre
15 Morden Hill
16 St Johns Medical Centre
17 Lee Road
18 Brockley Road
19 Hilly Fields Medical Centre
20 Honor Oak
21 Triangle
22 Rushey Green
23 Woodlands Health Centre
24 Nightingale
25 Hurley Group Practice

Neighbourhood 3 Practices

26 South Lewisham
27 Torridon Road
28 Baring Road
29 ICO Moorside Clinic
30 Downham Family Practice
31 Winlaton
32 ICO Chinbrook
33 Parkview
34 ICO Marvels Lane Health Centre
35 Muirkirk Road
36 ICO Boundfield Road Medical Centre
37 Oakview

Neighbourhood 4 Practices

38 Jenner
39 Sydenham Green
40 Woolstone Medical Centre
41 Sydenham Surgery
42 Wells Park
43 Bellingham Green
44 Vale Medical Centre

Our population

Lewisham CCG needs to understand the characteristics of Lewisham's population and future trends to be able to effectively plan and buy the most appropriate health services. The information we use to understand the make-up and health and wellbeing of the people of Lewisham is obtained from Lewisham's Joint Strategic Needs Assessment (JSNA). This brings together in one place, to an extent, a wealth of information on the health and social care needs of Lewisham's citizens, complemented by information on the social environmental and population trends that are likely to impact on people's health and wellbeing. The JSNA also includes the community and patient view on local health and social care services. It shows that:

- **Population growth -** Overall the population is expected to grow over the next five years, especially in the 20-64 age group. There has been a sustained rise in the birth rate in Lewisham for several years, reflecting a similar rise in London and the country as a whole. The trend is expected to level off in Lewisham in future years, but because of the previous rise in births the population of children, in particular those aged 5 to 14, will continue to rise.

- **Ethnicity** - Lewisham is a very ethnically diverse borough, particularly in the younger age groups, with 46.5% of the population from black and ethnic minority (BME) groups compared to 40.2% in London as a whole, and 12.5% in England. In 2011, the latest year for which figures are available, the two largest groups were black African (12%) and black Caribbean (11%). Three quarters of school children (77%) are from BME groups and together speak over 170 languages.

- **Deprivation -** deprivation is increasing in Lewisham. The 2010 Index of Multiple Deprivation (IMD) ranked Lewisham as the 31st most deprived borough (out of 354 local authorities in England). This compares to 39th in 2007:

    - There is deprivation across Lewisham, demonstrated by there being no wards in the top 20% of most affluent areas in England.
    - Within the borough there are significant inequalities between wards. Evelyn ward in the north of the borough is the most deprived ward, followed by Bellingham, and Downham in the south. Rushey Green in the centre of Lewisham borough ranks as the 4th most deprived ward;
    - Life expectancy for both men and women in New Cross and Lewisham Central wards is significantly lower than the rest of Lewisham, London and England.
    - A third of Lewisham households are one-person households (34%) compared to 30% in England. Of these, nearly a third are aged 65 and over.
    - Lewisham has a higher proportion of lone parent households (11%) compared to London (9%) and England (7%).
    - Lewisham also has a higher than average problem with housing poverty, for example .

- **Local inequalities -** Unemployment, lack of education and living in poor conditions all have an impact on health.

  There are also significant health inequalities among different ethnic groups. Some of these are genetic related, to an extent, with some ethnic groups more likely to develop coronary heart disease or diabetes. Some are about accessing services: for example, uptake of breast screening is lower in black women, while late diagnosis of HIV infection is more common in black African heterosexual men and women. Black teenage girls are

more likely to get pregnant than white teenage girls. White men and women have higher rates of admission for alcohol-related problems.

Our health challenges

Life expectancy is below that of London and England for both men (78 years) and women (82 years) (2010-12 figures). The Life Expectancy gap between Lewisham and England is reducing. This is improving across the whole borough although there are still variations in different areas.

The main causes of death are cancer, circulatory disease and respiratory disease, similar to many other parts of the country. Compared with London as a whole, both men and women are more likely to die from these conditions before they reach the age of 75.

In Lewisham our particular health challenges include:

- **Health promotion -** Health promotion is the process of enabling people to increase control over, and to improve, their health. Health promotion activities include developing a supportive environment with easy access to information, life skills and opportunities to make healthy choices, such as to stop smoking and to eat more healthily. Specific issues for Lewisham are:

    - A fifth (21%) of the population smoke, more than the national average, with higher rates among those on lower incomes.
    - Around a third of adults in the borough are overweight or obese, compared to just under a quarter (24.2%) in England as a whole.
    - Lewisham also has a high level of childhood obesity, with over four in ten children aged 10-11 and nearly a quarter of 4-5 year olds obese in 2011-2012.
    - Adults in Lewisham are less likely to take part in sport or active recreation compared to both London and the rest of England.
    - Alcohol-related harm is increasing in Lewisham**.**

- **An increase in long-term conditions -** a long-term condition is a health problem that cannot be cured but can be controlled by medicines or other treatments. Examples include diabetes, heart disease, chronic obstructive pulmonary disease (COPD), dementia and depression.

    - Research indicates that nearly 20% of people have more than two long-term conditions and this proportion increases steeply with age. The prevalence of those with two or more long-term conditions is also higher in more deprived populations.
    - Projections suggest that from about 2015 the number of residents over 65 years old will begin to rise. The proportion of over 65s in Lewisham was 9% in 2013, but is expected to rise to 11% by 2028. This is likely to be reflected in an increase in the number of people with long-term conditions.

- **Mental health -** mental health problems are very common. About a quarter of the population experience some kind of mental health problem in any one year. In Lewisham almost 40,000 people a year experience depression, anxiety, panic attacks or phobias.

- **Access and Outcomes –** one of the key health challenges is to commission appropriate services which continue to ensure that they are accessible and appropriate to Lewisham people's diverse needs.

- **Late diagnosis and intervention –** in Lewisham some people seek advice and treatment late which can mean that the treatment is less effective:

    - more than 30,000 residents are estimated to have undiagnosed and therefore untreated high blood pressure
    - uptake of cancer screening is significantly worse than London, with implications for cancer survival, particularly for women, who miss the benefits of early diagnosis
    - one in four HIV infections is diagnosed late when treatment is less effective.

Our partners

We work closely with other commissioning organisations, including London Borough of Lewisham, NHS England, and other CCGs to ensure that we are making the best plans for people in Lewisham and to coordinate health and care services.

The People of Lewisham

We work in partnership with the public. We are committed to engaging with and involving the public to ensure that our plans for health services do meet the needs of local people. Lewisham people are ethically very diverse. So when we carried out a range of public engagement activities during 2013, we tried to reach all our different communities to gather their views on our draft commissioning strategy. In March 2014 we held a Quality Summit to hear the views of Lewisham residents on what quality in healthcare means to them. At these events people requested:

- More support from and services delivered through voluntary and community organisations
- Improved telephone contact and access to GPs
- More Health checks available
- Improved Mental Health Services for adults and young people
- Better communication and publication of support services and self-referral services such as Improving Access to Psychological Therapies (IAPT)
- Better monitoring of Care Homes and publication of monitoring data
- Improved discharge communication with GPs
- Support for individual care plans – held or accessed by patients
- Access to performance data
- Communication – about everything that affects patients; not just on paper
- Respect, Dignity and honesty in all healthcare interactions
- Reduced waiting times – for test results and outpatient appointments
- Greater role for patients in prevention

Elsewhere in this report you can see how some of this work is already in progress; the comments have been incorporated into our commissioning intentions for the next two years.

Lewisham Health & Wellbeing Board - we are a member of the Health & Wellbeing Board, a statutory committee of the London Borough of Lewisham (LBL). It is responsible for jointly planning how best to meet local health and care needs and to promote greater integration and partnership working in Lewisham.

The Health and Wellbeing Board oversees the work of the Children and Young People's Partnership and the Adult Integrated Care Programme. The Public Health and Health Protection team of London Borough of Lewisham support the work of the Health and Wellbeing Board with specific responsibility for the co-ordination of the information on the health and wellbeing of the people of Lewisham, which is summarised in Lewisham's Joint Strategic Needs Assessment (JSNA).

The Health and Wellbeing Board's strategy, agreed in September 2013, sets out the wider health and wellbeing prevention strategy for Lewisham, with nine priority areas:

- achieving a healthy weight
- increasing the number of people who survive colorectal, breast and lung cancer for 1 and 5 years
- improving immunisation uptake
- reducing alcohol harm
- preventing the uptake of smoking among children and young people and reducing the numbers of people smoking
- improving mental health and wellbeing
- improving sexual health
- delaying and reducing the need for long term care and support
- reducing the number of emergency admissions for people with long term conditions.

The CCG is fully supporting the delivery of all priorities identified in the Health and Wellbeing strategy, with a specific focus on reducing smoking, alcohol harm, obesity, improving sexual health and increasing cancer awareness, screening and early diagnosis. More details about the Lewisham Health and Wellbeing Strategy for all by 2023 can be found at: http://councilmeetings.lewisham.gov.uk/ieListDocuments.aspx?CId=315&MId=3165&Ver=4

The Joint Strategic Needs Assessment (JSNA is the basis for the CCG plans and the Health and Wellbeing Board's priorities. This means that the Health and Wellbeing Board's priorities are aligned with Lewisham CCG's commissioning priorities, as set out in the Strategic Plan, Commissioning Intentions and Operating Plan.,

South East London Clinical Commissioning Groups - the six CCGs in south east London - Lewisham, Lambeth, Southwark, Greenwich, Bexley and Bromley - have established collaborative arrangements to meet their shared and interdependent commissioning responsibilities. The reason for working collaboratively with the six CCGs is that we believe that we can transform the way services are delivered faster, learn from one another and implement some programmes collectively at scale.

- The commissioners are working together but also in partnership with local people, patients and carers, NHS England, local councils, hospitals, community services, and mental health services on the development of a new strategy. The strategy aims to improve health, reduce health inequalities and to ensure the provision of health services across south east London that meet safety and quality

standards consistently, are sustainable in the longer term and encompass the South East London Community Based Care Strategy

- The strategy is commissioner-led and clinically-driven. It builds on what already works well and is shaped and developed by the views of all the partners and local stakeholders - especially patients and local people. These views are being used from the beginning and throughout the planning process to make sure the strategy is right for south east London. The SEL Strategy has been informed also by the Borough based JSNAs and Health and Wellbeing Strategies.
- Each CCG carried out engagement on the emerging case for change narrative with patients and local people via their existing local engagement mechanisms during January 2014. Feedback has been used to inform development of the full draft case for change. During March 2014, CCGs undertook further engagement with patients, local people and members to finalise the case for change and emerging strategic opportunities.

Our providers

Lewisham people have a wide choice of acute providers across London. The main provider of acute (hospital) services is Lewisham and Greenwich NHS Trust. Lewisham people also use King's College Hospital and Guy's and St Thomas's Hospital.

Lewisham and Greenwich NHS Trust was created in October 2013 as an outcome of the Trust Special Administrator (TSA) programme for South London Healthcare NHS Trust. (There is more detail about this TSA programme later in the report). Lewisham and Greenwich NHS Trust also provides the majority of community health services for Lewisham residents.

Mental health services are mainly provided by the South London and Maudsley NHS Foundation Trust and the voluntary sector.

Our contracts with providers are managed effectively by robust contract management systems, including an integrated performance monitoring report reviewed by our Delivery Committee. We work with providers to ensure that we commission services which are safe and compassionate and listen to patients and relatives when they tell us about their care. Having robust quality performance meetings, receiving reports on quality, undertaking unannounced visits and working closely with the CQC are all examples of how we work with our NHS and non-NHS providers of healthcare.

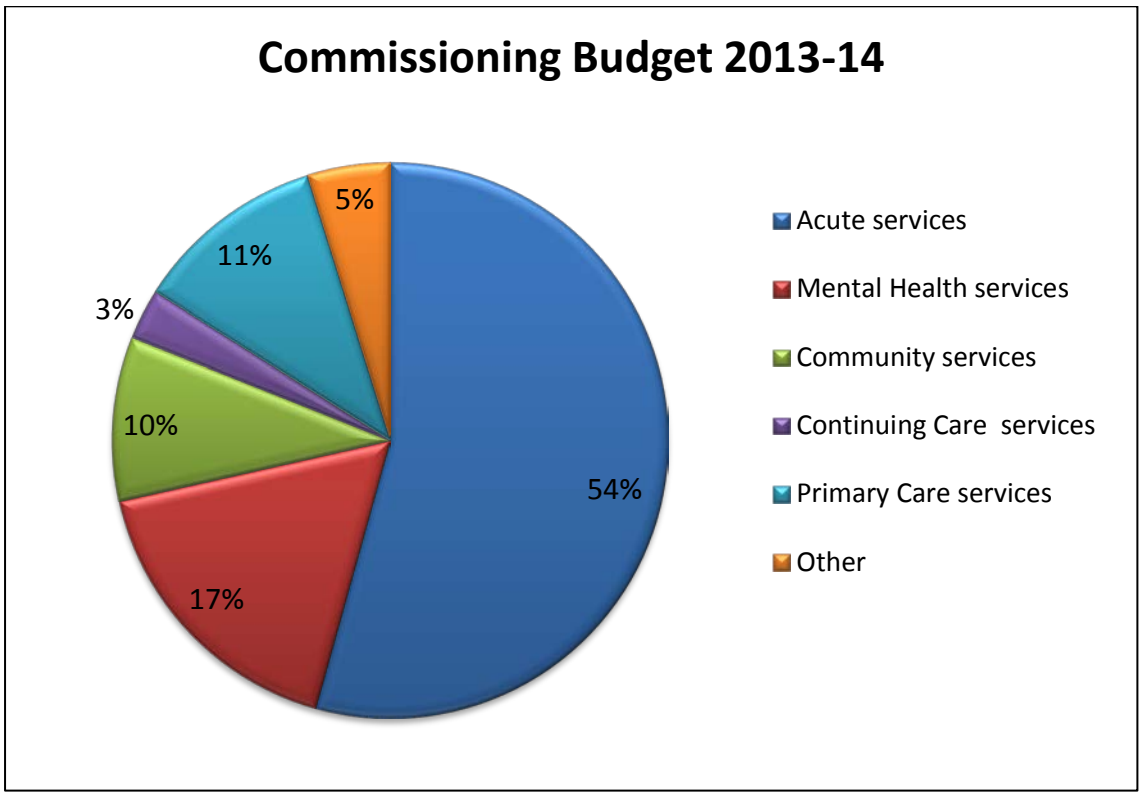
Lewisham CCG is the coordinating commissioner for the Lewisham and Greenwich NHS Trust, working closely with Greenwich and Bexley CCGs. For the 2014/15 contract negotiation the CCGs worked collaboratively with a joint negotiating team consisting of leads from each CCG supported by a range of clinically-led groups and the South London Commissioning Support Unit

A four-Borough arrangement - Croydon, Lambeth, Southwark and Lewisham CCGs – is in place to collaboratively co-ordinate the adult mental health contracts with South London and Maudsley NHS Foundation Trust.

Primary care services, across the country, are having to manage increasing demand for their services because of an ageing population and the rising number of people with long-term conditions, including dementia. This is combined with the higher public expectations of a customer-orientated service, wanting easier access 7 days a week. This has meant that during 2013/14 local GP practices have been considering how they can work together

differently to respond to this increased demand effectively, in a way in which is more sustainable in the longer term.

The following chart shows how we planned to spend our commissioning budget (£365m as April 2013) across different healthcare settings; acute (hospitals), mental health, community and continuing healthcare services.



Trust Special Administrator (TSA)
Following decisions by the Secretary of State for Health in January 2013 on the Trust Special Administrator's report into South London Healthcare NHS Trust, a legal challenge was launched by both Lewisham Council and The Save Lewisham Hospital Campaign into the service change decisions. The outcome of the judicial review was announced in late October 2013.

The CCG welcomed the judgement, although the CCG has always recognised the significant service challenges facing health services and that these need to be addressed through locally determined models which has support of clinicians and local people, hospital providers and other partners including colleagues in South East London CCGs and NHS England to deliver high quality and financially sustainable health services. We have begun work on this through a South East London strategy. Other Secretary of State decisions related to the TSA report have been implemented supported by the CCG leading to the successful dissolution of South London Healthcare NHS Trust on 1st October 2013, including the transfer of the Queen Elizabeth Hospital and merger with Lewisham Hospital to form the Lewisham and Greenwich NHS Trust – further details are provided as an Appendix to this report.

The Francis Report

The importance of public engagement, of listening to patients and carers, was a key finding of the **Francis report into Mid Staffordshire NHS Foundation Trust.** The report raised serious concerns about the care of vulnerable older people and made 290 recommendations to the Secretary of State for Health to improve patient safety. All NHS organisations have been required by NHS England to publish an action plan detailing how the recommendations will be implemented.

In May 2013 Lewisham CCG established a working group to review the Francis Report and prepare a response and action plan. Lewisham CCG supports the Government's response to the Francis Report and is committed to ensuring that the 281 recommendations accepted by the Government are implemented appropriately across the local health system in a timely way. We have identified 56 recommendations which are directly relevant to our work, and prioritised them into four levels of urgency. Of these, 21 are already in place and are being monitored, and 21 have been deemed a priority for 2014/15.

The CCG will work with its service providers to ensure that the remaining 225 recommendations are implemented at the appropriate level across the local health system and with our membership to ensure a fully inclusive response.

In line with the Francis report's recommendations on the need to ensure that patients' and carers' voices are heard, we are committed to engaging with patients and the public.

Our Strategy – responding to the challenges

Our Strategic Vision

Our strategic aim is to improve the health of Lewisham residents by securing the best possible health and care services in order to reduce health inequalities and improve health outcomes, recognising the specific challenges in Lewisham highlighted above.

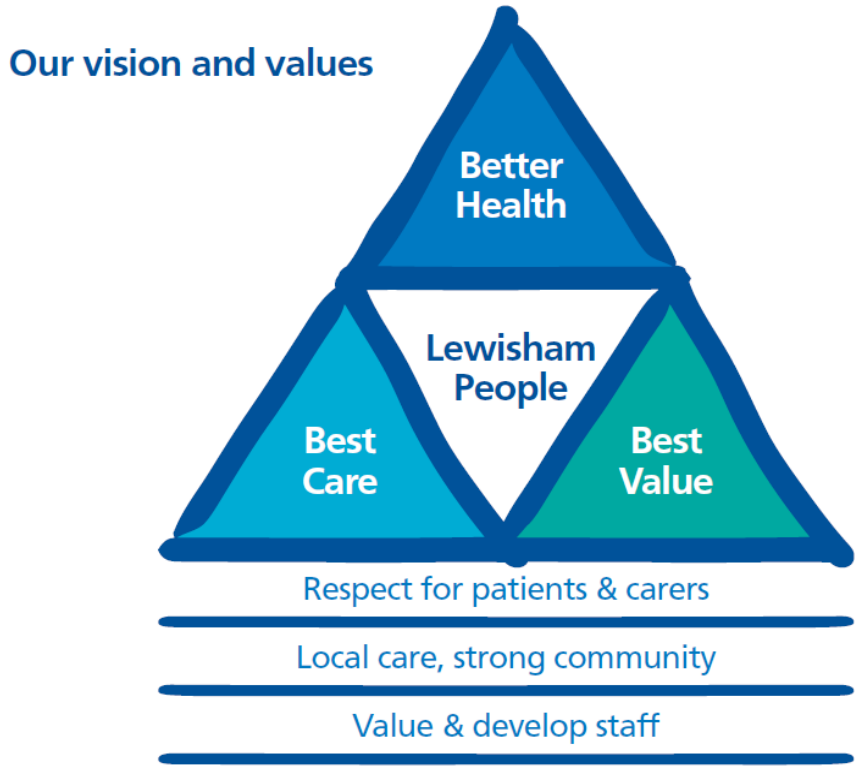
Lewisham CCG's five year Strategic Plan (2013-18) is based on our strategic vision for better health, best care and best value for everybody in Lewisham:

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

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

- **Best Value -** to commission services which are integrated and sustainable so delivering high quality, effectiveness and value for money.

- **Lewisham People -** working together with Lewisham people is at the centre of everything we do.



In practice, our values mean respecting for patients and carers, providing local care in a strong community and with staff that are valued and developed to make the best use of their skills.

Our model of care

The CCG has developed an overall model of care (our 'business model') to deliver high-quality support and care in partnership with other commissioners and the public, which is affordable. The successful delivery of this model of care will shift advice, support and care to be:

- proactive and planned, with a focus on early detection, diagnosis and intervention
- patient centred, personalised to the individual's preferences and choices and considering the whole person rather than specific health conditions
- empowering the individual to be confident in their management and decision making about their own care, as far as they want and are able to
- developing local neighbourhoods and communities to help people and communities to manage their health and wellbeing by finding local solutions.

Our strategic focus

Looking at the main health needs and trends in Lewisham, listening to feedback from our public and engaging with our partners, we identified three key areas of strategic focus to transform the way in which future services are delivered in Lewisham;

- Healthy living for all – helping people to live healthy lifestyles and make healthy choices, and tackling health inequalities in the borough
- Frail and vulnerable people – ensuring that they are supported and cared for at all times with dignity, compassion and respect
- People with long-term conditions, such as diabetes or heart disease– empowering them to have greater control over managing their condition.

Our strategic outcomes

Our strategic ambition is to reduce the gap in key health outcomes between Lewisham and England by 10% over the five year period and inequalities within the Borough. We will determine our success in improving the health of Lewisham people by measuring life expectancy, rates of premature mortality from the three biggest causes of death in Lewisham (cancer, respiratory diseases and cardiovascular disease), infant mortality, patient experience and end of life care.

A key indicator for Lewisham CCG is reducing premature mortality – potential years of life lost. This indicator is a measure of the ambition to secure additional years of life for people with treatable mental and physical conditions. It compares expected mortality to actual in 5 year cohorts through the population, eg a child death would lose 70 years of expected life, but a 70 year old death may lose 8 years. The rate shown is the total per 100,000 population and the numbers are standardised per registered population.

In previous two year trend in Lewisham has been a nearly 5% reduction per annum. In 2012/13, the potential years of life lost was 2114, which was less than 'like' CCGs of 2226, and slightly higher than England's average of 2061 potential years of life lost per 100,000 registered population.

Below are summarised the high level indicators that we are using to monitor the delivery of the CCG's strategic plan in improving health outcomes. The Strategy and Development Committee monitor these outcome measures. However as these are long-term indicators the

CCG also monitors key performance indicators (KPIs) which are summarised later in this report.

Strategic Outcomes	Measures	Current Level	Target 2018/19
Life Expectancy	Potential years of life lost from causes amenable to healthcare	Females 2110.5 Males 2415.3	Females 2091.1 Males 2409.0
	Life expectancy at birth	Females 81.3 Males 76.7	Females 83.8 Males 79.8
	Disability-free life expectancy at age 65	Females 9.01 Males 8.99	Females 9.20 Males 9.11
Causes of death	Premature mortality Under 75 mortality rate from cancer	125.4 deaths per 100,000	104 deaths per 100,000
	Under 75 mortality rate from cardiovascular disease	84.8 deaths per 100,000	54 deaths per 100,000
	Under 75 mortality rate from respiratory disease (bronchitis, emphysema and other COPD)	36.4 deaths per 100,000	31.5 deaths per 100,000
Infant mortality	Infant mortality Neonatal mortality	3.6 per 1000	*To be confirmed*
	Stillbirths	6.1 per 1000	*To be confirmed*
Patient experience	People feeling supported to manage their condition	61.4%	TBC
End of life care	Proportion who die in hospital; Proportion who die at home	58.3% 20.4%	55.1% 23.1%

The strategic financial assumptions.

CCG allocations are known and published for 2014/15 and 2015/16. This provides a more sound short term footing for Lewisham CCG's future financial plans. The CCG has developed a two year plan in support of the Operating Plan for 2014/15 to 2015/16 and in March 2014 the Governing Body considered a draft budget for these two years. At the same time the CCG has set out a high level five year financial view using NHS England and local planning assumptions. This will be tested and refined during 2014/15 using the South East London Commissioner model in association with other NHS Commissioners in South east London.

Income

In 2013/14 the CCG's revenue allocation was based on the disaggregation of Lewisham Primary Care Trust's budgets. From 2014/15 targeted CCG allocations are set using a new national CCG funding formula. This has been used to inform published allocations for CCGs for the two years 2014/15 and 2015/16. NHS Lewisham CCG is deemed to be under target (i.e. receives less income than a "fair share") and consequently has received higher than minimum growth funding in both years as part of NHS England's "distance from target" approach. The revenue allocation confirmed for 2014/15 is £381.6m and for 2015/16 £395.5m.

Expenditure
Despite higher than minimum growth over the next two years, the predicted cost of healthcare for the current and projected Lewisham population is higher than the CCG's income on a "do nothing" basis. Consequently the CCG must generate financial efficiencies in order to keep pace with the predicted costs of healthcare demand. The efficiency requirement for the two years 2014/15 to 2015/16 is in the order of £25m net (or 3.2% of the CCG's income). The CCG has identified potential savings using the national QIPP framework as part of its commissioning intentions for the two years, with a focus on reducing the number of avoidable hospital admissions through improvements in integrated and urgent care for people with long term conditions.

The CCG has set aside non recurrent investment funds in line with NHS England planning guidance. The CCG will continue its 2013/14 commitment to invest 1% (circa £3.6m per annum) of its budget in the CCG's community-based care transformation strategy in each of the three years 2014/15 to 2016/17. The CCG has identified £1.5m to support the provision of a comprehensive and coordinated package of care for people aged 75 and over, for those with complex needs and to reduce avoidable admissions.

In 2015/16 the CCG will contribute £19.7m of its revenue allocation to the Lewisham Better Care Fund; a joint fund shared between the CCG and the London Borough of Lewisham, for health and social care services, to deliver better outcomes and greater efficiencies through more integrated services for older and disabled people.

A copy of the CCG's Strategic Plan can be found here:
http://www.lewishamccg.nhs.uk/newspublications/Publications%20page%20documents/Commissioning%20strategy%202013-18.pdf

2013-14 – putting our vision into practice

The first year of any new organisation is a relatively challenging period, and for the CCG this has been compounded by the fact that we have been designing and implementing new systems and managing our resources in a period of unprecedented change for the NHS as a whole. However, the detailed preparatory work that we carried out as a shadow CCG meant that we started with strong foundations, including financial governance and management arrangements, in place.

We identified the following eight commissioning priorities that we have focused on to transform services during 2013/14.

Strategic Themes	Commissioning Priorities
Healthy Lifestyles and Choice	Health Promotion – smoking cessation, reducing alcohol harm, obesity and preventing cancer
	Maternity and children's care in hospital
Frail and Vulnerable People	Frail older people (including end of life care)
Long Term Conditions	Long Term Conditions – e.g. COPD, diabetes, CVD, dementia
	Mental Health
Deliver Services Differently	Primary care development and planned care
	Urgent Care
	Adult Integrated Care

We can now look back on some significant achievements during our first year of operation, to review the improvements we have made in each priority area, always keeping focussed on our vision of better health, best care and best value for everybody in Lewisham.

Commissioning Priority: Health Promotion

Stopping smoking, health checks and immunisations are three key areas for improving health in the borough, and ones where GPs have a key role to deliver improvements.

Immunisation – an early clinical priority identified with members was improving MMR immunisation at year 2. With huge effort the CCG has improved vaccination rates by 10% in a 12 month period, making us one of the most improved CCGs in London on this measure. We are looking to sustain and improve other vaccination levels.

Lewisham CCG worked in partnership with Lewisham Public Health to develop and deliver a programme to support GP practices in achieving improvements in these health promotion areas. The programme was supported by the CCG's clinical commissioning facilitators, who have been working with member practices. This included developing toolkits and support packs for smoking, health checks and immunisations, in liaison with the Public Health team. These were made available to practices via the CCG bespoke GP Interactive (GPi) website. Also a series of visits were conducted by the facilitators to support practices with systems and processes, sharing best practice and improving outcomes for patients.

Commissioning Priority: Maternity care and Children's Care

Maternity care centred on the mother - Lewisham maternity and early year's services face a number of challenges. As well as a rising population and consequent demand for maternity services, there is a higher risk of adverse outcomes because of underlying health issues, such as increasing obesity rates in women. These present challenges to services and have an impact on health outcomes both for women, new-borns and children under five. Like the rest of London, Lewisham has high caesarean section rates, which have a higher risk of adverse outcomes and potentially impact on women's longer-term health.

A further issue is recruiting and keeping the highly-skilled workforce required to deliver a service across all health settings. In particular, a high number of midwives are eligible for retirement in the next five years. This could also impact on midwifery staffing ratios to achieve the NHS London standard of one midwife to 30 births, across all birth settings.

A project to pilot a new model of delivering maternity services in Lewisham - the team around the mother – has been designed to meet these challenges, which was given the go-ahead by the CCG. This model places the mother and child at the centre of care and integrates community services, especially primary care, health visiting and children's centres, with the midwife supporting the mother at each stage. The intention is that ante-natal and post-natal care, and where possible intra-partum care will be provided within a setting of the mother's choice, be it at home, within acute obstetric-led units or midwifery birthing units. The ultimate purpose is to enable mothers and babies to achieve the best health outcomes.

Extending take-up of vitamin D – before April 2013 Public Health made provision of Healthy Start Vitamin D products through health/children centres. However, less than 5% of the population eligible for free supplementation accessed supplies and access was identified as a barrier for those who had purchased the vitamins. Locally, paediatricians reported a worrying number of infants with bone problems and vitamin D deficiency. Community Pharmacy was approached to see if wider access could be achieved within the local diverse population.

The Local Pharmaceutical Committee (LPC) and Lewisham CCG medicine team were already working with the borough's pharmacies to achieve Healthy Living Pharmacy (HLP) status supporting Health Champion training and accreditation.

The initiative signposted mothers (with their infants) into local community pharmacies to collect their free vitamin D and to seek the advice their pharmacy team can offer. Within three months, HLPs enrolled 5500 mothers/infants into the scheme and had given drops to 2899 infants, tablets to 1336 women with children under 1 year and tablets to 432 pregnant women.

Pharmacies reported the impact as very positive, allowing them to open up conversations about the benefits of Vitamin D and to talk about other vitamins, and what would be best for women and their families. Mothers visiting local community pharmacies to collect free vitamin D for themselves can take advantage of other advice their pharmacy team can offer. Health champions can promote other Healthy Start initiatives, such as provision of vouchers for milk and fruit/vegetable produce.

Commissioning priority: frail older people

Promoting take-up of vaccinations - one of Lewisham CCGs priority areas for 2013-14 was to reduce respiratory-related emergency admissions, especially for older people. The seasonal influenza vaccination programme is a vital tool in this, as there is a direct link between the uptake of the vaccination and associated emergency attendances and admissions.

Lewisham CCG developed and implemented a full immunisation programme in line with the national Directed Enhanced Services scheme, supported by a Local Incentive Scheme to support GP practices to achieve higher uptake of seasonal flu immunisations. We commissioned a dedicated flu coordinator, who worked directly with practices, supporting delivery, managing vaccine availability and developing individual flu action plans for practices.

The programme was widened to encompass primary care and district nurses to enable increased access for housebound patients. This also included enabling GPs who support care homes across Lewisham to identify all 'at risk' residents to ensure they received timely vaccination. The programme saw an increased uptake in all at-risk groups by 3% compared with the previous year, achieving more than 70% uptake in the over 65 at-risk group.

Medicines Optimisation in Practice - older patients and those with long term conditions are gaining more benefit from their medicines from a unique collaboration between Lewisham CCG and Lewisham Council. The Medicines Optimisation Project (MOP) has engaged patients, social workers, domiciliary care staff, pharmacists, doctors and nurses. An overarching joint medication policy, drawn up with input from patients and carers sets out for both NHS and Social Care teams how patients should be supported in managing their medicines.

The policy defines a service that promotes independence and facilitates the care of people in their own homes. It is driving a whole system change in the way patients are assessed and supported in the community for their medicine needs.

Community pharmacies in the borough have been commissioned to provide an enhanced service to support the supply of compliance aids and medication records. GPs have been encouraged to modify prescribing practices. A specialist team, the Lewisham Optimisation Service, have been commissioned to support the project.

Additional support and care - in January 2013, we commissioned a pilot project at a residential and nursing care home, Brymore House, aimed at preventing unnecessary admissions and readmissions to acute services. We provided additional staff and equipment to support patients, so that "double handed support" – two members of staff per patient – was available where patients needed it. At the end of the pilot, the project was evaluated and found:

- a positive patient experience with patients valuing the support of the 'double handers' in aiding their independence
- the majority of patients were discharged home, so readmissions to acute care were prevented
- a cost saving to the health economy.

A second phase of the pilot has been commissioned for 2014/15.

Commissioning priority: people with long-term conditions

Minimising risk – risk profiling is a mechanism for identifying patients at risk of an unplanned hospital admission. Once identified, the patient's health and social care needs are assessed and stabilised in order to reduce the likelihood of an admission, enhance the patient's experience of healthcare services and improve the quality of their lives.

The CCG developed a pilot in 2013, which enabled GP practices to identify which of their patients were at risk of an unplanned admission. Specifically, these were patients who had recently been admitted to hospital, who had not attended a recent outpatient clinic appointment or had other indicators of pressing health and social care support.

In order to ensure that patients were adequately supported once identified by their GP, a multi-disciplinary team approach was adopted, with input from both health and social care

professionals. The pilot began in May 2013 and was completed by 36 out of 41 GP practices in March 2104.

A separate piece of work was conducted to identify frail and elderly people. An event like a fall can be catastrophic for such patients, and the aim was to identify people at risk in order to stabilise their health and social care needs before they experienced such an event. Four practices participated in this pilot. The identified patients were invited to see their GP or nurse in order to establish the support they needed to reduce the likelihood, or speed, of any deterioration which might increase the likelihood of such an event. The pilot ran until April 2014. It will be fully evaluated and risk profiling for patients will continue throughout 2014/15, with support being provided for those patients deemed to be at risk.

Working with patients to improve their health – a collaborative care plan is an agreement between the patient and a health professional to help manage the patient's condition. The aim is to improve the quality of care and outcomes for people with a long-term condition by engaging them more in decisions about their care and helping them to take control of their own health.

This process provides a more collaborative approach with patients, enabling them to proactively manage their conditions. The CCG delivered the first phase of training for 15 GPs, practice nurses and diabetes specialist nurses in March 2014. The programme will be implemented in GP practices in 2014-15 – enabling all patients with a long-term condition to be offered a collaborative care plan.

Diabetes Community Champions - Type 2 diabetes is a growing problem in Lewisham, and latest figures show there are now 15,382 people with diabetes in the borough – with one in five unaware they have the condition. This is expected to soar to nearly 18,400 residents by 2020. You are more at risk of type 2 diabetes if you are from a black and minority ethnic background.

Lewisham CCG commissioned Diabetes UK to deliver a Community Champions programme as a part of our plans to improve diabetes care in Lewisham. Fifteen Lewisham residents from mainly Black, Asian and minority ethnic backgrounds were trained to help their communities to better understand the potentially devastating effects of diabetes. We would wish to consider this model for other long term conditions.

The Lewisham Community Champions have been involved in awareness raising events, which have so far reached over 1,000 Lewisham residents, and last November were presented with awards for their work.

3R's: Register, Recall & Review - Early identification is the cornerstone of enabling people with diabetes to manage their condition better. The CCG developed a programme to enable GP practices to implement best practice, actively managing disease registers, recall and review systems.

Adopting this approach resulted in people with diabetes being recalled at least once a year for review by their GP or practice nurse for an annual check. To complement this approach, the CCG developed its GP Peer2Peer (P2P) programme to support GP practices to improve their 3Rs processes. In addition, practices were offered tools to help them assess what they needed to improve processes.

Improving care for people with respiratory conditions - Lewisham CCG has been providing leadership for the Respiratory Care Pathway programme. The aim is to improve health outcomes for people by reducing A&E attendances, admissions and length of hospital

stay – ensuring an integrated approach to both acute and chronic disease management across the borough.

We knew from our work in 2012-13 that for people with chronic obstructive pulmonary disease (COPD) we needed to concentrate efforts on diagnosis and management for patients in the early stages of the condition. All practices now have a named primary care key worker who is provided with on-going training and access to advice and support from the specialist nurse team.

Access to new equipment and education is provided to all practices with a dedicated resource. The respiratory nurse consultant team provides specialist care outreach. The nurses work alongside community matrons, providing 7 day working.

The CCG also committed to improving the Asthma Pathway. In this context a pathway is described as a journey a patient may take through the health system from prevention to treatment to after care. This involved developing a framework for the education and skills required. New systems to improve efficient prescribing and, crucially, gaining consensus from all providers to improve current pathway delivery.

To support a reviewing of the pathway the CCG held a public event to increase patient awareness, self-management and care of asthma in Lewisham. By involving patients and the public early, we enabled them to influence and shape care pathways at the earliest possible stage – before decisions are made – so that we could be sure that those decisions meet their needs.

Commissioning Priority – Mental Health

Redesign of the dementia pathway - following extensive discussions with users and stakeholders the vision and key outcome measures for local dementia services were clarified to be:

- encourage help-seeking and help-offering (referral for diagnosis) by changing public and professional attitudes, understanding and behaviour
- make early diagnosis and treatment the rule rather than the exception; and achieve this by locating the responsibility for the diagnosis of mild and moderate dementia in a specifically-commissioned part of the system. The aim will be to make each diagnosis well, to break the diagnosis sensitively, and provide individuals with immediate treatment, care and peer and professional support as needed.
- enable people with dementia and their carers to live well with dementia by the provision of good-quality care for all with dementia from diagnosis to the end of life, in the community, in hospitals and in care.

Services were then decommissioned and new services commissioned in 2013/14 to provide:

- new Dementia Assessment, Diagnosis and Treatment service with a single point of Access
- new voluntary sector service to provide support and information on dementia
- new Carer Support Worker specifically for dementia
- new Lewisham dementia services guide for the public
- new training provision for staff within hospitals and care homes
- extended provision of assistive technology
- extended support within day care services

Awareness, Advice and Advocacy – CCG commissions a wide range of diverse voluntary sector groups to provide advice, support and care for people with mental health problems. An example of this is the MindCare service, which provides advice and advocacy to Lewisham residents who have been diagnosed with dementia. They provide a range of activities, including dementia-friendly exercise groups, a walking group and several different advocacy groups. Another important part of the MindCare contract is the provision of Dementia Awareness training, which are free sessions open to members of the public as well as family carers, care workers and other professionals.

Since the commencement of the current contract, the MindCare service has seen a steady increase in the number of referrals and the number of users accessing the service each quarter. In the first three quarters of 2013-2014, the total case load has increased from 190 at the end of 2012/13 to over 750 in the first 9 months of 2013/14.

Commissioning Priority – Primary care development and planned care

Proactive Primary Care - is the process by which a GP practice actively contacts patients with long-term conditions to ask about their wellbeing and support them to access any services they might need, manage their own care better and ultimately improve their health and wellbeing. Its effectiveness in reducing hospital emergency admissions and inpatient stays among chronically ill patients has been repeatedly demonstrated.

The CCG carried out a study to assess the viability of proactive telephone support across Lewisham. The success of the study enabled Lewisham CCG to successfully apply for NHS London Innovation funding to implement a pilot in the borough for Proactive Primary Care. The pilot began in November 2013.

Improving access - a workshop in July 2013 helped GPs to improve access to practices for patients. The Primary Care Foundation was commissioned to support individual practices to review access arrangements by way of a development plan, with 38 out of 41 practices completing the programme. The CCG successfully received funding from Health Education South London to support telephone triage/consultation training for GP practices.

Outpatients' strategy –a Local Incentive Scheme (LIS) pilot to support practice review of referrals was launched in November 2013. It is one of a number of initiatives that has been explored in order to determine how the CCG can best support practices in formalising approaches to clinically appropriate referral review and improving the quality of referrals, as Lewisham CCG has higher levels of outpatient referrals compared to best practice.

Working with primary care to improve services to patients - In July and September 2013 the CCG brought together practices to explore different approaches and models of working together to enable greater sustainability of services to patients. This was further explored with GP practices on an individual basis. The outcome is that the CCG has 2 Pathfinder groups taking this further in 2014/15.

Commissioning Priority – Urgent Care

The Yellow Men were part of an eye-catching NHS poster campaign which was run across south east London to explain that people should only go to A&E when it is absolutely necessary. Lewisham CCG participated in the campaign, aimed at helping people to understand what health services they should use when they are ill and remind them that A&E is only for serious and life-threatening emergencies. The 'yellow men', with their various ailments, appeared across Lewisham in the shopping centre, billboards, in Lewisham Life

and on buses. According to national surveys 39% of A&E attendances could have been treated elsewhere. Across south east London A&Es see around 1500 patients a day and this figure increases over the winter months.

The yellow men highlighted the alternative places people can get the expert advice and treatment they need, including, taking care of themselves at home, GPs, pharmacies and when to come to the urgent care service and A&E.

Effective winter planning of services - in 2013/14 the CCG along with partners from across south east London commissioned an urgent care network manager covering Bexley, Greenwich & Lewisham and a south east London urgent care project manager. Their role was to support effective winter planning across Lewisham. The CCG also allocated £1m to support additional schemes across the health and social care economy, which helped prevent admissions and supported early discharge from Lewisham Hospital.

Commissioning Priority – Integrated Care

By bringing together different professional groups and working across services, we are transforming the way services are delivered to achieve an integrated approach that delivers a better service and aims to meet all a patient's needs. New approaches this year include

Neighbourhood Multi-disciplinary Teams - our GP practices are grouped into four neighbourhood areas, to help ensure local knowledge and a response to local needs. We are establishing multi-disciplinary teams (MDTs) across the borough, covering the same areas, bringing together social workers and occupational therapists employed by Lewisham Council and the community staff employed by Lewisham and Greenwich Healthcare Trusts. The designated practitioners attend regular practice meetings and have built wider links with community mental health practitioners, pharmacists and a range of voluntary sector services to ensure there are a range of support services accessible and available to support individuals.

The teams form part of a wider integration programme that aims to support people at the first point of contact with information and advice, with services that promote wellbeing and early treatment, and with effective management of long term conditions.

Community connections teams, co-ordinated by the voluntary sector, are already established and are actively involved in developing services and supporting people to access a range of support activities which are freely available in the local area. In addition, a single point of access is being established to ensure the pathways are effective to support hospital discharge and to promote opportunities that will avoid a hospital admission.

In 2014/15 there will be further development of the multi-disciplinary teams by using a key worker and joint case management approach, so that the most appropriate practitioner is identified to co-ordinate the individual's support package. Working in partnership across the health economy with collaborative care plans, the MDT will have a range of options available to ensure that support can be tailored to meet the individual's specific needs.

Bringing together adult care - in May 2013, the Government announced its ambition to make joined up and co-ordinated health and social care the norm by 2018. Their goal was for 'care and support built around the needs of the individual, their carers and family that gets the most out of every penny we spend.' The Lewisham Health and Wellbeing Board responded by establishing a group to take forward its Adult Integration Care Programme, underpinned by the Better Care Fund, and building on the work already carried out to develop joint working.

Its focus is on the co-ordination of services around the user and on the integration of care, not of organisations. This will require breaking down organisational boundaries, achieving culture change across the whole system, improving information sharing, and ensuring care is properly coordinated across all settings.

Health and social care partners in Lewisham have already taken steps to integrate services in a number of areas. This programme will bring all appropriate adult services to work together to improve health and care and reduce health inequalities by increasing self-help and independence, creating a culture of self-responsibility, prevention and early intervention and providing affordable high-quality advice, care and support close to, or in, people's own homes.

The Virtual Patient Record (VPR) Business Case was approved by Lewisham CCG which will enable primary, community, secondary and social care professionals to share the same patient record. The VPR uses the NHS number as an identifier, with due account of an individual's right to confidentiality, and will enable professionals to view patient records from across the health and care system in the future.

Public Engagement

Public Engagement is intrinsic to all our commissioning activities and during 2013-14 we increased the scope and depth of our engagement activities. Our approach is underpinned by our Engagement Strategy, adopted by our Governing Body in November 2013 and driven by our Public Engagement Group (PEG). PEG is made up of engagement leads from our partner organisations, including the local authority, providers, Healthwatch Lewisham and the voluntary sector. The PEG Chair, who is also our Governing Body Lay Member with responsibility for public and patient involvement, provides a bi-monthly report to our Strategy and Development Committee.

Engaging the public in our commissioning decisions

During October 2013 wide public engagement took place on our Five Year Strategic Plan 2013 to 2018, 'A Local Health Plan for Lewisham'. Over 200 participants gave their views as part of our initiatives, including: focus groups, public meetings and an online questionnaire. We used a range of methods to reach as broad a range of our diverse community as possible, including people with the protected characteristics. Activities included focus groups at supported housing and with homeless people, working with Foodbank, presentations to voluntary sector organisations and we prepared an easy read version of the strategy. Through these activities we identified almost 40 residents who want to remain engaged with us and signed up to our involvement register.

Since January 2014 we have been engaging on our 2-year Commissioning Intentions in partnership with the local authority. The adult integration programme within Lewisham is embedded across the Commissioning Intentions due to our alignment with the borough's Health and Wellbeing strategy. As part of this engagement we established a public reader panel to test the Commissioning Intentions document, including learning-disabled residents and carers, and as a result of their comments we radically changed it and produced a summary.

A significant outcome from this engagement was the suggestion to introduce 'home UTI (urinary tract infection) testing' for people with specific long-term conditions. We will be

working with the local Parkinson's Support Group to develop a pilot project as part of our work to reduce emergency admissions.

Many of our commissioning initiatives involve and build on public and patient views received during our larger engagement exercises. Patients views have informed many of our commissioning initiatives, including:

- 2000 Patient surveys collected during the Review of Urgent Care Appointments
- patient representative on the Improving Diabetes Care Pathway Project Group
- trained 15 local residents as Diabetes Champions
- diabetes patients reviewed and improved a leaflet for the DESMOND programme, a programme of education and self management for people with, or at risk of, type 2 diabetes
- diabetes patients identified need for collaborative care plans
- 40 patients attended a public event to 'Improve the Asthma Care Pathway'
- 35 patients involved in our End of Life Care Event to provide direction and work plan for a newly appointed Macmillan Nurse post.
- 2 lay members will be appointed to the Referral Support Service Project Group.

Engagement with the Healthier Communities Select Committee
We ensure that we meet the requirements of the Health and Social Care Act, 2012 to engage with our Healthier Communities Select Committee on health and social care matters in Lewisham. We attend every meeting as contributors to the general scrutiny of health and care services.

Through our presence at the Committee, we have built further relationships with partners who have presented items to the Committee. We have:

- developed a relationship with and attended local community run libraries
- accepted invitations to attend local ward assemblies.

Public engagement with and through Healthwatch Lewisham

As a key partner, Healthwatch Lewisham takes an active role in the planning, design and delivery of our engagement activities. The Healthwatch Manager and a Healthwatch representative are members of our Public Engagement Group, enabling direct involvement in the strategic planning and monitoring of our engagement initiatives.

We frequently use their local knowledge and understanding as the patient champion body to inform processes and practices of engagement. Recognising their access to the wider community, we have commissioned Healthwatch Lewisham to undertake a number of initiatives in partnership and on behalf of the CCG. We commissioned them to undertake face-to-face interviews as part of our engagement on the five year Strategy and with housebound people for our review of district nursing services. We invite Healthwatch Lewisham to attend all our local events
and provide regular briefings for wider distribution through their newsletter

As they are a locally-funded voluntary sector organisation, we have a corporate objective to provide support to them, for example by providing contacts and network opportunities. We organised a secondment for our engagement officer to work with them one day per week.

The Joint Public Engagement Group and our strategy for the future

Reflecting our strategic role within the Borough's Health and Wellbeing Board and Adult Integration Programme, we are responsible for a new cross partnership group, the Joint Public Engagement Group (JPEG).

The role of JPEG is to function as a sub group of the Health and Well Being Board to ensure that appropriate engagement takes place as part of the Adult Integration Programme, utilising the expertise and existing capacity across the member organisations. It reports through the Health and Wellbeing Board and together with the Chair's report to our Strategy and Development Committee, this ensures a strategic approach aligned with the needs of the whole borough.

We know that we have a long way to go to ensure we do hear the voices of all of the diverse community of Lewisham. In particular we need to be more strategic in reaching those groups whose voices are less often heard. We will build on the activities of our first year by:

- developing our patient reference group
- developing a volunteer participation policy so that participants are repaid out of pocket expenses
- defining our financial needs group
- developing a programme of activity for the South East London Five Year Commissioning Strategy.

Our end of year position for 2013/14

So what has been the impact of our first year's programme?

You can read in this report about some of the programmes we have commissioned to improve health and health care for residents of Lewisham.

Principal Risks

The Governing Body rated four risks with a very high residual risk score at the beginning of the year, these included:

- failure to achieve adequate Information Governance Standards
- claims for NHS Funded Continuing Health Care affecting financial plans
- transfer of Specialist Commissioning will not be cost neutral to the CCG
- failure to safeguard adults.

Further details regarding the systems and processes by which the CCG has managed these risks and uncertainties is provided in the CCG's Governance Statement for 2013/14.

Key Performance Indicators – Non Financial

Lewisham CCG's Governing Body is using a range of performance indicators to assess its progress in delivering its strategic vision and performance. These include a range of outcome, patient experience and quality measures. The CCG is performing well against similar CCG peers on primary care experience measures, including how well people feel supported with their long-term condition, and we have low levels of CDifficile Infections

(Clostridium difficile, a type of bacterial infection that can affect the digestive system)**.** However the CCG has been performing less well in reducing emergency admissions and Improving Access to Psychological Therapy (IAPT) recovery rates. For these areas, where better performance should be achieved, the CCG has put in place Improvement Plans for 2014/15. The CCG also has further to go to identify people with dementia in Lewisham to meet the national aspiration.

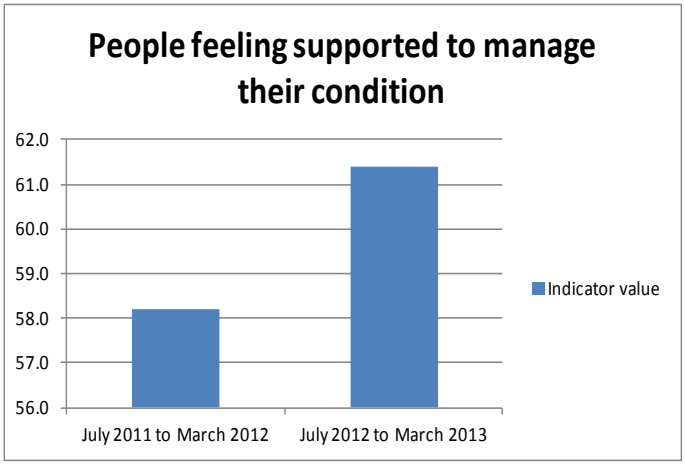
Summarised below are further details about the non-financial indicators.

People feeling supported to manage their condition

This measures the percentage of people with a long term condition who feel supported by services with their long term condition over the last 6 months. Lewisham people respond through the GP Patient Survey, of which this is one of the questions. Improvement would be an increase in this measure.

This encompasses all services, including improvements to care for people with long term conditions that can be achieved through changes to integrated services between health and social care funded through the joint Better Care Fund. As a result this indicator has been chosen as the joint local measure with an aspiration for 14/15 of 64%. This will take Lewisham a long way to the England benchmark of 65.6%.

The improvements in this measure have been consistent and more recent GP Patient Survey results show this measure continuing to improve. This improvement now places the CCG above the London score of 59.4%. Both the London and England scores are lower in 12/13 than in 11/12, which places Lewisham CCG's higher percentage in context



Improving patient experience of primary care and out of hours – this indicator is a measure of the ambition to increase the number of people having a positive experience of care outside hospital, in general practice and in the community. The GP survey of 2012-13 identified on average 6.7% of experiences as negative (or people stating that they had a poor experience). Our performance compares favourably to 'like' CCGs, who score 7.9% of experiences as poor, but less favourably with England's average of 6.1%.

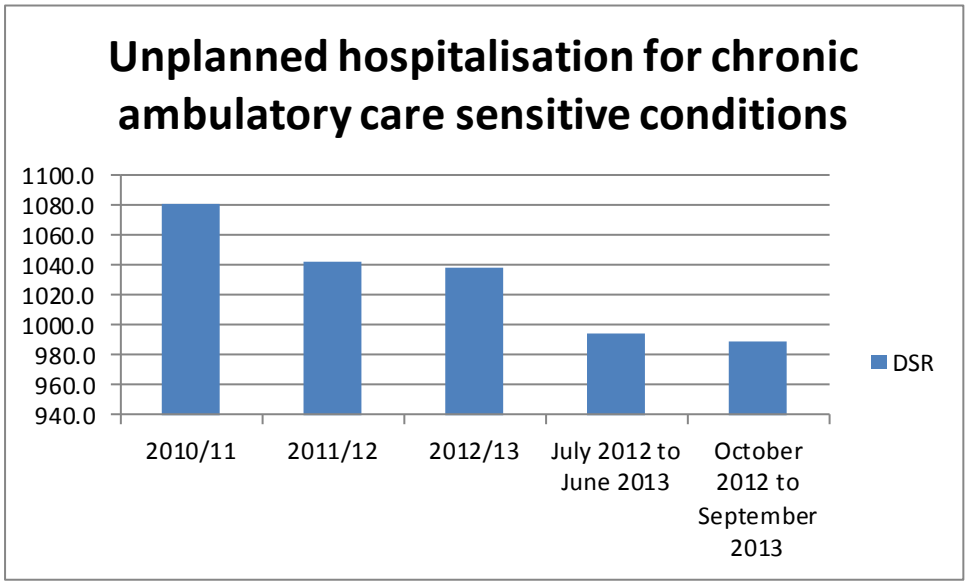
Emergency Admissions Composite Indicator - this indicator measures the amount of time people spend avoidably in hospital, through better and more integrated care outside of

hospital. The following are rates per 100,000 population, directly age-sex standardised (DSR) to the England population, covering:

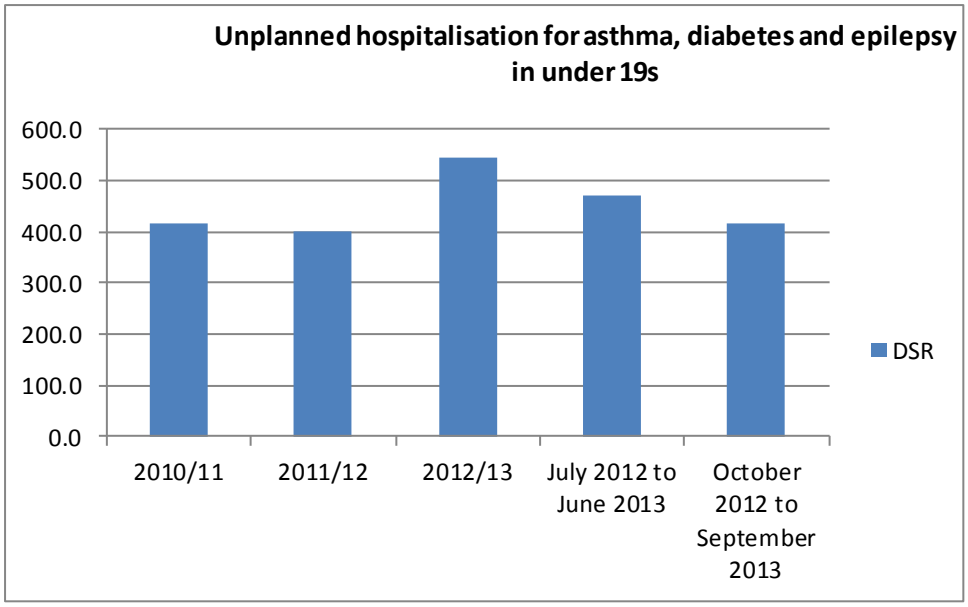
- unplanned hospitalisation for chronic ambulatory care sensitive conditions
- unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s
- emergency admissions for acute conditions that should not usually require hospital admission
- emergency admissions for children with lower respiratory tract infections (LRTI)

The detailed trends for the individual indicators is summarised below:

- Unplanned hospitalisation for chronic ambulatory care sensitive conditions and unplanned hospitalisation for asthma, diabetes and epilepsy in under 19s. These measures are derived from hospital episode statistics and relate to emergency admissions for conditions for which alternatives can be put in place e.g. diabetes, heart failure and respiratory conditions, so reductions in these measures are an improvement. They are made into a directly standardised rate by dividing them by the relevant registered population and are measured per 100,000 population. The numbers are rolling annual figures. Both of these measures are reducing in the most recent measures.



DSR= rates per 100,000 population, directly age-sex standardised



DSR = rates per 100,000 population, directly age-sex standardised

- Emergency admissions for acute conditions that should not usually require hospital admission and emergency admissions for children with lower respiratory tract infections. Both of these are derived from Hospital Episode Statistics and represent hospital admissions, which should not normally be admitted. Recent data shows the growth in these measures being stabilised and reversed.

Dementia Diagnosis Rates - this is a measure of the number people identified with dementia on GP registers compared to an expected prevalence (developed by the national Dementia Team but based on Lewisham's population). Current performance for 2012/13 is 53.7%, which is marginally better than London (50.2%) and England (51.8%). The expectation by 2015/16 is that 67% of people with dementia are identified, which is important for early diagnosis and referral to treatment/support. So the CCG's operating plan includes an implementation plan to increase the dementia diagnosis rate.

CDifficile Infections - is measuring the number who acquired Cdifficile infection while staying in hospital or identified in the community and tested at hospital laboratories. Lewisham CCG had 34 infections during 2012/13 and 39 for 2013/14. This is a significantly lower level of infections per registered population compared to England and to our like CCGs.

Improving Access to Psychological Therapy (IAPT) Recovery Rate - measures the number of people entering the service who reach a recovery level at the end of treatment i.e. that people's outcome from treatment is that they have recovered. The current rate for Q2 2013/14 is 33% for Lewisham CCG and the planned actions will aim to achieve 50% tby the end of 2014/15. Lewisham CCG is meeting its plan for the number of people entering treatment.

Urgent and Emergency Care - Long waiting times in accident and emergency departments deliver poor quality in terms of patient experience. Nationally, there is an operational standard of 95% for patients being seen and discharged within 4 hours and we use this

measure to be sure patients are being treated quickly. For Lewisham hospital site performance on the 4 hour standard was 94.6% for 2013/14, just below the national target .

London Ambulance Services (LAS) prioritises all 999 calls into categories with category A being the potentially life-threatening category. The LAS is expected to reach the national standards of 75 per cent of Category A calls within eight minutes and 95 per cent of Category A calls within 19 minutes. For Lewisham CCG performance for both standards has been met for 2013/14.

Waiting times – an individual has the legal right to start their NHS consultant-led treatment within a maximum of 18 weeks from referral, unless they choose to wait longer or it is clinically appropriate that they should wait longer. Nationally, the Referral to Treatment (RTT) operational standards are that 90 per cent of admitted and 95 per cent of non-admitted patients should start consultant-led treatment within 18 weeks of referral. For Lewisham CCG performance on both standards have been met for 2013/14. However there were ten patients on an incomplete pathway (i.e. still on the waiting list) beyond 52 weeks without being treated at the end of February 2014. Most of these patients were on waiting lists at King's College Hospital and the situation is being addressed.

Cancer waiting time targets – patients can expect to be treated at the right time and according to their clinical priority. Patients with urgent conditions, such as cancer, should be able to be seen and receive treatment more quickly. The NHS Constitution sets out the following range of standards for cancer against which performance is monitored:

- a maximum 31-day wait from diagnosis to first definitive treatment for all cancers
- a maximum 31-day wait for subsequent treatment where the treatment is surgery
- a maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy
- a maximum 31-day wait for subsequent treatment where the treatment is an anti-cancer drug regimen
- a maximum 62-day wait from urgent referral for suspected cancer to first treatment for all cancers
- a maximum 62-day wait from referral from an NHS cancer screening service to first definitive treatment for cancer
- a maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers).

For Lewisham people, all cancer standards have been met for 2013/14 with the exception of GP referred patients waiting within 62 days from referral to treatment. For 2013/14 the performance was 83.2 per cent, whereas the national standard is 85 per cent. The Cancer Intensive Support Team are working with local Trusts to improve cancer pathways and agree the recovery actions to improve the performance in this area.

Diagnostic test waiting times - patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral. In Lewisham the performance was 98.5 per cent for 2013/14 against the target of 99 per cent. Unfortunately, in January 2014 Lewisham and Greenwich NHS Trust had some short term problems in their endoscopy booking process and the number of people waiting over 6 weeks has increased, but the Trust aims to recover

the position as quickly as possible and it is expected that this standard will be delivered for 2014/15.

Key performance indicators – Financial

The accounts have been prepared under a direction issued by the NHs Commissioning Board under the National Health Service Act 2006(as amended)

The key financial performance indicators for the CCG are:

- managing within the revenue resource limit notified by NHS England
- managing within the capital resource limit notified by NHS England
- managing within the maximum cash drawdown notified by NHS England
- delivering a 1% surplus against the CCG's recurring revenue budget
- prompt payments as per the Better Payments Practice Code

For 2013/14 the CCG achieved all of the above key financial performance targets. The CCG planned to deliver a 1% surplus of £3.69m against its revenue resource. The actual surplus delivered was £3.73m. The CCG did not receive a capital resource limit for 2013/14 and spent no capital monies. The maximum cash drawdown was not exceeded and the CCG had cash in bank value of £38k at year end (i.e. within the £250k limit as per NHS England guidance). The CCG paid over 95% of invoices (by number and by value) within 30 days of receipt of a valid invoice. The Better Practice Payment Code target is 95%. In addition, the CCG delivered its targeted £12.1m Quality, Innovation, Productivity and Prevention (QIPP) efficiency target in the year. We were not successful in meeting our plans to reduce significantly the numbers of emergency admissions that should not usually require a hospital admission and the level of new outpatient referrals, so we brought forward in year plans to mitigate the overall financial impact The QIPP programme for 2014/15 will focus on reducing unnecessary or inappropriate activity in these areas.

The figures below summarise the key financial performance for the year.

Statement of Comprehensive Net Expenditure

NHS Lewisham CCG

	Administrative Costs	Programme Costs	2013-14 £'000 Total
Other Operating Revenue	(115)	(3,632)	**(3,747)**
Gross Employee Benefits	2,886	1,075	**3,961**
Other Costs	3,624	371,830	**375,454**
Net Operating Costs before Financing	**6,395**	**369,273**	**375,668**
Financing			
Net Operating Costs for the Financial Year	**6,395**	**369,273**	**375,668**
Revenue Resource Limit	**7,160**	**372,250**	**379,410**
(Surplus)/Deficit	**(765)**	**(2,977)**	**(3,742)**

Statement of Financial Position

NHS Lewisham CCG

	31-Mar-14 £'000
Total Non-current Assets	**0**
Current Assets	
Trade & Other Receivables	6,516
Cash & Cash Equivalents	38
Total Current Assets	**6,554**
Total Current Liabilities	**(28,426)**
Total Non-current Liabilities	**(453)**
Total Assets Employed	**(22,325)**
General Fund	(22,325)
Total Taxpayers' Equity	**(22,325)**

Statement of Changes in Taxpayers' Equity

NHS Lewisham CCG

	General Fund	Revaluation Reserve	Total
	£'000	£'000	£'000
CCG Balance at 01 April 2013	0	0	**0**
Transfer of assets and liabilities from closed NHS bodies as a result of the 1 April 2013 transition	0	0	**0**
Adjusted CCG Balance at 01 April 2013	**0**	**0**	**0**
Changes in CCG Taxpayers' Equity for 2013-14			
Net operating costs for the financial year	(375,668)	0	**(375,668)**
Total revaluations against revaluation reserve	(375,668)	0	**(375,668)**
Net Recognised CCG Expenditure for the Financial Year	**0**	**0**	**0**
Net funding	353,343	0	**353,343**
CCG Balance at 31 March 2014	**(22,325)**	**0**	**(22,325)**

Statement of Cash Flows

NHS Lewisham CCG	2013-14 £'000
Cash Flows from Operating Activities	
Net operating costs for the financial year	(375,668)
Depreciation and amortisation	0
(Increase)/decrease in trade & other receivables	(6,516)
Increase/(decrease) in trade & other payables	27,264
Provisions utilised	0
Increase/(decrease) in provisions	1,615
Net Cash Inflow (Outflow) from Operating Activities	**(353,305)**
Cash Flows from Investing Activities	
Net Cash Inflow (Outflow) from Investing Activities	**0**
Net Cash Inflow (Outflow) before Financing	**0**
Cash Flows from Financing Activities	
Net funding received	353,343
Net Cash Inflow (Outflow) from Financing Activities	**353,343**
Net Increase (Decrease) in Cash & Cash Equivalents	**38**
Cash & Cash Equivalents at the Beginning of the Financial Year	**0**
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year	**38**

Better Payment Practice Code 2013/14	**By number**	**By value**
Non-NHS Payables		
Percentage of Non-NHS Trade invoices paid within target	95.09%	97.18%
Percentage of NHS Trade Invoices paid within target	96.00%	99.03%

The Better Payment Practice Code requires the CCG to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

Our plans for the future

Looking back over our first year of operation, we are building on what has worked well, and learning from what needs to improve, to produce our plans for how we will spend our annual budget of around £365 million over the next two years.

Operating Plan for 2014/15 and 2015/16

With so many challenges facing us in the NHS it is vital that we prioritise the areas that we must focus on to achieve our vision of better health for everybody in Lewisham, best care and best value. Based on extensive feedback from member practices, the public, our partners and other key stakeholders for health in Lewisham, our high level priorities for the next couple of years have been agreed to be:

Key Corporate Objectives 2014/15
Cancer - increase the rate of early detection of cancer in primary care.
Health Promotion - support the wider Public Health work on health promotion by Clinical Commissioning Facilitators working with practices
Maternity - develop and implement integrated team 'mother centred' approach for pre, and post-partum care and providing continuity of services.
Children - support the wider work of the Children's Joint Commissioning to develop and implement children's integrated care pathways for Chronic Diseases Management
End of Life Care - improve systems, processes and care pathways to support people to die in the place of their choice.
Long Term Conditions - secure the sustainable improvement in the integration of services to deliver co-ordinated care pathways for adults with long term conditions.
Integrated neighbourhood based teams - establish and sustain effective, integrated multi-organisational and multi-disciplinary teams based in the neighbourhoods, supported by joint approaches and tools.
Community based services - Commission a continuum of high quality, effective community based care services, to reduce unnecessary emergency admissions.
Mental Health - commission a mental health service system where all providers whether statutory, independent or third sector are focused on the key aims of outcomes, safety, choice and access.
Primary Care - implement with Members the priorities for local primary care development and quality improvement strategy with a particular focus on population based commissioning to improve health outcomes.
Urgent Care - commission a simpler, more effective, integrated urgent care network, working with local providers.
Quality - commission high quality care services: Develop and implement a transformation of the local nursing workforce –across primary, community, secondary and social care. Implement effective discharge planning and rehabilitation which delivers the objectives on admissions and maximises the potential for re-enablement.
Public Engagement - ensure that public engagement is intrinsic to all commissioning activities.
Health Outcomes - demonstrate the delivery of better health outcomes for the Lewisham population.
Governance - ensure the CCG have robust governance arrangements for quality, equality, finance, risk management and constitutional requirements.
Partnerships - ensure that the CCG works effectively in partnership with others to realise benefits, including improving population health outcomes.
Leadership - ensure the CCG have strong and robust leadership at all levels to proactively respond to strategic opportunities and challenges effectively.

Refreshing the CCG's Strategic Plan

We will continue to actively engage with members, residents and other key stakeholders as we refresh and update our Strategic Plan by June 2014. Our strategic plan will both inform and be informed by the wider strategic work being undertaken in collaboration with the other CCGs in south east London (Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark) and by NHS England

Sustainability Strategy

The CCG have agreed a Sustainability Policy and the first phase of a Sustainable Development Management Plan. The aim of the plan is to measure our current carbon footprint so that we can develop a realistic strategy to reduce our footprint by 80% by 2050. This is a long term plan and will focus, in 2014/15 in establishing a baseline that we will be able to report next year.

Equality and Diversity Report

Equality Delivery System

Lewisham CCG has adopted the Equality Delivery System (EDS) for the NHS. The EDS gives NHS organisations an opportunity to improve fairness in service commissioning and performance evaluation for the benefit of the whole community – patients, carers and staff. It also enhances collaboration with local stakeholders and interest groups by enabling the analysis of service commissioning, provision and performance which leads to clearer identification of equality objectives and ensures compliance with statutory equality obligations.

The EDS enabled NHS Lewisham to meet the aims of the Equality Act 2010 which is a legal requirement of all public organisations to take the necessary actions to achieve:

- elimination of unlawful discrimination
- advancement of equality of opportunity
- fostering of good relations between individuals and communities.

Lewisham CCG's constitution commits the organisation to work towards meeting the public sector equality duties of the Equality Act 2010 and reduce health inequalities. As commissioners of services, Lewisham CCG recognises that it must account for not only its own organisational equality performance but also that of the providers of services that it commissions.

When making decisions about the services to be commissioned Lewisham CCG ensures that equality and diversity intelligence informs its decisions by routinely using the Joint Strategic Needs Assessment (JSNA) and by carrying out Equality Analysis. Commissioning plans look carefully at population needs, including demographics, inequalities and access to services and set objectives to reduce health inequalities, improve outcomes for patients, ensuring services are accessible and responsive to patient needs.

Our Equality & Diversity Strategy sets out our commitment to fulfilling our equality and diversity responsibilities, as well as to improving health outcomes and reducing health inequalities in Lewisham, and within the strategy we have defined five interim Equality Objectives (to be reviewed during 2014-15). They are:

1. Improvements to primary care access are recognised as being positive for older people and people with long-term conditions
2. Improve the format and methods of materials and systems to support increased understanding of navigating the NHS System for people, including people not familiar with system
3. Ensure that discharge information that patients and GPs receive is sensible, appropriate and communicated well, including drug prescriptions that should be accurate and fully understood
4. Ensure that pathway development plans incorporate training and information for staff in all relevant settings
5. Ensure that papers that come before Lewisham CCG's major committees identify equality-related opportunities, risks and say how these risks are to be managed – this has been delivered already.

We recognise and act upon our responsibilities and duties under the Equality Act 2010 and the Human Rights Act 1988. Our commissioning processes, service access and delivery are grounded in human rights principles known as "the FREDA Principles". This means that commissioning decisions will be subject to:

- Fairness
- Respect
- Equality
- Dignity
- Autonomy

Lewisham CCG published its Public Sector Equality Duty report including Equality Objectives and Action Plan on 31 January 2014. Please click here to view the report http://www.lewishamccg.nhs.uk/news-publications/Publications%20page%20documents/Public%20sector%20equality%20duty%20annual%20report%20(april%202013-Jan2014).pdf

Achievements during 2013/14 include:

- **Public Sector Equality Duty (PSED) compliance : t**he CCG complied with the general and specific duties of the Equality Act 2010 by publishing Equality Objectives in October 2013 and publishing its first annual PSED report by 31 January 2014.

- **CCG Commissioning Strategic Plan to contribute to reducing inequalities**: an equality analysis of the CCG's strategic aims and priorities was undertaken by Lewisham Public Health. It examined the CCG's eight strategic priorities and for each one identified potential positive, negative and neutral outcomes. It concludes that overall the strategy should contribute to reducing inequalities, and highlights potential positive outcomes for disadvantaged groups and for those that share protected characteristics. Further work on equality impact assessment will be undertaken as part of the development of the CCG's commissioning plans.

- **Improving diversity in engagement:** The Public Engagement team of the CCG have been exploring additional opportunities to engage with local people and have developed relationships with local groups and representative organisations to access the voice of patients who do not usually get involved in health dialogues. This will be enhanced as we explore different models of 'social prescribing', referring patients with social, emotional or practical needs to a range of local, non-clinical services,

often provided by voluntary, community and faith sector (VCFS) organisations with in depth knowledge of local communities.

- **Equality analysis** (previously Equality Impact Assessments): An equality analysis form part of Lewisham CCG's commissioning cycle and is considered during the redesign of a service or policy to ensure that the needs of our community groups are being met. Equality Analysis is integrated into the commissioning process enabling commissioners to assess impacts and inform decision making.

  Lewisham CCG will continue to work closely with local partners and Healthwatch Lewisham to ensure that equality and diversity requirements are embedded across its business activities in accordance with the Equality Act 2010.

- **Ethnicity monitoring** - our intention is to improve ethnicity monitoring undertaken by our Quality Monitoring group – FLAG (For Learning and Action Group) - in specific service areas such as IAPT and pressure sores incidents.

Our Employees

We have a stable workforce with low levels of sickness absence (less than 1%), turnover (below 10%) and vacancy rates (5%) (all as at January 2014). These are monitored on a monthly basis.

The members report describes the CCG's approach to staff involvement, including a staff survey, equal opportunities and disability considerations in relation to staffing, statutory and mandatory training requirements and access to learning and development opportunities for our employees.

The Governance Statement summarises the number of persons of each sex who were on the Governing Body and Clinical Directors Committee.

The Remuneration Report summarises the number of other Very Senior Managers (VSM) of each sex.

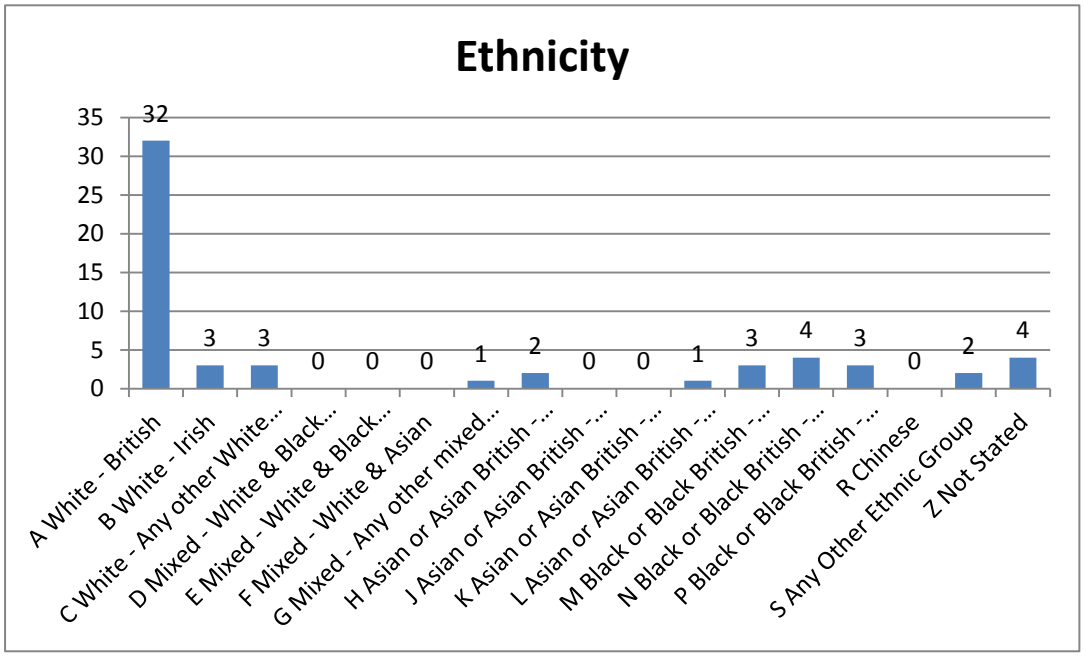
Workforce profile (January 2014)

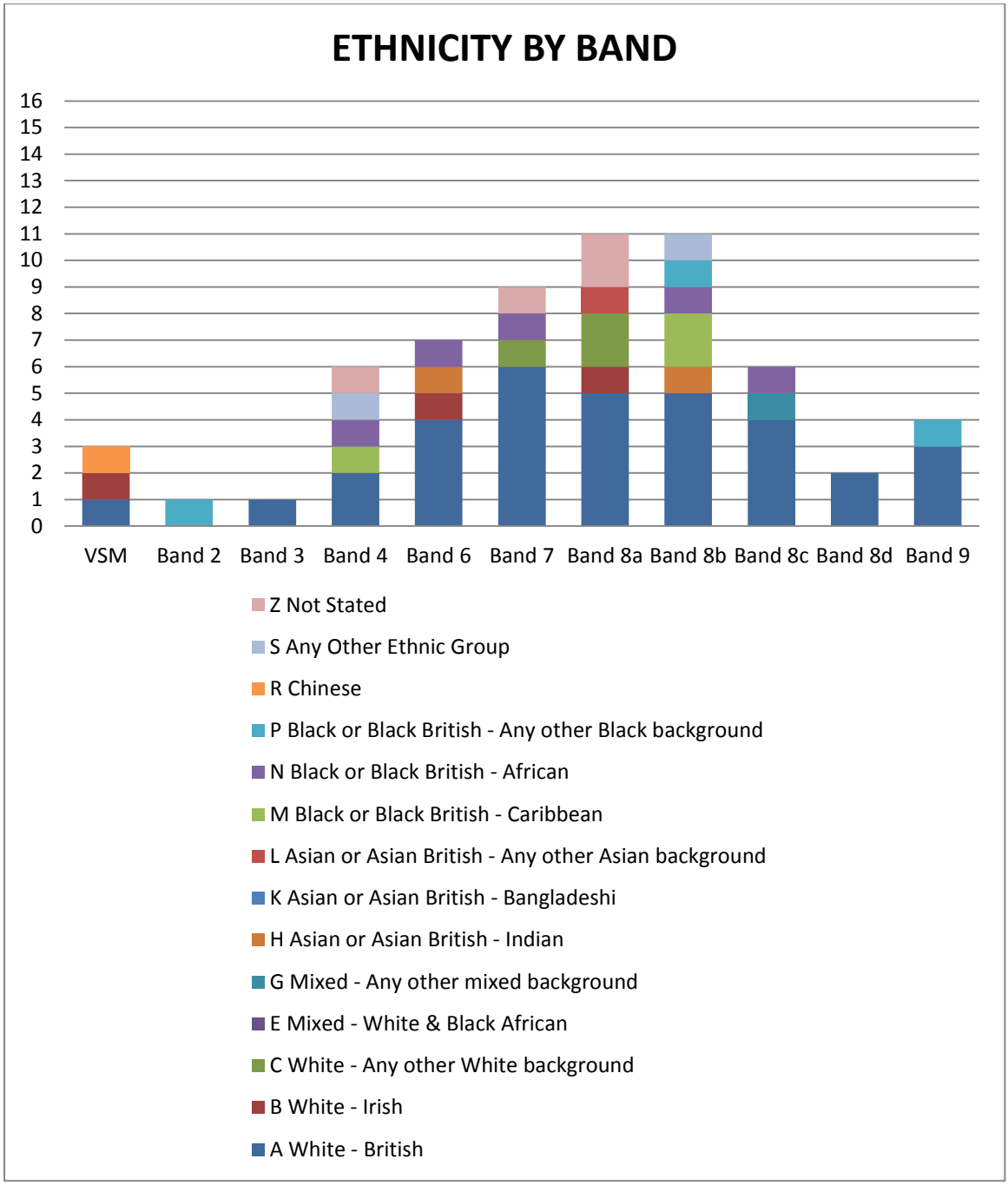
Established posts	Established posts (wte)	In post headcount	In post wte
55	51.6	53	49.08

Equalities profile (January 2014)

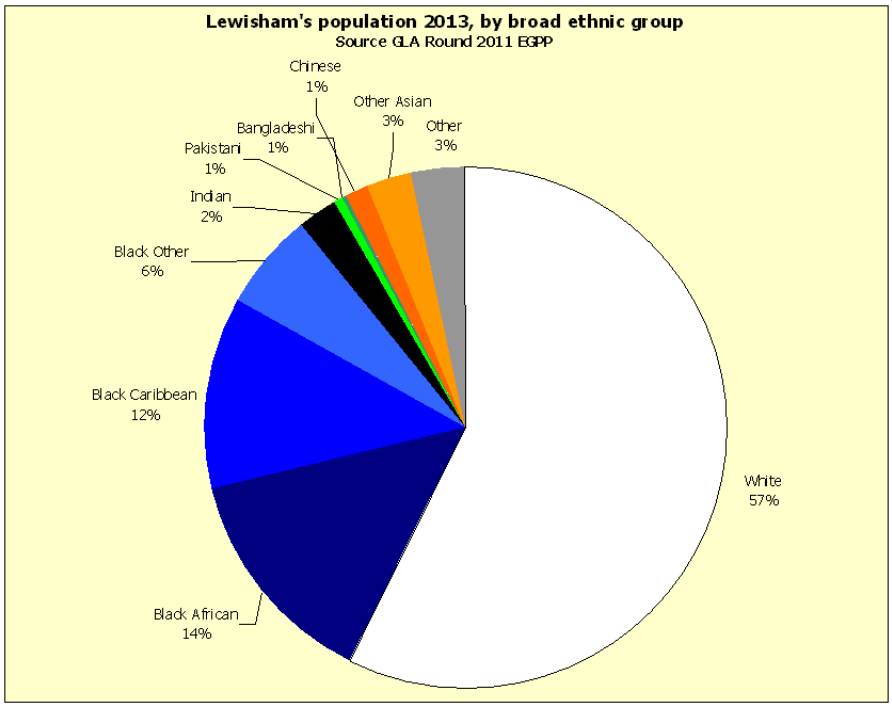
The following charts reflect the profile of the organisation (includes some hosted posts not included in the workforce headcount above), relating to six of the nine protected characteristics. On-going monitoring will help to identify any priority areas to address.

The ethnicity profile of the CCG's staff is shown in these charts:

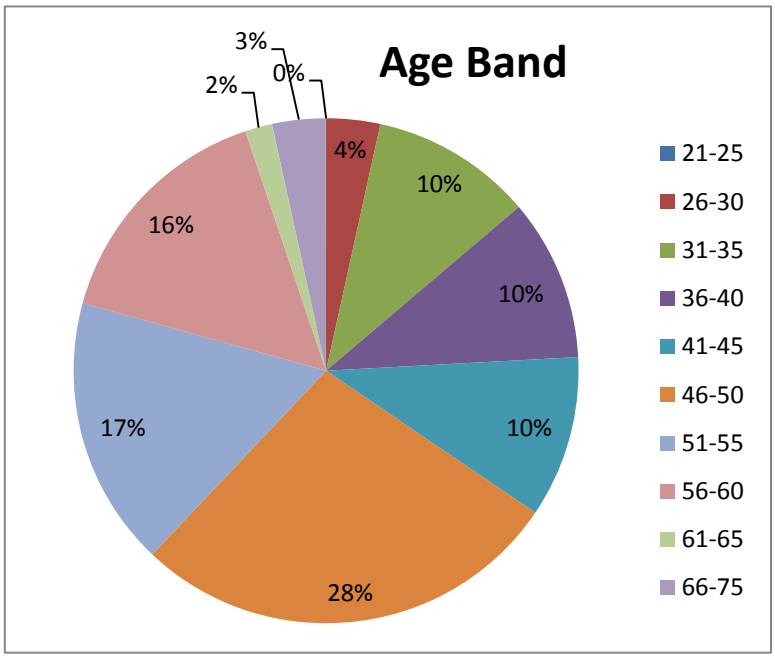


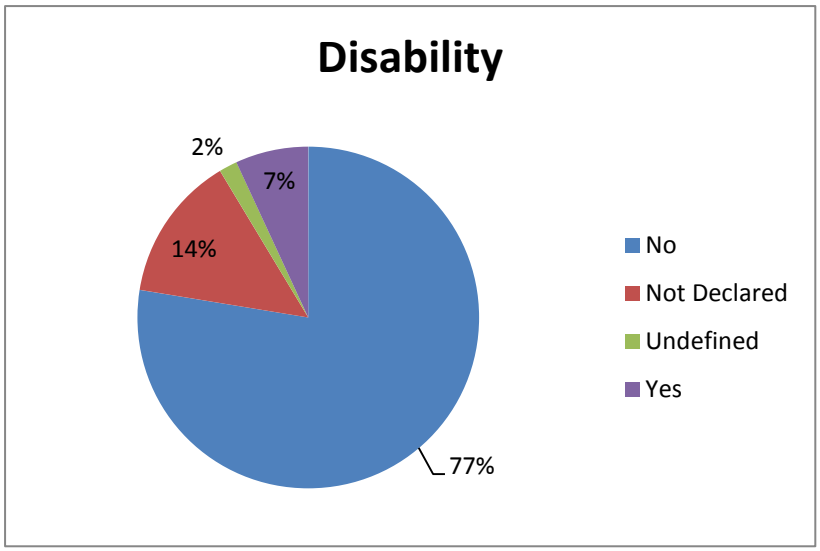

ETHNICITY BY BAND
16
15
14
13
12
11
10
9
8
7
6
5
4
3
2
1
0
VSM
Band 2
Band 3
Band 4
Band 6
Band 7
Band 8a
Band 8b
Band 8c
Band 8d
Band 9
Z Not Stated
S Any Other Ethnic Group
R Chinese
P Black or Black British - Any other Black background
N Black or Black British - African
M Black or Black British - Caribbean
L Asian or Asian British - Any other Asian background
K Asian or Asian British - Bangladeshi
H Asian or Asian British - Indian
G Mixed - Any other mixed background
E Mixed - White & Black African
C White - Any other White background
B White - Irish
A White - British

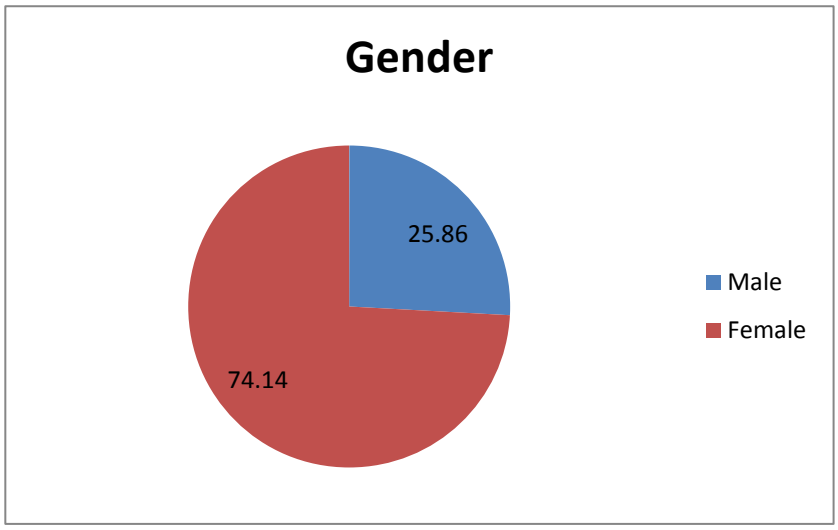
In comparison, the ethnicity profile for the population of Lewisham is as follows:

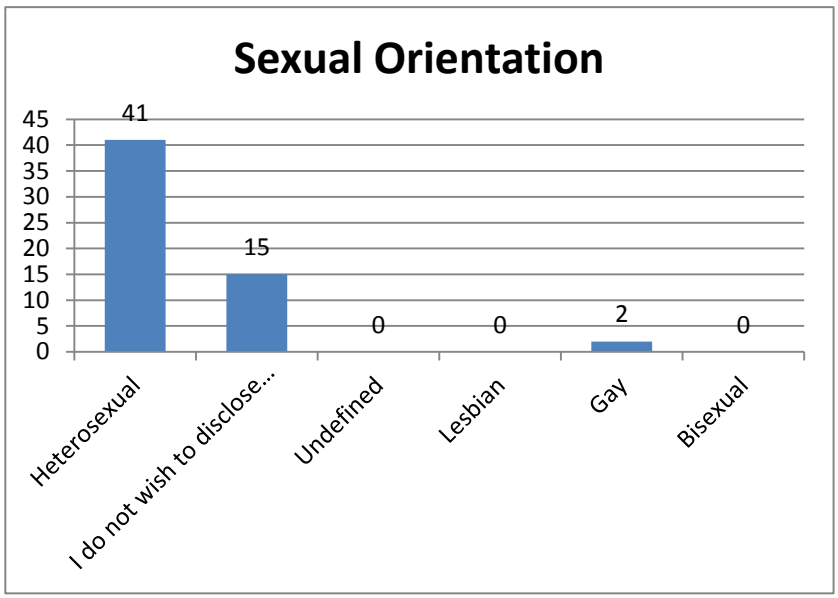


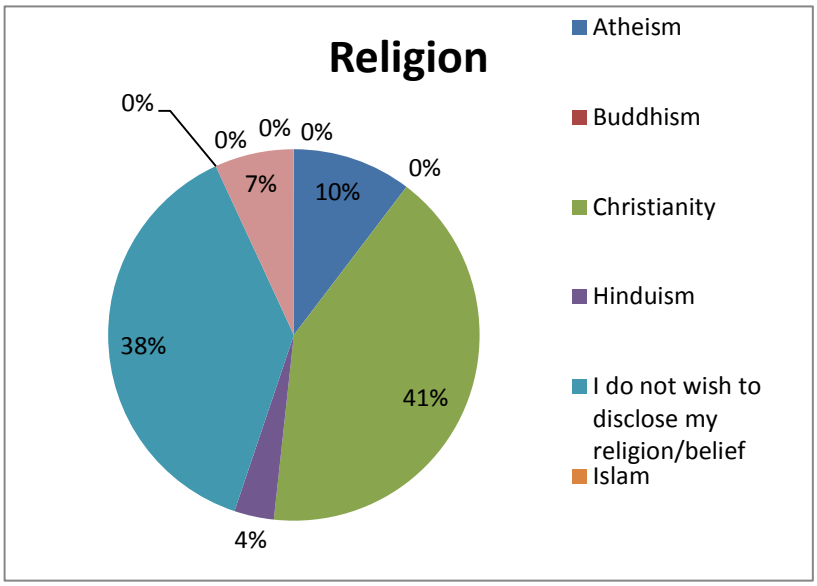
Charts showing the profile of the CCG's staffing by age, gender, disability, sexual orientation and religion are as follows




Disability
2%
7%
14%
77%
No
Not Declared
Undefined
Yes


Gender
25.86
74.14
Male
Female


Sexual Orientation
45
40
35
30
25
20
15
10
5
0
41
15
0
0
2
0
Heterosexual
I do not wish to disclose...
Undefined
Lesbian
Gay
Bisexual



Conclusion

This Strategic Report has reviewed Lewisham CCG's first year in operation and how well the CCG has progressed in delivering the strategic aims, as set out in the CCG's constitution and the NHS Constitutional standards.

At the start of 2013/14 Lewisham CCG faced a number of challenges:

- **Health Challenges** - our population is increasing, with high levels of deprivation and significant health inequalities. Overall life expectancy is improving, however the life expectancy for people living in Lewisham is shorter than for London and England. Mental health problems are greater in Lewisham. In common with other CCGs, we serve a population which is ageing and has increasing numbers of people with long term conditions. This will inevitably mean a greater demand for health and care services.

- **Re-organisational Challenges** – the CCG has different responsibilities from the previous Primary Care Trust (PCT), so had to form new relationships, building on the historical good collaborative working within Lewisham. Particularly important relationships are with other commissioning organisations, including London Borough of Lewisham, NHS England, and other CCGs to ensure that we are making the best co-ordinated plans for people in Lewisham and the best use of resources.

- **Financial Challenges** – it is estimated that the cost of healthcare for the Lewisham population is higher than the CCG's income. So the CCG will have to generate financial efficiencies in order to keep pace with the predicted costs of healthcare demand.

- **Service Challenges** – the public and members engagement activities during 2013 enabled us to hear the many concerns the public and members have about local services, including District Nursing, primary care access, availability of information for patients and the importance of integrating health and social care services. The national debate on the Francis report further highlighted the importance of quality of care, especially for vulnerable older people.

- **Provider Challenges** – in response to the TSA review and the Secretary of State's decisions, the CCG, working with other commissioning colleagues, oversaw the smooth establishment of the new Lewisham and Greenwich NHS Trust. Whilst the judicial review overturned the decision to change A&E and maternity services on the Lewisham Hospital site, NHS Lewisham Clinical Commissioning Group recognises the need to make changes to local health services in order to ensure high quality services are sustainable within available funding. The CCG will not shy away from difficult decisions in our pursuit of our goals to improve patient care and health outcomes for Lewisham people. NHS Lewisham CCG is working with the GP membership and local partners including Lewisham people, NHS providers, NHS England, other local CCGs and the London Borough of Lewisham to ensure that any changes are well planned to the best advantage of Lewisham people

Lewisham CCG has developed a clear vision – to deliver **better health, best care and best value** for everybody in Lewisham. Through dialogue and active engagement with the public we developed our five year Strategic Plan and our two year Commissioning Intentions, which is informing the refreshed SEL Strategic Plan. We believe these plans will enable us to respond effectively to the above local challenges, ensure that we use our finite resources to best effect and improve the health of Lewisham people.

We recognise that we have to do things differently in partnership with the public and our local providers. We need to shift the balance of care from emergency responses to care that is proactive and planned. It means developing local neighbourhoods and communities so that services respond to those local needs and we are better placed to tackle inequalities in the borough. Above all it means always putting the individual patient at the centre of care, seeing the whole person and empowering them to act as a partner in improving health.

This Strategic Report attempts to provide a fair review of the CCG's performance. It summarises key aspects of the commissioning work undertaken during 2013/14 and the early indication of its impact on outcomes, national standards and key performance indicators.

After just one year in operation, we believe we have demonstrated some improvements in the quality and safety of local health care, but there remains much more to do to improve patient experience, particularly in community services, maternity and inpatient care – especially around discharge of patients from hospital – and variation in quality and access to primary care services.

We believe that the new clinician-led approach to commissioning is improving the quality and safety of health care in Lewisham. Underpinning everything we do is our dialogue and engagement with Lewisham people as our belief is that by working together we can meet these challenges and achieve our goals for the people of Lewisham.

5th June 2014
Martin Wilkinson
Chief Officer

APPENDIX A

Trust Special Administrator (TSA) programme for South London Healthcare NHS Trust

The TSA programme was completed at the end of September 2013. It had achieved the dissolution of South London Healthcare NHS Trust and the safe and effective transfer of the Trust's services, staff and sites to other local NHS organisations, in accordance with the decisions of the Secretary of State for Health:

- The transfer of the Queen Mary's Sidcup site to Oxleas NHS Foundation Trust, with a range of acute hospital services to be delivered on that site by Dartford and Gravesham NHS Trust, Guy's and St Thomas' NHS Foundation Trust and King's College Hospital NHS Foundation Trust.
- The acquisition of the Princess Royal University Hospital by King's College Hospital NHS Foundation Trust
- The transfer of the Queen Elizabeth Hospital to Lewisham NHS Trust, as a merger by acquisition.
- The Secretary of State's remaining decisions were implemented as follows:
- Implementation of the efficiency savings decision for the transferred hospitals is continuing as part of the efficiency programmes of the NHS organisations to which the hospitals were transferred.
- Oxleas NHS Foundation Trust working with NHS Bexley Clinical Commissioning Group, the local authority, other NHS organisations and other partners to implement the decision to develop the Queen's Mary's Hospital site in Bexley as a vibrant hub for local services.
- The decision that vacant or poorly utilised premises should be vacated and sold where possible was partially actioned by South London Healthcare NHS Trust prior to dissolution and the NHS organisations to whom premises were transferred are continuing the programme.
- The decision that the Department of Health should pay the additional annual funds to cover the excess costs of the PFI buildings at Princess Royal and Queen Elizabeth hospitals was implemented.

The decisions made to aid implementation that:

- the Department of Health should write off South London Healthcare Trust's accumulated debt was implemented.
- the Department of Health should provide additional funds to cover the implementation of the recommendations was implemented. Additional funds were provided by the Department of Health and commissioners. The detail is set out in the NHS Trust Development Authority's board report 'Securing sustainable healthcare for the people of South East London'
- a programme board be appointed under an independent Chair, reporting to Sir David Nicholson as Chief Executive of the NHS Commissioning Board and David Flory as Chief Executive of the NHS Trust Development Authority, to ensure the changes are effectively delivered - A programme board was appointed to oversee the implementation of the changes delivered by the TSA programme. The TSA continued to act as chair of the programme board until the dissolution of South London Healthcare NHS Trust, in line with the TSA report
- the decision relating to operational service changes across south east London, subject to the amendments proposed by Sir Bruce Keogh, could not be implemented due to the outcome of Judicial Reviews.

Members' report

NHS Lewisham CCG was made up of the following member practices during 2013/14:

Practice Name	Neighbourhood	Address
Mornington Surgery	1	433 New Cross Road, SE14 6TJ
Queens Road Practice	1	387 Queens Road, New Cross, London, SE14 5HD
Kingfisher	1	Kingfisher Medical Centre, Staunton Street, Deptford, SE8 5DA
Clifton Rise	1	Clifton Rise Family Practice, Waldron Health Centre, Stanley Street, London, SE8 4BG
New Cross Health Centre	1	New Cross Health Centre, 40 Goodwood Road, New Cross, SE14 6BL
Grove Medical Centre	1	Windlass Place, London, SE8 3QH
Vesta Road Surgery	1	58 Vesta Road, London, SE4 2NH
Amersham Vale Training Practice	1	Waldron Health Centre, Stanley Street, London, SE8 6TJ
Deptford Surgery	1	502-504 New Cross Road, London, Se14 6TJ
Waldron Family Group Practice	1	Waldron Health Centre, Stanley Street, London, SE8 4BG
Deptford Medical Centre	1	2 Pearsons Avenue, SE14 6TG
Belmont Hill	2	The Surgery, 36 Belmont Hill, Lewisham, SE13 5AY
Lee High Road	2	Lewisham Medical Centre, 308 Lee High Road, Lee, SE13 5PJ
Lee Health Centre	2	Lee Health Centre, 2 Handen Road, Se12 8NP
Morden Hill	2	The Surgery, 21 Morden Hill, London, SE13 7NN
St Johns Medical Centre	2	56-60 Loampit Hill, Lewisham, SE13 7SX
The Surgery, 20 Lee Road	2	The Surgery, 20 Lee Road, Blackheath, SE3 9RT
Brockley Road	2	465-467 Brockley Road, Brockley, SE4 2PJ
Hilly Fields Medical Centre	2	172 Adelaide Avenue, Brockley, SE4 1JN
Honor Oak Group Practice	2	Honor Oak Health Centre, 20 Turnham Road, SE4 2LA
Triangle Group	2	The Triangle Group Practice, 2 Morley

Practice Name	Neighbourhood	Address
		Road, London, SE13 6DQ
Rushey Green	2	The Primary Care Centre, Hawstead Road, London, SE6 4JH
Woodlands Health Centre	2	4 Edwin Hall Place, Hither Green Lane, London, SE13 6RN
Nightingale	2	2 Handen Road, SE12 8NP
Hurley Group	2	Waldron Health Centre, Amersham Vale, London, SE14 6LD
South Lewisham	3	50 Conisborough Crescent, Catford, London, SE6 2SP
The Surgery, Torridon Road	3	The Surgery, 80 Torridon Road, Catford, SE6 1RB
Downham Family Practice	3	Downham Health and Leisure Centre, 7-9 Mooreside Road, Downham, BR1 5EP
The Surgery, Downham Way	3	The Surgery, 481-483 Downham Way, Downham, Kent, BR1 5HU
The Surgery, Winlaton	3	139 Winlaton Road, Bromley, Kent, BR1 5QA
The Surgery, Chinbrook	3	32 Chinbrook Road, Grove Park, London, SE12 9TH
Parkview Surgery	3	186 Brownhill Road, Catford, London, SE6 1AT
Marvels Lane Health Centre	3	37 Marvels Lane, Grove Park, SE12 9PN
The Surgery, Muirkirk Road	3	50 Muirkirk Road, Catford, London, SE6 1BQ
The Surgery Boundfield Road	3	The Surgery, 103 Bounfield Road, Catford, SE6 1PG
Oakview Family Practice	3	190 Shroffold Road, Downham, Kent, BR1 5NJ
Baring Road Medical Centre	3	Baring Road Medical Centre, 282 Baring Road, London, SE12 0DS
Jenner Practice	4	201 Stanstead Road, Forest Hill, London, SE23 1HU
Sydenham Green Group Practice	4	26 Holmshaw Close, Sydenham, London, SE26 4TH
Woolstone Medical Centre	4	Woolstone Road, London, SE23 2TR
Sydenham Surgery	4	2 Sydenham Road, Sydenham, SE26 5QW
Wells Park Practice	4	The Wells Park Practice, 1 Wells Park Road, Sydenham, London, SE26 6JQ

Practice Name	Neighbourhood	Address
Bellingham Green Surgery	4	Bellingham Green Surgery, 24 Bellingham Green, Catford, London, SE6 3JB
Perry Vale Medical Centre	4	The Vale Medical Practice, 195-197 Perry Vale, Forest Hill, London, SE23 2JF

The Chair of the CCG was Dr Helen Tattersfield until 31st August 2013 and from 1st September the Chair of the CCG has been Dr Marc Rowland. Mr Martin Wilkinson has been the Accountable Officer for the entire year.

The Membership Body, which at NHS Lewisham CCG has been known locally as the Clinical Directors Committee (supported by wider membership structures as set out in our constitution), has comprised the seven elected GP members of the CCG's Governing Body plus the Accountable Officer (or his deputy).

During 2013/14 this included:

- Dr Helen Tattersfield (Chair) – until 31st August 2013.
- Dr Marc Rowland (Chair from 1st September 2013 – previously a Clinical Director)
- Dr David Abraham (Senior Clinical Director)
- Dr Judy Chen (Clinical Director)
- Dr Hilary Entwistle (Clinical Director)
- Dr Arun Gupta (Clinical Director)
- Dr Faruk Majid (Senior Clinical Director)
- Dr Jacky McLeod (Clinical Director – from 1st October)
- Mr Martin Wilkinson (Accountable Officer)

The Governing Body during 2013/14 has included the members of the Clinical Directors Committee shown above, Mr Tony Read, the Chief Financial Officer and four independent members:

- Dr Suparna Das (Designated secondary care doctor) – to 1st June 2013
- Prof Ami David (Designated nurse member)
- Mrs Diana Robbins (Lay member)
- Mr Ray Warburton (Lay member)

The CCG's Audit Committee comprised the following members during the year ending 31st March 2014:

- Mr Ray Warburton (Chair)
- Mrs Diana Robbins
- Dr Faruk Majid
- Dr Suparna Das (until 1st June 2013)
- Prof Ami David

Details of the members of other committees can be found in Annual Governance Statement and further details of the Governing Body and Clinical Director's Committee can be found in the Remuneration Report.

Pension liabilities
The accounting policy for pension liabilities is detailed in note 1.7.2 to the Financial Statements. Note 4.5 to the Financial Statements provides detail on the treatment of pension liabilities. The Remuneration report provides details of pension disclosures for Governing Body members and CCG Directors.

Sickness absence data
A table is included in the financial statements at note 4.3.

The CCG's Sickness Absence Policy confirms the importance of promoting and supporting the health and welfare of its employees whilst at the same time being committed to achieving excellence in terms of attendance at work. An employee assistance scheme is provided to support staff. Our policies also confirm that the CCG will ensure that it abides by its duty of care to all staff, and other such legislation in order to provide a supportive environment within which sickness absence levels can be reduced.

This can be achieved by the implementation of positive procedures and guidelines. A consistent and pro-active approach to improving attendance is being applied in the following areas:

- monitoring the attendance of staff on a regular basis
- positively reinforcing the good attendance of staff
- showing an understanding towards those who need to be absent from work on a long term basis through sickness; and dealing fairly and consistently with staff whose attendance is of concern
- ensuring that managers are supported, trained and encouraged to manage sickness absence competently, fairly and consistently in line with good practice.

Sickness absence rates are affected, among other things, by leadership and the working culture. At the CCG, there is an inclusive and supportive leadership style and culture. Our sickness absence rate is currently running at 0.96% (year to date) which is significantly lower than the NHS national average of 3.8%. Sickness absence is recorded, verified, monitored and reported (monthly in arrears) as part of the monthly HR Workforce Report to the CCG management team. Sickness absence data reported includes sickness absence reason, days lost, full time equivalent days lost, and number of episodes. It also categorises the absence by short and long term. The HR Business Partner works closely with managers to ensure that sickness absence cases are managed in a timely way and in accordance with the CCG's Sickness Absence Policy.

External audit
The external auditor for the CCG, appointed by the Audit Committee for 2013/14 was Grant Thornton UK LLP. The 2013/14 fee is £111k; including a premium for first year audit costs of £8k refunded to the CCG by the Audit Commission.

Audit Services:	£103k
Other Services	£0

Disclosure of Serious Untoward Incidents
Information relating to the disclosure of incidents involving data loss and confidentiality breaches can be found in the Annual Governance Statement.

Cost allocation and setting charges for information
We certify that the clinical commissioning group has complied with HM Treasury's guidance on cost allocation and the setting of charges for information.

Principles for remedy

The Health Service Ombudsman is responsible for handling complaints from the public that relate to maladministration and has set out the six principles which underpin this work, which are to:

- get it right
- be customer focused
- be open and accountable
- act fairly and proportionately
- put things right
- seek continuous improvement.

The CCG continues to work hard to meet the standards set within these principles, working closely with partner agencies such as Healthwatch Lewisham, providers of NHS services and NHS England to ensure a robust service which reflects the principles of being open and enabling continuous improvement to meet the needs of residents within the borough.

NHS Lewisham CCG encourages feedback, positive and negative, so that we can make improvements based directly on the concerns of patients and the public. During 2013/14, there were 16 formal complaints, of which eight were complaints regarding access and eligibility for services, for example individual funding requests considered by the CCG and access to IVF, four were sent to the complaints office for information only, 3 related to treatment and 1 to continuing care services.

The investigations into complaints about the CCG have resulted in changes and learning, for example:

1. A complaint was received about a member of staff who had conducted a care assessment, focusing on attitude and outcome of the assessment. The CCG has, as a result, reviewed communication processes in the joint commissioning team and is addressing the individual issues through the line management process. The CCG is committed to listening to the concerns raised by members of the public about its staff and acting on them to improve the delivery of services.
2. A complaint was received relating to a delay in oxygen therapy for a child. The CCG has facilitated a meeting between the family and the safeguarding children team to resolve issues that have arisen and ensure that effective communication and planning take place in the future.

Employee consultation

Organisational change is managed in accordance with the principles and procedures contained within the CCG's Organisational Change Management Policy. This policy has been recently updated and is awaiting ratification. The CCG also informally communicates with employees via a monthly staff bulletin and monthly staff briefing. The CCG is also participating in the NHS Staff Survey. This will provide the CCG with the opportunity to build up a picture of staff experience, and to compare and monitor change over time and to identify variations between staff groups. All permanent members of staff were eligible to participate between 27th January and 9th March 2014. The CCG response rate was a 68%, compared to a national response rate of 49%. The results are being communicated to staff and an action plan developed to address any issues and concerns.

Disabled employees

Disabled employees are protected under the "protected characteristics" of the Equality Act 2010. The CCG's Equality & Diversity Policy confirms that the CCG will make reasonable adjustments to working conditions or to the physical working environment where that would help overcome the practical effects of a disability. The policy also confirms that the CCG will provide support to enable disabled members of staff to participate fully in meetings and training courses. Reasonable adjustments will be taken into account and full use will be made of the advice and assistance available via current government employment initiatives when consideration is being made of a disabled applicant's suitability for a vacant post. The CCG's Sickness Absence Policy confirms that every effort will be made to facilitate an employee's return to work including making reasonable adjustments under the Disability Discrimination Act 1995 which may include applications for grants where appropriate and taking advice from Disability Advisers in the Employment Service. This policy has recently been updated and is awaiting ratification.

Emergency preparedness, resilience and response

NHS Lewisham CCG is a Category 2 responder under the terms of the Civil Contingency Act (2004). Under the terms of the Act the CCG is required to support Category 1 responders. In the NHS in London, NHS England takes the lead role for emergency preparedness, resilience and response and has developed London wide incident response plans. The CCG has played an active part in supporting the development and testing of these plans.

In addition the CCG has developed and tested its own Business Continuity Plan, which is consistent with the requirements of NHS England.

Statement as to Disclosure to Auditors

Each individual who is a member of the Membership Body at the time the Members' Report is approved confirms:

- So far as the member is aware, that there is no relevant audit information of which the clinical commissioning group's external auditor is unaware; and,

- That the member has taken all the steps that they ought to have taken as a member in order to make them self aware of any relevant audit information and to establish that the clinical commissioning group's auditor is aware of that information.

5th June 2014
Martin Wilkinson
Chief Officer

Remuneration Report

As the Accountable Officer for NHS Lewisham Clinical Commissioning Group I am required to produce and sign a remuneration report as part of the CCG's Annual Report and Accounts. I am not a member of the CCG's Remuneration Committee, which is established within the CCG's constitution and is accountable to the CCG's Governing Body. The role of the Remuneration Committee is to make recommendations to the Governing Body on determinations about the remuneration, fees and other allowances, including pensions, for members of the Governing Body and the CCG's very senior managers.

My role in the area, as delegated to me by the CCG Membership in the CCG's constitution, is to approve arrangements for discharging the CCG's statutory duties as an employer and to approve human resources polices for employees and for other person's working for the CCG.

The Remuneration Committee comprised of four members and met on two occasions during the past year. Chair of the committee is Mr Ray Warburton, Lay Member of the CCG's Governing Body. A full list of members, their roles and the number of meetings each attended is below.

Members	Role	30-May	27-Jun
Prof Ami David	Designated Nurse	Y	Y
Mrs Diana Robbins	Lay Member	Y	Y
Mr Ray Warburton	Lay Member	Y	Y
Dr Suparna Das*	Designated Secondary Care Doctor	Y	X

* Dr Suparna Das resigned her position at the CCG on the 1st June. A new Designated Secondary Care Doctor took up his post in April 2014
In addition to the members listed above, the following CCG employees provided the committee with services and/or advice which was material to the committee's deliberations.

Name	Role	Service
Mr Martin Wilkinson	Chief Officer	Advice
Mrs Lesley Aitken	Corporate Services Manager	Administration

The following persons who are not employees of the CCG also provided services and/or advice to the committee. Both are employees of NHS England at South London Commissioning Support Unit and provide specialist Human Resources support to the CCG as part of commissioning support service level agreement agreed with CCGs in south London. The CCG paid South London Commissioning Support Unit £82k for Human resources support in 2013/14.

Name	Role	Service
Ms Gail Tarburn	Head of Human Resources	Advice
Ms Caroline Linden	Human Resources Business Partner	Advice

Remuneration Policy

The Committee's deliberations are carried out within the context of national pay and remuneration guidelines, local comparability and taking account of independent advice regarding pay structures.

The CCGs remuneration policy is consistent with nationally agreed pay awards for very senior managers and Agenda for Change Terms and Conditions of Employment. The Remuneration Committee assesses the performance of staff employed on Very Senior Manager (VSM) Pay in line with the VSM Framework, comparable benchmarking and local pay arrangements and agree proposed performance assessment ratings.

Senior managers' performance related pay
The CCG does not have a policy of performance related pay for senior managers.

Senior managers' service contracts
The CCG's policy concerning senior managers' contracts is that they are on-going (reviewed on an annual basis), with a notice period of 6 months. Termination payments are calculated on the basis of one month's pay for every completed year of service.

CCG may terminate the appointment at any time and with immediate effect by making a payment in lieu of notice, as a lump sum payment equal to that of the basic salary (as at the date of termination) which would have been payable during the notice period, less income tax and national insurance contributions. Payments in lieu of notice are at the sole and absolute discretion of the CCG and with the approval of the CCG's Remuneration Committee.

Payment in lieu of notice do not include: a) any additional payments that might otherwise have been due during the period for which payment in lieu is made; b) any payment in respect of benefits one would have been entitled to receive during the period; c) any payment in respect of any holiday entitlement that would have accrued during the period for which the payment in lieu is made.

Payments to past senior managers

No significant awards were made to past senior managers during the financial year 2013/14.

Senior managers' salaries and allowances (audited)

2013-14

Name and title	Salary & Fees (bands of £5,000) £000	Taxable Benefits (rounded to the nearest £00) £000	Annual Performance Related Bonuses (bands of £5,000) £000	Long-term Performance Related bonuses (bands of £5,000) £000	All Pension Related Benefits (bands of £2,500) £000	TOTAL (bands of £5.000) £000
Martin Wilkinson	110 – 115	1.6			105 – 107.5	215 – 220
Diana Braithwaite	85 - 90	0			27.5 – 30	115 – 120
Antony Read	100 - 105	0			40 – 42.5	140 – 145
Susanna Masters	60 - 65	0			25 – 27.5	90 – 95
Alison Browne	90 - 95	0.2			42.5 - 45	135 - 140
Dr Helen Tattersfield	20 - 25					20 - 25
Dr Marc Rowland	50 - 55	0				50 - 55
Dr David Abraham	55 - 60	0				55 - 60
Dr Faruk Majid	55 - 60	0				55 - 60
Dr Judy Chen	30 - 35	0				30 - 35
Dr Hilary Entwistle	25 - 30	0				25 - 30
Dr Arun Gupta	25 - 30	0				25 - 30
Dr Jacqueline McLeod	10 - 15	0				10 - 15
Ray Warburton	10 -15	0				10 -15
Diana Robbins	5 - 10	0				5 - 10
Dr Suparna Das	0 - 5					0 - 5
Professor Ami David	10 - 15	0				10 - 15

Senior Managers' Pension Benefits (audited)

NHS Lewisham Clinical Commissioning Group is required to disclose the pension benefits for those persons disclosed in the Senior Managers' Salaries and Allowances table, where the Clinical Commissioning Group has made a direct contribution to a pension scheme.

GP members of the Governing Body are office holders and are not deemed as employees of the CCG. The posts are therefore not pensionable.

From 1 April 2013, NHS England became the employing agency for all types of GPs and pension contributions have been made by NHS England rather than the CCG. Where fees for service have been paid directly to GP practices, the practice is the employing agency and not the CCG.

During 2013-14 the CCG incorrectly collected pension contributions from two GP officer holders and paid pension contributions to the NHS Pensions Agency. The CCG has made arrangements for the contributions to be refunded and the pension records to be corrected.

Name and title	Real increase in pension at age 60 (bands of £2,500) £000	Real increase in pension lump sum at aged 60 (bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2014 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2014 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2013 £000	Cash Equivalent Transfer Value at 31 March 2014 £000	Real increase in Cash Equivalent Transfer Value £000	Employer's contribution to partnership pension £000
Martin Wilkinson	5.0 - 7.5	15.0 - 17.5	27.5 - 30.0	80 - 85	325	419	88	15
Diana Braithwaite	0.0 - 2.5	5.0 - 7.5	10.0 - 12.5	35 - 40	154	188	30	12
Antony Read	0.0 - 2.5	5.0 - 7.5	35.0 - 37.5	105 - 110	532	599	55	13
Susanna Masters	0.0 - 2.5	2.5 - 5.0	35.0 - 37.5	105 - 110	672	737	51	8
Alison Browne	0.0 - 2.5	5.0 - 7.5	20.0 - 22.5	65 - 70	418	492	66	12

Pay multiples (audited)

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in the financial year 2013/14 was £150k - £155k (pro rata). This was 3.23 times the median remuneration of the workforce, which was £46,398.

In 2013/14 no employees received remuneration in excess of the highest paid member of the Membership Body/Governing Body. Remuneration ranged from £13k to £150k.

For the purposes of calculating pay multiples remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

Off-payroll Engagements

	Number
Number of new engagements or those that reached six months in duration between 1 April 2013 and 31 March 2014.	1
Number of the above which include contractual clauses giving the CCG the right to request assurance in relation to Income Tax and National Insurance obligations.	1
Number for who assurance has been requested.	1
Of which, the number:	
For whom assurance has been received.	1
For whom assurance has not been received.	0
That has been terminated as a result of assurance not being received.	0

	Number
Number of off-payroll engagements of Membership Body and/or Governing Body members, and/or, senior officials with significant financial responsibility, during the financial year	2
Number of individuals that have been deemed " Membership Body and/or Governing Body members, and/or, senior officials with significant financial responsibility", during the financial year (this figure includes both off-payroll and on-payroll engagements)	14

One of these engagements lasted for 5 months and one for 12 twelve months. These members of the Governing Body were paid by their general practices which, in turn, were reimbursed by the CCG in compliance with HMRC guidance.

Membership Body and Governing Body profiles
The Membership Body for the NHS Lewisham CCG is known as the Clinical Director's Committee. The table below shows the list of members of the Governing Body and the Clinical Directors Committee.

Members	Role	Governing Body Member	Clinical Directors Committee Member
Prof Ami David	Designated Nurse	Y	N
Dr Arun Gupta	Clinical Director	Y	Y
Dr David Abraham	Senior Clinical Director	Y	Y
Mrs Diana Robbins	Lay Member	Y	N
Dr Faruk Majid	Senior Clinical Director	Y	Y
Dr Helen Tattersfield*	Chair	Y	Y
Dr Hilary Entwistle	Clinical Director	Y	Y
Dr Jacky McLeod	Clinical Director	Y	Y
Dr Judy Chen	Clinical Director	Y	Y
Dr Marc Rowland**	Clinical Director / Chair	Y	Y
Mr Martin Wilkinson	Chief Officer	Y	Y
Mr Ray Warburton	Lay Member	Y	N
Mr Tony Read	Chief Finance Officer	Y	N
Dr Suparna Das ***	Designated Secondary Care Doctor	Y	N

* Dr Helen Tattersfield resigned her post as Chair and member of the Governing Body effective from 1st September.

** Dr Marc Rowland became Chair of the Governing Body from 1st September, previously he had been a Clinical Director.

*** The role of Designated Secondary Care Doctor was vacant from 1st June 2013 until 1st April 2014.

Profiles of Governing Body Members and Clinical Director Committee Members

Professor Ami David MBE
Designated Nurse Member of the Governing Body.
Visiting professor of primary care nursing at London South Bank University, Non-Executive Director Medway Community Health Care; formerly Non-Executive Director NHS Bromley and senior management roles in PCTs, Strategic Health Authority, and Health Authorities.

Member of:
Governing Body
Audit Committee
Remuneration Committee

Dr Arun Gupta
Clinical Director

Partner of South Lewisham Group Practice. Previously National Clinical Lead for Choose and Book. A Lewisham GP for 14 years.

Member of:
Governing Body
Clinical Directors Committee
Strategy and Development Committee

Dr David Abraham
Senior Clinical Director
Partner of Morden Hill and a GP in Lewisham for 25 years. Former member of Lewisham PCT Professional Executive Committee.

Member of:
Governing Body
Clinical Directors Committee
Strategy and Development Committee (Chair)

Mrs Diana Robbins
Lay Member
Consultant working in health and social care, local and central government. Formerly a Non-Executive Director, South London and Maudsley NHS Mental Health Trust and for Lewisham and Guy's NHS Mental Health Trust.

Member of:
Governing Body
Audit Committee
Remuneration Committee
Strategy and Development Committee

Dr Faruk Majid
Senior Clinical Director
Partner of Hilly Fields Medical Centre and a former member of Lewisham PCT Professional Executive Committee. A Lewisham GP for 23 years.

Member of:
Governing Body
Clinical Directors Committee
Audit Committee
Delivery Committee

Dr Helen Tattersfield
Chair
Formerly chair of Lewisham Federation for practice based commissioning and neighbourhood medical lead for Lewisham PCT. GP principal of Oakview Family Practice for 21 years.

Member of:
Governing Body (Chair) – until 1st September 2013
Clinical Directors Committee (Chair) – until 1st September 2013
Strategy and Development Committee – until 1st September 2013
Delivery Committee (Chair) – until 1st September 2013

Dr Hilary Entwistle
Clinical Director
Partner of Woolstone Medical Centre for 24 years. Formerly PCT neighbourhood medical lead and co-chair of neighbourhood practice based commissioning group.

Member of:
Governing Body
Clinical Directors Committee

Delivery Committee

Dr Jacky McLeod
Clinical Director
Dr Jacky McLeod has been a Lewisham GP for 20 years. She is currently a salaried GP at the Vale Medical Centre where she has worked since 1996, and is also an experienced GP Appraiser and Tutor.
Member of:
Governing Body – from 1st October 2013
Clinical Directors Committee – from 1st October 2013
Delivery Committee – from 1st October 2013

Dr Judy Chen
Clinical Director
Partner of Rushey Green Group Practice for 17 years. Named GP for Children's Safeguarding in Lewisham.
Member of:
Governing Body
Clinical Directors Committee
Delivery Committee

Dr Marc Rowland
Chair
Partner of the Jenner Practice and formerly co-chair of neighbourhood practice-based commissioning group and vice chair of the Lewisham Federation. Has been with the practice for 34 years.
Member of:
Governing Body (Chair – from 1st September 2013)
Clinical Directors Committee (Chair – from 1st September 2013)
Strategy and Development Committee
Delivery Committee (Chair – from 1st September 2013)

Mr Martin Wilkinson
Chief Officer
Previous roles include Director of Strategy & System Management and Director of Commissioning (NHS Lewisham), Director of Service Development (Bexley Care Trust)
Governing Body
Clinical Directors Committee
Strategy and Development Committee
Delivery Committee

Mr Ray Warburton OBE
Lay Member
Consultant supporting health and social care organisations. Previously, roles in Older People & Vulnerable Adults Branch / NHS Equality Team, Department of Health, higher education and local government.
Member of:
Governing Body
Audit Committee (Chair)
Remuneration Committee (Chair)
Delivery Committee

Mr Tony Read
Chief Financial Officer
Previous roles in the NHS include senior positions in finance and strategy across south east London including Director of Strategy for NHS South East London. Tony is a Fellow of the Chartered Association of Certified Accountants.
Member of:
Governing Body
Strategy and Development Committee
Delivery Committee

Dr Suparna Das
Designated Secondary Care Doctor
Consultant anaesthetist, with previous roles as Assistant Director of South London Cardiac and Stroke Network, as well as in business and management consultancy positions. Governing Body Secondary Care Doctor role held jointly with Lambeth and Southwark CCGs.
Member of:
Governing Body (until 1st June 2013)
Remuneration Committee (until 1st June 2013)

Other senior managers
Mrs Susanna Masters
Corporate Director
Member of:
Strategy and Development Committee

Ms Diana Braithwaite
Commissioning Director
Delivery Committee

Ms Alison Browne
Nurse Director

Register of interests

Name and role in organisation	Company/ Organisation	Position/ Shareholding/ remuneration	Directorships and or other significant interests	Any connection with a voluntary or other organisation contracting for the NHS	Research funding / grants that may be received by the individual or any organisation they have a role in	Other specific interests / Any other specific relationship which the public could perceive would impair or otherwise influence the individuals judgement or actions in their role within the CCG	Personal interest or that of a family member or close friend
Dr Marc Rowland Chair	Partner in Jenner GP Practice	South East London Doctors Cooperative (SELDOC)	None	None	Small sum for GP research received by the Practice Approx £5000 to Practice	Professional Advisor to the Institute of Medical Education at the London Southbank University	
Dr Arun Gupta Clinical Director	Partner Half time – South Lewisham Group Practice	Partner South East London Doctors Cooperative (SELDOC)	None	Attend BHF Board for IKIC	None	Clinical Advisor to Public Health	
Dr Hilary Entwistle Clinical Director	Senior Partner Woolstone Medical Centre Member of SELDOC	Senior Partner South East London Doctors Cooperative (SELDOC)	None	None	None	None	
Dr David Abraham	Morden Hill	GP South East				Member of IFR panel and is	

Senior Clinical Director	Medical Practice	London Doctors Cooperative (SELDOC				remunerated for one session a month.	
Dr Faruk Majid Senior Clinical Director		GP South East London Doctors Cooperative (SELDOC)	None	None	None	None	
Martin Wilkinson Chief Officer	Lewisham CCG	Chief Officer Lewisham CCG	None	None	None	None	
Tony Read Chief Finance Officer	Lewisham CCG	Chief Financial Officer Lewisham CCG	None	None	None	None	
Aileen Buckton Director of Adult Social Care	Non-voting member Lewisham CCG	None	None	Director of Adult Social Care Lead Commissioner for Joint commissioned services (Adult)	None	None	
Ray Warburton Lay Vice Chair	Lewisham CCG	None	Director of Ray Warburton's Perspectives Limited		None	Member of the NHS Equality and Diversity Council	
Diana Robbins Lay Member	Lewisham CCG	None	None				
Dr Judy Chen	Partner Rushey Green Group	None	None	My practice supports Rushey Green Time		One of my salaried GPs is the Drug and	I am a carer in Lewisham for a

Clinical Director	Practice – practice provides cover to UCC for one day a week			Bank I am named GP for safeguarding		Alcohol lead for Lewisham and the practice provides an in-house service for community detox for alcohol. Grant Thornton UK LLP is Rushey Green Group Practice accountant.	young adult with learning difficulties. My daughter and I as her carer use the services provided by the Children's Transition Team and Adults with Learning Disabilities Team
Prof. Ami David MBE Board Member Nurse	Lewisham CCG			Director AD Community Nursing Consultant a subsidiary of Prasand International Limited specialising in risk management and offering consultancy/project management to health care organisations (private and NHS) and Royal Colleges. Visiting Professor of Nursing Leadership and Expert Practice London South Bank University. Fellow Queens Nursing Institute Nurse Member Lambeth and Southwark CCGs			

				Governing Body Nurse Member			
Dr Jacqueline McLeod Clinical Director	Practice	GP Appraiser, NHS SE London; GP Tutor, NW London Shared Services. Occasional OOH GP sessions for Lewisham Hospital UCC SELDOC					
Dr Helen Tattersfield Chair	Oakview Family Practice	GP (Proprietor) Oakview Family Practice South East London Doctors Cooperative (SELDOC)	None	Chair Downham Nutrition Partnership	None	None	Husband (Marco Lenzi) Is Business Manager
Dr Suparna Das Secondary Care Doctor	Lewisham CCG		Director e3 Intelligence Ltd Healthcare Consultancy	Lambeth and Southwark CCGs and Governing Body Secondary Care Doctor	None		

5th June 2014
Martin Wilkinson
Chief Officer

Statement of Accountable Officer's Responsibilities Requirements

The National Health Service Act 2006 (as amended) states that each Clinical Commissioning Group shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHS England). NHS England has appointed Mr Martin Wilkinson to be the Accountable Officer of the Clinical Commissioning Group.

The responsibilities of an Accountable Officer, including responsibilities for the propriety and regularity of the public finances for which the Accountable Officer is answerable, for keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Clinical Commissioning Group and enable them to ensure that the accounts comply with the requirements of the Accounts Direction) and for safeguarding the Clinical Commissioning Group's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities), are set out in the Clinical Commissioning Group Accountable Officer Appointment Letter.

Under the National Health Service Act 2006 (as amended), NHS England has directed each Clinical Commissioning Group to prepare for each financial year financial statements in the form and on the basis set out in the Accounts Direction. The financial statements are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Clinical Commissioning Group and of its net expenditure, changes in taxpayers' equity and cash flows for the financial year.

In preparing the financial statements, the Accountable Officer is required to comply with the requirements of the *Manual for Accounts* issued by the Department of Health and in particular to:

• Observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;

• Make judgements and estimates on a reasonable basis;

• State whether applicable accounting standards as set out in the *Manual for Accounts* issued by the Department of Health have been followed, and disclose and explain any material departures in the financial statements; and,

• Prepare the financial statements on a going concern basis.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my Clinical Commissioning Group Accountable Officer Appointment Letter.

Martin Wilkinson
Accountable Officer
5th June 2014

Governance Statement by the Chief Officer as the Accountable Officer of NHS Lewisham Clinical Commissioning Group

Introduction

The clinical commissioning group was licenced from 1 April 2013 under provisions enacted in the Health & Social Care Act 2012, which amended the NHS Act 2006.

The clinical commissioning group operated in shadow form prior to 1 April 2013, to allow for the completion of the licencing process and the establishment of function, systems and processes prior to the clinical commissioning group taking on its full powers.

As at 1 April 2013, the clinical commissioning group was licensed in full without any conditions.

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Clinical Commissioning Group's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me in *Managing Public Money*. I also acknowledge my responsibilities as set out in my Clinical Commissioning Group Accountable Officer Appointment Letter.

I am responsible for ensuring that the Clinical Commissioning Group is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity.

Compliance with the Corporate Governance Code

We are not required to comply with the UK Corporate Governance Code. However, we have reported on our Corporate Governance arrangements by drawing upon best practice available, including those aspects of the UK Corporate Governance Code we consider to be relevant to the CCG and best practice.

The Clinical Commissioning Group Governance Framework

Governing Body

The National Health Service Act 2006 (as amended), at paragraph 14L(2)(b) states:
"The main function of the governing body is to ensure that the group has made appropriate arrangements for ensuring that it complies with such generally accepted principles of good governance as are relevant to it."

The CCG is governed by its constitution, signed by all the CCG's members. The constitution sets out the CCG's governance structures and processes including the role of the Governing Body and its individual members. In summary, each member of the Governing Body shares responsibility as part of a team to ensure that the group exercises its functions effectively, efficiently and economically, with good governance and in accordance with the terms of its constitution. Each Governing Body member brings their unique perspective, informed by their skills, knowledge and experience.

During the year, the Governing Body:

- has been responsible for approving the functions of the group
- led the development of our vision as set out in our 5-year strategic plan
- signed off the two-year commissioning plan and monitored in year performance
- Received an integrated performance report, with additional exception reports, through which the Governing Body has been advised of the quality and safety of commissioned services and other performance and financial issues. Where necessary the Governing Body has taken appropriate action.

- received and taken assurance that strategic risks were effectively mitigated
- ensured that all conflicts of interest or potential conflicts of interest were effectively managed
- strengthened the strategic working relationship with the Lewisham Health and Well-Being Board and has contributed to the development and implementation of the Health and Well-Being Strategy in partnership with our colleagues at the London Borough of Lewisham and other members of the Health and Well-Being Board
- worked jointly more recently with the Local Authority, local providers and the public to take forward the integration of adult and children's services. This work has been supported by our planning for the Better Care Fund.

There were eight meetings of the Governing Body held in public during the year. All of the meetings were well attended and were quorate. The table below shows the Governing Body members and attendance record. The Governing Body and all other committees discussed below were supported by the CCG management team, with appropriate attendance, as required.

Members	Role	April	May	July	Sept	Oct	Dec	Feb	March
Prof Ami David	Designated Nurse	Y	Y	Y	X	Y	Y	Y	Y
Dr Arun Gupta	Clinical Director	Y	Y	Y	Y	Y	Y	X	Y
Dr David Abraham	Senior Clinical Director	Y	Y	Y	Y	X	Y	Y	Y
Mrs Diana Robbins	Lay Member	Y	Y	Y	Y	X	Y	Y	Y
Dr Faruk Majid	Senior Clinical Director	Y	Y	X	Y	Y	Y	Y	Y
Dr Helen Tattersfield*	Chair	Y	Y	Y	Resigned 1st September				
Dr Hilary Entwistle	Clinical Director	Y	Y	Y	Y	Y	X	X	Y
Dr Jacky McLeod	Clinical Director	Joined 1st October					Y	Y	Y
Dr Judy Chen	Clinical Director	X	Y	Y	X	X	Y	Y	X
Dr Marc Rowland**	Clinical Director / Chair	Y	X	Y	Y	Y	Y	Y	Y
Mr Martin Wilkinson***	Chief Officer	X	Y	Y	Y	Y	Y	Y	Y
Mr Ray Warburton	Lay Member	Y	Y	Y	Y	Y	Y	Y	Y
Mr Tony Read	Chief Financial Officer	Y	Y	Y	Y	Y	Y	Y	Y
Dr Suparna Das ******	Designated Secondary Care Doctor	Y	Y	Resigned 1st June					

* Dr Helen Tattersfield resigned her post as Chair and member of the Governing Body effective from 1st September.
** Dr Marc Rowland became Chair of the Governing Body from 1st September, previously he had been a Clinical Director.
*** Mr Tony Read deputised for Mr Martin Wilkinson on 4th April.
**** The role of Designated Secondary Care Doctor was vacant from 1st June 2013 until 1st April 2014.
Absences are normally agreed with the Chair as members are frequently required to attend other meetings.

The Governing Body's self-assessment of its effectiveness during 2013-14 was undertaken as a workshop on 3rd April 2014. The Governing Body used the NHS Leadership Academy's 'The Healthy NHS Board 2013, Principles for Good Governance' as the basis for its assessment.

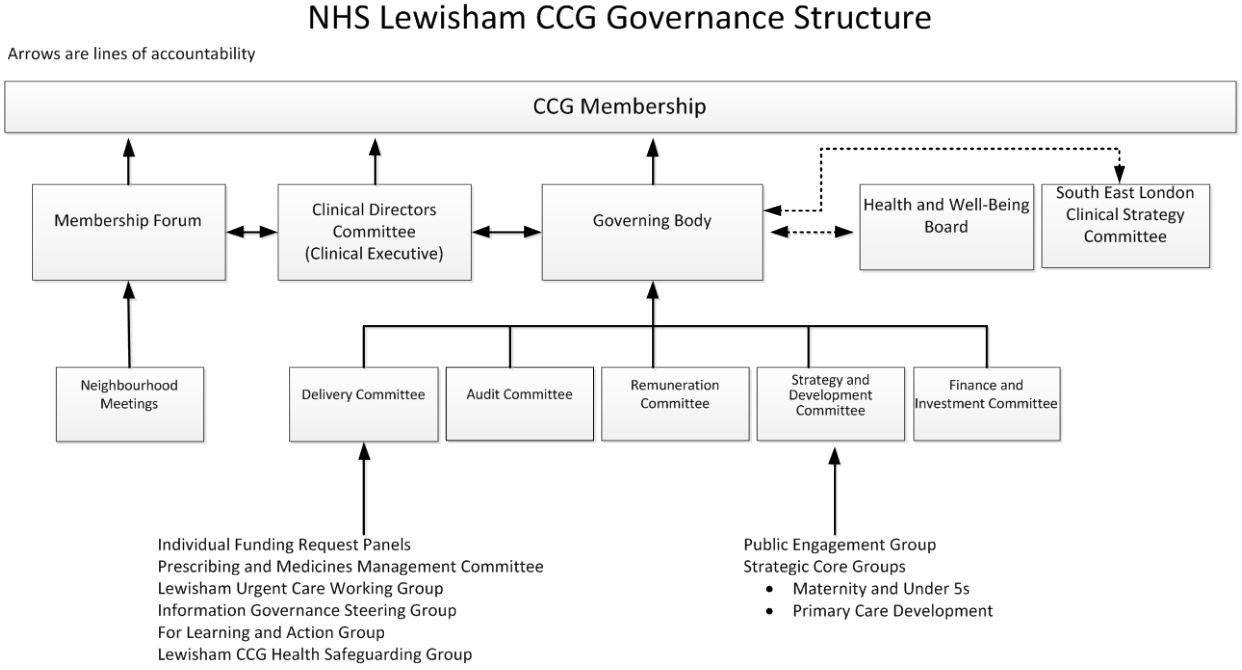
The members of the Governing Body assessed their collective and individual contributions to the leadership roles of formulating strategy, ensuring accountability, and shaping organisational

culture. The Governing Body reviewed how these roles are supported and informed by knowledge and understanding of the CCG's external context, information and intelligence, and engagement with patients and the public, the CCG membership, staff, and partners.

Recommendations for further development included ensuring greater clarity of the decision-making journey for recommendations that are made to the Governing Body, improving public involvement in Governing Body meetings held in public, greater use of clinical audit to support performance information, and reviewing its risk appetite.

In addition a shared committee was established with the other CCGs in South East London. The South East London Clinical Strategy Committee was established to develop a collaborative approach to commissioning decisions across South East London, particularly where these decisions impact on the populations of more than one CCG.

The CCG is a membership organisation with a federated structure. The organisational chart below shows the governance structures in place during the financial year ending 31st March 2014.



The chart indicates the inter-relationship between membership bodies on the left (the Clinical Directors' Committee, Membership Forum and Neighbourhood Meetings) and the key governance committees, headed by the Governing Body in the centre of the chart. The chart also shows the important links with our partner organisations including the Lewisham Health and Well Being-Board and the South East London Clinical Strategy Committee.

Clinical Directors Committee

The Clinical Directors Committee has been a standing Committee of Lewisham CCG, made up of the seven GPs elected to the Governing Body by the CCG members and included the Chief Officer. It has been the high level membership body to provide a formal connection, transacted through the Membership Forum, between the on-going business of the Governing Body and CCG member practices. It provided a vehicle in which the Clinical Directors sought and considered ideas, views and concerns from members and galvanised their support and participation to deliver the CCG's objectives.

During the year the work of the Clinical Directors Committee included:

- influenced the development of the CCG's strategic plans ensuring that the membership's views were incorporated
- promoted the CCG's strategic plans with the membership ensuring engagement, support and participation
- agreed plans for pathway redesign including for Chronic Obstructive Pulmonary Disease, heart disease, diabetes and asthma.
- discussed feedback from members about the quality of local services

There were eleven meetings of the Clinical Directors Committee during the year. All of the meetings were well attended and were quorate. The table below shows the members and attendance record. The Clinical Directors Committee was supported by the CCG management team, with appropriate attendance, as required

Members	Role	April	May	June	July	Aug	Sept	Oct	Nov	Jan	Feb	March
Dr Arun Gupta	Clinical Director	X	Y	Y	Y	Y	Y	Y	X	Y	Y	Y
Dr David Abraham	Senior Clinical Director	Y	X	Y	X	X	Y	Y	Y	Y	Y	Y
Dr Faruk Majid	Senior Clinical Director	Y	Y	Y	Y	Y	Y	X	Y	Y	Y	Y
Dr Helen Tattersfield*	Chair	Y	Y	Y	Y	Y	Resigned 1st September					
Dr Hilary Entwistle	Clinical Director	Y	Y	Y	Y	X	X	Y	Y	Y	Y	Y
Dr Jacky McLeod	Clinical Director	Joined 1st October						Y	X	Y	Y	Y
Dr Judy Chen	Clinical Director	Y	X	X	Y	X	Y	X	X	X	Y	Y
Dr Marc Rowland**	Clinical Director / Chair	X	Y	Y	Y	Y	Y	X	Y	X	X	Y
Mr Martin Wilkinson***	Chief Officer	Y	X	X	X	Y	X	Y	Y	X	X	Y

* Dr Helen Tattersfield resigned her post as Chair and member of the Clinical Directors Committee effective from 1st September.
** Dr Marc Rowland became Chair of the Clinical Directors Committee from 1st September, previously he had been a Clinical Director.
*** Deputies for Mr Martin Wilkinson included the Corporate Director (May and February), the Commissioning Director (June, September and January), and the Chief Financial Officer (July) Absences are normally agreed with the Chair as members are frequently required to attend other meetings.

Audit Committee
The committee was established to take an independent and objective view of the CCG's financial systems, compliance with laws and compliance with best practice in its arrangements for corporate governance.

During the year, the work of the Audit Committee included:

- induction, for which independent support was provided
- discussing the Internal Audit plan for 2013/14 and commenting on the reports of the reviews
- approving the Counter Fraud Work Plan for 2013/2014 and reviewing relevant policies

- reviewing the CCG's governance arrangements and the relationships between committees
- supporting the establishment of a Finance and Risk Working Group
- inquiring about the scope and range of clinical input into commissioning decisions which led to a CCG workshop to strengthen "clinical commissioning"
- approving the appointment of internal and external auditors
- scrutinising financial processes to learn lessons from elsewhere, such as from Croydon Primary Care Trust
- scrutinising and advising on the format and content of the Board Assurance Framework, including deeper dives into particular high risks.

There were four meetings of the Audit Committee during the year. The table below shows the members and attendance record. The Audit Committee was supported by the CCG management team, with appropriate attendance, as required. The Chief Financial Officer was in attendance at all the meetings.

Members	Role	July	Oct	Jan	March
Prof Ami David	Designated Nurse	Y	Y	Y	Y
Mrs Diana Robbins	Lay Member	Y	Y	Y	Y
Dr Faruk Majid	Senior Clinical Director	X	Y	Y	Y
Mr Ray Warburton	Lay Member	Y	Y	X	Y
Vacant*	Designated Secondary Care Doctor	X	X	X	X

* The Designated Secondary Care Doctor resigned her position at the CCG on the 1st June. A new Designated Secondary Care Doctor took up his post in April 2014.

Remuneration Committee

The Remuneration Committee has been responsible for approving the terms and conditions, remuneration and travelling or other allowances for Governing Body members, including pensions and gratuities in addition to the terms and conditions of employment for all employees.

During the year, the Remuneration Committee agreed levels of remuneration for Governing Body members.

There were two meetings of the Remuneration Committee during the year. The table below shows the members and attendance record. The Remuneration Committee was supported by the CCG management team, with appropriate attendance, as required. Due process was followed when conflicts of interest occurred during meetings.

Members	Role	30-May	27-Jun
Prof Ami David	Designated Nurse	Y	Y
Mrs Diana Robbins	Lay Member	Y	Y
Mr Ray Warburton	Lay Member	Y	Y
Dr Suparna Das*	Designated Secondary Care Doctor	Y	X

* Dr Suparna Das resigned her position at the CCG on the 1st June. A new Designated Secondary Care Doctor took up his post in April 2014

Strategy & Development Committee

The Strategy and Development Committee was established to set and maintain the CCG's strategic direction for commissioning and to develop formal strategic and operational plans for approval by the Governing Body.

The committee established a number of sub groups to develop detailed operational plans, including public engagement.

There were six meetings of the Strategy and Development Committee during the year. The table below shows the members and attendance record. The Strategy and Development Committee was supported by the CCG management team, with appropriate attendance, as required.

Members	Role	04-Apr	06-Jun	01-Aug	07-Nov	02-Jan	06-Mar
Dr Arun Gupta	Clinical Director	Y	Y	Y	Y	Y	X
Mr Charles Malcolm-Smith	Head of Strategy & Organisation Development	Y	Y	Y	Y	Y	Y
Dr David Abraham	Senior Clinical Director	Y	Y	Y	Y	Y	Y
Mrs Diana Robbins	Lay Member	Y	Y	Y	Y	Y	Y
Dr Helen Tattersfield	Chair	Y	Y	X	Resigned 1st September		
Dr Marc Rowland	Clinical Director	Y	Y	Y	Y	Y	Y
Mr Martin Wilkinson*	Chief Officer	X	X	Y	Y	X	Y
Mrs Susanna Masters	Corporate Director	X	Y	Y	Y	Y	Y
Mr Tony Read	Chief Financial Officer	Y	X	Y	Y	X	X

*Deputies for Mr Martin Wilkinson included the Chief Financial Officer (April) and the Corporate Director (June and January).

During the year, the work of the Strategy and Development Committee included:

- developing the CCG 5-year strategic plan in alignment with the strategy of the Health and Well-Being Board
- developing a public engagement strategy
- working in partnership with the Local Authority for a joint bid for improved children's services
- developing a strategy to improve end of life care in nursing homes
- developing an integration strategy for adult services that was shortlisted for "Integrated pioneer" and was the basis for the allocation of the Better Care Fund.
- developing a Joint Carer's Strategy

Delivery Committee

The Delivery Committee was established to monitor the performance of commissioned health services in all aspects and to monitor delivery of the CCG's operational plans. The committee reviewed the CCG's position against key performance, quality and financial metrics, and identified mitigating steps where delivery was off-track.

The Delivery Committee established a number of subgroups to monitor performance against plans in detail and these included groups to monitor quality, information governance and risk management.

There were twelve meetings of the Delivery Committee during the year. The table below shows the members and attendance record. The Delivery Committee was supported by the CCG management team with appropriate attendance as required.

Members	Role	April	May	June	July	August	Sept	October	Nov	Dec	January	Feb	March
Ms Diana Braithwaite	Commissioning Director	Y	Y	Y	Y	Y	X	Y	Y	X	Y	X	X
Dr Faruk Majid	Senior Clinical Director	X	Y	Y	Y	Y	Y	Y	Y	X	Y	Y	Y
Dr Helen Tattersfield	Chair	Y	Y	Y	Y	Y	Resigned 1st September						
Dr Hilary Entwistle	Clinical Director	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	X
Dr Jacky Mcleod	Clinical Director	Joined 1st October						Y	Y	Y	Y	Y	X
Dr Judy Chen	Clinical Director	Y	Y	X	Y	Y	Y	Y	Y	X	Y	X	Y
Dr Marc Rowland	Clinical Director	Replaced Dr Tattersfield					X	Y	X	Y	X	Y	X
Mr Martin Wilkinson	Chief Officer	Y	Y	X	X	Y	X	Y	Y	Y	Y	X	Y
Mr Ray Warburton	Lay Member	Y	Y	Y	Y	Y	Y	Y	Y	X	X	Y	Y
Mr Tony Read	Chief Financial Officer	Y	X	Y	X	X	Y	Y	Y	Y	Y	Y	Y

During the year the work of the Delivery Committee included supporting and monitoring plans which:

- improved health promotion interventions for smoking cessation, alcohol use and healthy weight
- improved services for mothers and infants
- improved management of pressure sores
- improved management of long term conditions including respiratory disease, diabetes, heart failure and cardiovascular disease
- improved services for people with dementia
- improved GP referrals to hospitals
- improved governance and quality processes
- the Delivery Committee reviewed work that the CCG found particularly challenging during the year and recommended solutions. Such work included:
- where performance was below plan, such as:
    - recovery rates for psychological therapies
    - waiting times at accident and emergency services
    - 62-day wait from referral to first definitive treatment for cancer
    - 18 week referral to treatment targets in some service areas
    - 52 week waits at one provider
- where quality of services did not meet expected standards, such as
    - with aspects of community nursing services
    - with aspects of post natal care
    - with pressure sore management
    - with communications between services, particularly at discharge from hospital

The Risk Management Framework

In line with good practice, the CCG adopted a risk management process which has been designed to provide continuous identification, assessment, control, communication and

monitoring of risk with clear escalation processes. When faced by risks, the CCG takes a positive and controlled approach to risk management, acceptable to the Governing Body, as described below.

Risks to achieving the CCG's objectives and business plans were identified at project or programme board meetings, at assurance committees when inadequate or no assurances were given or at routine business meetings. Wherever a risk was identified the escalation route was the same.

Project and programme risks were assessed and managed at the project or programme management level. Where risks were considered to have an impact on the CCG's corporate objectives, these were escalated to the Risk Management Group. The role of the Risk Management Group has been to:

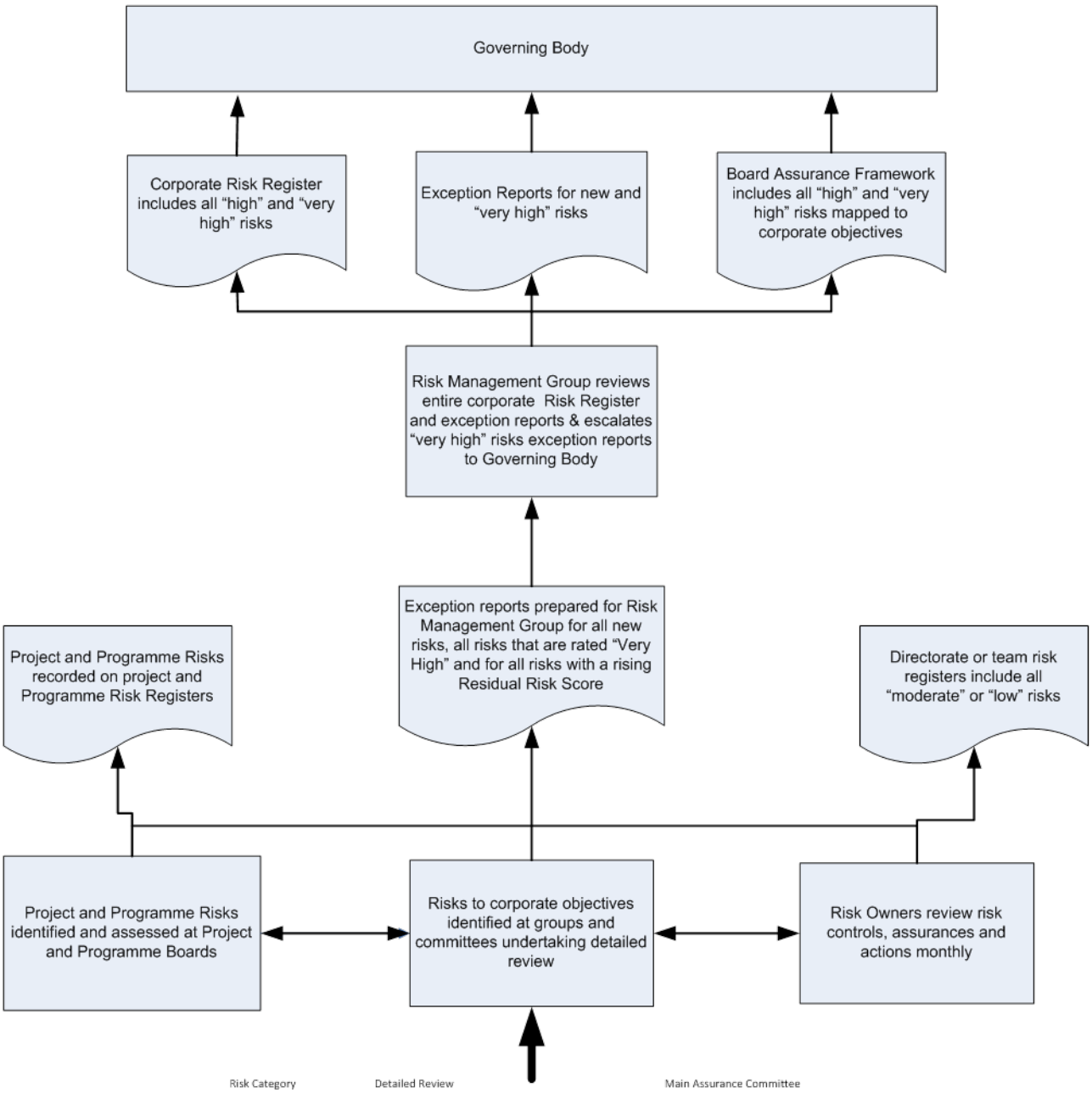
- review, evaluate and agree exception reports for new and amended risks and instruct that the Risk Register is updated accordingly.
- review and evaluate exception reports for new and "very high" risks and recommend these to the Governing Body
- review the risk register by scrutinising the existing controls and assurances ensuring that the register is an accurate summary of the risks to the organisation and recommend the Risk Register and the Board Assurance Framework to the Governing Body.

"Risk owners" at Director or senior manager level were assigned to all risks and risk owners have been responsible for identifying controls and actions to mitigate risks to target levels. Controls have included the development of policies, for example for the management of personal confidential data, mandatory training programmes, in safeguarding and fraud prevention, and the development of strategies and action plans to mitigate risks to achieving our corporate objectives. All this information has been collated over the year in the Board Assurance Framework which is discussed at the meetings of the Governing Body.

The management of risk is the duty of all staff, inclusive of the reporting of incidents and near-misses in accordance with the policies and procedures in place. All managers are accountable for the day-to-day management of risks within their areas of responsibility, ensuring assessments are undertaken and risk registers updated with action plans as appropriate regularly updated. Directors are responsible for providing risk management leadership and sponsorship across the CCG.

The chart below illustrates how risks have been identified and escalated through the organisation to the Governing Body. The bottom of the chart includes a table which shows the type of risk, shown here as the "risk category," the committee or work group where detailed review of the risk and controls took place and the main assurance committee that held oversight of the risk. The main body of the chart shows how risks are escalated to the Governing Body.

Lewisham CCG Risk identification and Escalation Process



Risk Category	Detailed Review	Main Assurance Committee
Change / Transition	Programme Management Meeting	Delivery Committee
Clinical and Quality	Clinical Quality Review Groups	Delivery Committee
	Public Engagement Group	
	Core Contract Meetings	
	Patient Safety Advisory Group	
	NHS Lewisham CCG Health Safeguarding Group	
	Pharmacy and Medicines Management Committee	
	For Learning and Action Group	
Environmental	Senior Management Team	Delivery Committee
Financial	Finance and Risk Group	Delivery Committee
Governance	Senior Management Team	Delivery Committee
Information Governance	Information Governance Steering Group	Delivery Committee
Information Management & Technology	Senior Management Team	Delivery Committee
Operations	Senior Management Team	Delivery Committee
Partnership and Contractual	Core Contract Meetings	Delivery Committee
People	Senior Management Team	Delivery Committee
Reputation	Patient Engagement Group	Delivery Committee
	Senior Management Team	
Strategic	Strategy and Development Committee	Delivery Committee (in year)
		Health and Well Being Board

The Assurance Framework is a key process for the identification and control of risks, and is designed to provide the CCG with assurance that the organisation is effectively managing, or

has plans in place designed to manage risks that may threaten the achievement of the organisation's corporate objectives which are reviewed annually.

The Assurance Framework ensures:

- a comprehensive method is established for the effective and focussed management of the principal risks to meeting the CCG's objectives.
- the Governing Body is confident that its principal objectives can be achieved.
- strategic controls are in place to manage those risks.
- the Governing Body is satisfied with assurance that the controls are effective and risks are managed appropriately.
- positive assurances are identified along with gaps in controls and/or assurances.

The risk controls in place, enable the CCG to determine whether the risks are being managed effectively through:

- policies, procedures and guidelines.
- education, training and staff development.
- equipment and facilities.
- staff competency.
- induction programme.
- any other measures deemed necessary.

The Assurance Framework has been improved and developed during the year following discussions with the Audit Committee and Governing Body members. Improvements have included work to identify gaps in assurance, providing more details of evidence of assurance and adding greater details of planned mitigation actions. The CCG has also responded positively to in-year recommendations from Internal Audit.

Equality Impact Assessments (EIA) are a core part of policy, strategy and project development within Lewisham CCG. The NHS Lewisham CCG Policy on Policies ensures that there is a regulated approach to the development of policies and procedural documents and a requirement for all policy and procedural documents developed by the CCG and for the CCG to describe how they meet the Public Sector Equality Duty.

EIA training has been provided to facilitate understanding behind the principles and practical application of the assessments. Support, guidance and tools are provided by the Equality and Diversity team on an on-going basis. The team has supported the CCG to assess a wide range of areas including strategies, policies, commissioning plans and QIPP projects.

As a key partner, Healthwatch Lewisham provided a representative voice of patients from the many diverse communities in Lewisham into our risk management processes. Their involvement in the CCG structure included membership of our Public Engagement Group, our For Learning and Action Group, which reviewed 'quality' in respect of patient safety, clinical effectiveness and patient experience of the services we commissioned for our population, and membership of the Clinical Quality Review Groups for Lewisham and Greenwich NHS Trust and for the South London and Maudsley NHS Foundation Trust.

As representatives of local people, Healthwatch Lewisham has added a valuable voice of local people. A significant recent initiative driven by the CCG in partnership with our partners including Healthwatch Lewisham, was the delivery of a large public listening event 'Quality in Health and Social Care; A People's Summit', which attracted 100 residents to discuss quality, aspirations and expectations with service providers listening to understand the patient voice. Learning from this public event will inform our approach to risk management for 2014/15 as well as our wider commissioning responsibilities.

The Clinical Commissioning Group Internal Control Framework

A system of internal control is the set of processes and procedures in place in the clinical commissioning group to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness.

Information Governance

The NHS Information Governance Framework sets the processes and procedures by which the NHS handles information about patients and employees, in particular personal identifiable information. The NHS Information Governance Framework is supported by an information governance toolkit and the annual submission process provides assurances to the clinical commissioning group, other organisations and to individuals that personal information is dealt with legally, securely, efficiently and effectively.

We place high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. We have established an information governance management framework and are developing information governance processes and procedures in line with the information governance toolkit. We have ensured all staff undertake annual information governance training and have implemented a staff information governance handbook to ensure staff are aware of their information governance roles and responsibilities.

There are processes in place for incident reporting and investigation of serious incidents. We are developing information risk assessment and management procedures and a programme will be established to fully embed an information risk culture throughout the organisation.

The CCG's Information Governance Framework has been reviewed and reiterated during 2013/14. This is so that our Information Governance Framework reflects appropriately the implications of the Health and Social Care Act 2012 and the NHS Constitution.

The CCG's Information Governance Framework is established as a key and integral part of the CCG's Risk Management Assurance Framework. The Information Governance Framework requires review, decision making and directions at senior level governance forums such as the Governing Body and the Delivery Committee.

A Senior Information Risk Owner (SIRO) role that is accountable for leading the information risk culture and approach of the CCG has been put in place in line with NHS requirements. The Chief Financial Officer of the CCG fulfils the SIRO role.

The Senior Information Risk Officer (SIRO) is responsible for:

- Understanding how the strategic business goals of the CCG may be impacted by information risks: acting as an advocate for information risks on the Board and in internal discussions.
- Ensuring the Board is adequately briefed on information risk issues.
- Overseeing the development of an Information Risk Policy, and a strategy for implementing the policy within the CCG's Information Governance Framework.
- Reviewing the annual information risk assessment to support and inform the Annual Governance Statement.
- Taking ownership of risk assessment processes for information risks, supported by the Information Governance Manager, Information Security Lead, Records Manager and the Caldicott Guardian.
- Reviewing and agreeing action in respect of identified information risks.

- Providing a focal point for the resolution and/or discussion of information risk issues.

A separate Caldicott Guardian role is also now established to act as the conscience of the organisation regarding confidentiality and privacy matters affecting individual persons and to avoid a potential conflict of interest with the organisational responsibilities of the SIRO. The Director of Nursing fulfils the Caldicott Guardian role.

Support from the Lay Member for Governance helped assure that the requirements of the Information Governance Toolkit were achieved.

A developing governance model of Information Asset Owners and Information Asset Administrators and the South London Commissioning Support Unit provide assurance, support and expertise to the SIRO and Caldicott Guardian.

Both officers and the supporting governance model satisfy the requirements of NHS Information Governance policy as demonstrated by the achievement of Level 3 assurances on the NHS Information Governance Toolkit requirements that relate to the Information Governance accountability requirements for CCG's.

Risk Based Approach to Information Governance
The CCG's developmental approach to Information Governance is being taken forward through a risk based Information Governance approach.

The CCG recognises that culture is a strong influence and determinant of fair, proportionate and cost effective information risk decision-making outcomes.

The CCG therefore addresses the human element factor of information risk as a core part of its information risk approach. It has ensured the uptake of Information Governance Training by at least 95% of its staff. The SIRO has in addition undertaken additional strategic information risk management training.

As part of its risk based Information Governance approach, the CCG utilises the online NHS Information Governance Toolkit to assess and demonstrate its capacity and capability to satisfy the rapidly evolving information risk issues that relate to the handling of information.

The CCG has in its first year as a fully established statutory organisation satisfied the requirements of the Information Governance Toolkit and achieved an overall score of eighty per cent (80%). This was the highest score in South London, second best in London and 14th best in England.

The CCG has procured an information risk organisational development information risk management product to engage with and support staff and the CCG in iterating risk assessments regarding the CCG's flows of information and where its information assets are held.

Pension obligations
As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

Equality, diversity & human rights obligations
Control measures are in place to ensure that the clinical commissioning group complies with the required public sector equality duty set out in the Equality Act 2010. These include policy commitments and mandatory staff training.

Sustainable development obligations
We are developing plans to assess risks, enhance our performance and reduce our impact, including against carbon reduction and climate change adaptation objectives. This includes establishing mechanisms to embed social and environmental sustainability across policy development, business planning and in commissioning.

We will ensure the clinical commissioning group complies with its obligations under the Climate Change Act 2008, including the Adaptation Reporting power, and the Public Services (Social Value) Act 2012.

We are also setting out our commitments as a socially responsible employer.

During 2013/14 the CCG Governing Body agreed a policy for sustainable development and the first phase of our Sustainable Development Management Plan which sets out a 36 year vision to reduce our carbon footprint by 80%.

Risk assessment in relation to governance, risk management & internal control

The CCG's Risk Assessment Framework as set out in the Risk Management Strategy is based on the National Patient Safety Advice (NPSA) guidance and aligned to the adopted internationally recognised AS/NZS 4360:1999 guidelines which provides a model for identifying, assessing and controlling risks. Further information on how the CCG manages the principles of Risk Management, can be found under the Risk Management Framework section above.

As a new organisation, established on 1st April 2013, all the risks to the CCG, including those impacting our governance, risk management and internal control were identified within the year. Workshops were held at the beginning of the year to identify key risks and to identify and implement controls. The risks facing the new organisation were rated high, as controls were un-tested, there was no historical assurance and there was a level of uncertainty in the new health landscape in Lewisham.

The Governing Body rated four principle risks with a very high residual risk score at the beginning of the year, these included:

- failure to achieve adequate Information Governance Standards
- the development and implementation of appropriate policies and mandatory training for all staff ensured that this risk was mitigated during the year
- claims for NHS Funded Continuing Health Care affecting financial plans
- in year financial reserves were sufficient to mitigate this risk
- transfer of Specialist Commissioning will not be cost neutral to the CCG
- in year financial reserves were sufficient to mitigate this risk
- failure to safeguard adults
- the appointment of designated safeguarding staff and mandatory training for all staff ensured that this risk was mitigated during the year.

The establishment of the governance committees and groups described above have provided the Governing Body with assurance over the wide range of business risks.

Review of economy, efficiency & effectiveness of the use of resources

In year monitoring of performance against our plans has been carried out by our Delivery Committee which includes ensuring that projects and programmes are delivering economic and effective services. During the year the Delivery Committee established a Finance and Risk Group to take an overview of capital expenditure and to scrutinise the management of financial risk. In addition, the CCG Audit Committee during the year has taken an independent view of

the CCG's financial management. The Audit Committee is attended by our colleagues in Internal Audit and External Audit and reports to the Governing Body.

Review of the effectiveness of governance, risk management & internal control

As Accountable Officer I have responsibility for reviewing the effectiveness of the system of internal control within the clinical commissioning group.

Capacity to handle risk
To develop our capacity to manage risk a workshop was held with Governing Body members at the beginning of the year to describe and review the CCG's risk management processes. The Audit Committee review the Board Assurance Framework and risk management report at its meetings and give advice on potential improvement.

Our Risk Management Group has been chaired by the CCG's Chief Officer and is attended by directors and senior managers. The role of the group is described above. All of our key risks have been "owned" by a senior manager who are responsible for ensuring that controls are effectively implemented and appropriate actions are taken.

Our risk owners are supported by the Head of Integrated Governance and provided with monthly support to review their risks and mitigation plans. Training has been provided to staff at all levels in risk management processes and in how to use the CCG's risk management software.

Review of effectiveness

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers and clinical leads within the clinical commissioning group who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports.

The *Board Assurance Framework* itself provides me with evidence that the effectiveness of controls that manage risks to the clinical commissioning group achieving its principles objectives have been reviewed.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Governing Body, the Audit Committee and Risk Management Group and a plan to address weaknesses and ensure continuous improvement of the system is in place.

Clinicians and management have worked in partnership to ensure the effectiveness of our systems of internal control. Following challenge at the Delivery Committee, management and clinicians worked together to align the governance processes that form the CCG's system of internal control with the commissioning cycle. The key activities of the commissioning cycle were scheduled for the appropriate committees in a new system of forward planning, management responsibilities were clarified and terms of reference of committees were updated.

The Governing Body and Audit Committee have also provided regular feedback on the completeness and effectiveness of our systems of internal control via their comments and feedback on the completeness of the Board Assurance Framework. For example, the Head of Integrated Governance met members of the Audit Committee early in the year. Control and assurance gaps were identified; existing controls and assurances were reviewed and the distinction between controls and evidence of their effectiveness was clarified.

Internal Audit also provided helpful advice and recommendations during the year and the details of these audits are described below.

An Internal Audit review of risk and governance good practice, noted that:

- a review of committee papers found that sufficient information is provided to allow them to discharge their duties
- there is a good balance between allowing the Governing Body and sub-committees to fulfil their scrutiny roles and their decision-making responsibilities with agendas giving priority to those items which require a decision.
- the CCG is able to demonstrate that its membership structure, required number of meetings and quorum for each committee is largely consistent with NHS England guidance
- the CCG has an established Risk Management policy that outlines how risks should be scored in terms of likelihood and impact (consequence) and the Corporate Risk Register and Board Assurance Framework show the controls/assurance the CCG has obtained against each risk
- appropriate training is provided to staff, tailored to reflect their involvement in the risk management process including one-on-one sessions with risk owners
- the CCG demonstrates its commitment to maintaining an awareness of the level of risk around its corporate objectives by placing the Risk Management and BAF update as a standing item at the beginning of the agenda of each Governing Body meeting.
- the Conflicts of Interests policy clearly sets out what is expected of CCG employees and members. The register of interest is reviewed at the start of each Governing Body/sub-committee meeting to help ensure the CCG is operating transparently in its business dealings. The policy is also updated annually to ensure it is complying with good practice.

Following completion of the planned audit work for the financial year for the clinical commissioning group, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the clinical commissioning group's system of risk management, governance and internal control.

The Head of Internal Audit concluded that:

Head of Internal Audit Opinion on the effectiveness of the system of internal control for the year ended 31 March 2014

Roles and responsibilities

The Governing Body is collectively accountable for maintaining a sound system of internal control and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system.

The Annual Governance Statement (AGS) is an annual statement by the Accountable Officer, on behalf of the Governing Body, setting out:

- how the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives;
- the purpose of the system of internal control as evidenced by a description of the risk management and review processes, including the Assurance Framework process; and
- the conduct and results of the review of the effectiveness of the system of internal control including any disclosures of significant control failures together with assurances that actions are or will be taken where appropriate to address issues arising.

The Assurance Framework should bring together all of the evidence required to support the AGS.

In accordance with Public Sector Internal Audit Standards, the Head of Internal Audit (HoIA) is required to provide an annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the CCG's risk management, control and governance processes (i.e. the system of internal control). This is achieved through a risk-based plan of work, agreed with management and approved by the Audit Committee, which should provide a reasonable level of assurance, subject to the inherent limitations described below.

The opinion does not imply that Internal Audit has reviewed all risks and assurances relating to the CCG. The opinion is substantially derived from the conduct of risk-based plans generated from a robust and CCG led Assurance Framework. As such, it is one component that the Governing Body takes into account in making its AGS.

A further component will be the assurances provided on the operation of the systems of internal control the service organisations which provide financial services on behalf of the CCG during 2013-14 as follows:

- NHS South London Commissioning Support Unit (KPMG);
- NHS Shared Business Service (Grant Thornton); and
- McKesson: NHS Electronic Staff Records (PwC).

Assurances on the operation of these systems will be provided by ISAE3402 Service Auditor Reports issued by the internal auditors of these organisations.

The Head of Internal Audit Opinion

The purpose of our HoIA Opinion is to contribute to the assurances available to the Accountable Officer and the Governing Body which underpin the Governing Body's own assessment of the effectiveness of the system of internal control. This Opinion will in turn assist the Governing Body in the completion of its AGS, and may also be taken into account by the Care Quality Commission or other regulators to inform their own conclusions.

Our opinion is set out as follows:

- Overall opinion;
- Basis for the opinion; and
- Commentary.

Our overall opinion is that:

Substantial assurance can be given that there is a generally sound system of internal control on key financial and management processes. These are designed to meet the CCG's objectives, and controls are generally being applied consistently.

The basis for forming our opinion is as follows:

- An assessment of the design and operation of the underpinning Assurance Framework and supporting processes; and
- An assessment of the range of individual opinions arising from risk-based audit assignments, contained within internal audit risk-based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas.

Commentary

The commentary below provides the context for our opinion and together with the opinion should be read in its entirety.

Context for our opinion

Our opinion covers the full year 2013-14 and is based on the seven reviews during the year.

The design and operation of the Assurance Framework and associated processes

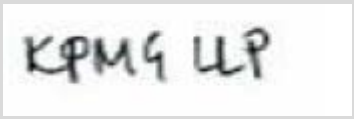
Overall our review found that the Assurance Framework in place is founded on a systematic risk management process and does provide appropriate assurance to the Governing Body. The review we have completed in this area has highlight areas for improvement that we believe could strengthen the process currently in place, although do not hinder out ability to issue an overall substantial assurance opinion. We will follow up recommendations raised during 2013-14 period.

The range of individual opinions arising from risk-based audit assignments, contained within risk-based plans that have been reported throughout the year.

We have provided one ‘adequate’ opinion during 2013-14 in relation to children and adult safeguarding. A ‘requires improvement’ opinion was provided on the following reviews: budgetary control/scheme of delegation, governance and risk management, acute contract management and performance reporting.

We have not given a rating to the data protection report completed by LAC. A preliminary review was completed earlier in the year but reported late in the year and so did not reflect the progress made by the CCG during the year. All recommendations raised from the review were implemented by the CCG on a timely manner.

No significant issues remained outstanding as at the year end which would impact upon our opinion.



KPMG LLP
Chartered Accountants
London
23 May 2014

The role of Internal Audit is to support the CCG by conducting appraisals of all internal controls, as identified through the Internal Audit Plan for the year, assessing their effectiveness and recommending improvements.

Following the review of a number of areas as identified in the CCG's Internal Audit Plan for 2013-14, the CCG has accepted a number of recommendations for development which are tracked by the Audit Committee to ensure implementation. The following areas have been subject to review, with further detail provided on areas which have resulted in limited assurance:

Governance and Risk Management
The CCG's governance and risk management arrangements are reviewed regularly, but following an assessment by our Internal Auditors, a number of areas were highlighted for improvement to develop and enhance our approach.

- ensure completeness of Minutes/Action Log identified through meetings.
- creation of Forward Plans for committees
- completeness of information on BAF and Corporate Risk Register Reporting
- allocate actions from the Francis Action Plan to responsible individuals for implementation
- completeness of BAF information
- review quorate criteria in committees' Terms of Reference
- improve robustness of Assurance Levels
- ensure web links stated within Constitution are relevant and correct
- review Declarations of Interest to ensure consistency and ensure it is up to date.

Acute contract management
The CCG accepted five recommendations for improvement following an assessment of the arrangements in relation to acute contract monitoring:

- agree a Service Level Agreement between the South London Commissioning Support Unit and the CCG
- reschedule the timing of the Delivery Committee
- establish greater contact with the South London Commissioning Support Unit
- include the provision of Community Contract performance
- maintain a log for action reporting and monitoring

Claims and performance management
Whilst highlighting areas for improvement, the Internal Auditors provided an overall adequate level of assurance regarding NHS South East London's claims and performance management processes which enable early challenge and resolution with providers.

Safeguarding children and adults
Following a review of the established arrangements regarding the safeguarding of children and adults at the CCG, an overall adequate level of assurance was concluded with respect to the CCG's discharge of responsibilities regarding safeguarding.

However, our Internal Auditors identified some areas for improvement to enhance the arrangements and ensure they reflect the requirements of NHS England.

Performance Reporting
In line with the CCG's anticipated level of assurance, our Internal Auditors concluded that the established arrangements for performance reporting at the CCG required improvement.

To enable the CCG to understand and review its performance and the performance of its providers to ensure it is operating effectively. Recommendations for development related to:

- development of a Performance Reporting Framework.

- report and monitor of the Outcomes Framework to the Delivery Committee.
- improve the format of the Integrated Performance Report.
- review the content of the Integrated Performance Report to ensure consistency before it is submitted to the Delivery committee.

Budgetary control and scheme of delegation
As expected, following a review of the design and operation of budgetary control and the scheme of delegation during the early part of the financial year, the Internal Auditors highlighted a number of areas for improvement to ensure greater robustness and appropriate decision making. Recommendations for development related to:

- improving the content of the Integrated Performance/Finance Reports.
- review the scheme of delegation to ensure decisions have been allocated to the appropriate committee/individual
- ensure consistency in the terms of reference for committees and the schedule of delegated matters
- develop a budget setting policy / procedure notes
- review authorised limits of approval for officers to ensure consistency with the limits described in the schedule of delegated matters
- develop a process to ensure decisions made by committees/individuals are commensurate with their delegated responsibility.

The CCG has responded positively to the recommendations from all of the Internal Audit reviews and are implementing resultant action plans.

Data quality

In line with the need to know principles set out in the Caldicott 2 Information Governance Review Report, the CCG ensures that information presented to the Governing Body and other governance forums does not identify individuals and is fully anonymised.

Senior Management diligently reviews information to be set out in governance and decision making information prior to consideration and presentation to the relevant governance forums.

The quality of information that the Governing Body and other governance forums receive to consider and direct decision making is also assured through the service level specification arrangements with the South London Commissioning Support Unit and the use of contractual arrangements with the commissioned providers.

Business-critical models

The Macpherson Report on the review of quality assurance (QA) of Government Analytical Models set out the components of best practice in QA making eight key recommendations.

In 2013/14, Lewisham CCG, working with other commissioners in South East London, began to develop the South East London Commissioning Model; a business critical analytical tool in modelling and appraising the impact of proposed changes in the local health economy over the next five years.

The development of the model follows the principles set out in the Macpherson report with an identified Senior Responsible Officer (a CCG Director of Commissioning), supported by a clear Governance Structure. The technical review group, chaired by the Bromley CCG Chief Financial Officer, draws upon multi-disciplinary specialist experience from all stakeholders, responsible for developing and using the model as well as providing quality assurance and peer review. This group is responsible for ensuring that there are effective processes underpinning the model, including appropriate guidance, documentation and training, as well as sharing best practice across disciplines and organisations.

The QA framework in place for this model will be used for all future business critical models.

Data security

We have submitted a satisfactory level of compliance with the information governance toolkit assessment.

Data security breaches
The Caldicott 2 Information Governance Review Report published in May 2013 advised a stronger focus on the scope of what constitutes a data breach to include any breach of the eight (8) principles of the Data Protection Act

The CCG has not recorded any breaches requiring rnvestigation and or further escalation during 2013/14.

Discharge of statutory functions

During establishment, the arrangements put in place by the clinical commissioning group and explained within the *Corporate Governance Framework* were developed with extensive expert external legal input, to ensure compliance with the all relevant legislation. That legal advice also informed the matters reserved for Membership Body and Governing Body decision and the scheme of delegation.

In light of the Harris Review, the clinical commissioning group has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, I can confirm that the clinical commissioning group is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

Responsibility for each duty and power has been clearly allocated to a lead Director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the clinical commissioning group's statutory duties.

Last, but not least, the CCG takes due account of the NHS Constitution and strives to uphold its values.

Conclusion

In conclusion I confirm that no significant internal control issues have been identified.

Mr Martin Wilkinson
Chief Officer
5th June 2014

Data entered below will be used throughout the workbook:

Entity name:	NHS Lewisham Clinical Commissioning Group
This year	2013-14
This year ended	31 March 2014
This year commencing:	1 April 2013

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INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF NHS LEWISHAM CLINICAL COMMISSIONING GROUP

We have audited the financia l statements of NHS Lewisham Clinical Commissioning Group

for the year ended 31 March 2014 under the Audit Commission Act 1998. The financial statements comprise the Statement of Comprehensive Net Expenditure , the Statement of Financial Position, the Statement of Changes in Taxpayers ' Equity, the Statement of Cash Flows and the related notes. The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by the NHS Commissioning Board with approval of the Secretary of State

We have also audited the information in the Remuneration Report that is subject to audit, being:

- the table of salaries and allowances of senior managers and related narrative notes;
- the table of pension benefits of senior managers and related narrative notes; and
- the section on pay multiples and related narrative notes.

This report is made solely to the members of NHS Lewisham Clinical Commission ing Group in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 44 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2014. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Clinical Commissioning Group (CCG)'s members and the CCG as a body, for our audit work ,for this report, or for opinions we have formed.

Respective responsibilities of the Accountable Officer and auditor

As explained more fully in the Statement of Accountable Officer's Responsibilities ,the Accountable Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards also require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the CCG's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the CCG; and the overall presentation of the financial statements.

In addition, we read all the financial and non-financial information in the annual report which comprises the Member Practices' Introduction, Strategic Report, Members' Report, Remuneration Report, Statement of Accountable Officer's Responsibilities and Governance Statement to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

In addition , we are required to obtain evidence sufficient to give reasonable assurance that the expenditure and income reported in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Opinion on regularity

In our opinion, in all material respects the expenditure and income have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Opinion on the financial statements

In our opinion the financial statements :

• give a true and fair view of the financial position of NHS Lewisham CCG as at 31 March 2014 and of its net operating costs for the year then ended; and
• have been prepared properly in accordance with the accounting policies directed by the NHS Commissioning Board with the approval of the Secretary of State.

Opinion on other matters

In our opinion:

• the part of the Remuneration Report subject to audit has been prepared properly in accordance with the requirements directed by the NHS Commissioning Board with the approval of the Secretary of State;and
• the information given in the annual report for the financial year for which the financial statements are prepared is consistent with the financ ial statements .

Matters on which we report by exception

We report to you if:
• in our opinion the governance statement does not reflect compliance with NHS England's Guidance;
• we refer a matter to the Secretary of State under section 19 of the Audit Commission Act 1998 because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made,a decision involving unlawful expenditure,or is about to take, or has taken, unlawful action likely to cause a loss or deficiency ; or
• we issue a report in the public interest under section 8 of the Audit Commission Act 1998.

We have nothing to report in these respects.

Conclusion on the CCG's arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice issued by the Audit Commission requires us to report any matters that prevent us being satisfied that the audited body has put in place such arrangements.

We have undertaken our audit in accordance with the Code of Audit Practice, having regard to the guidance issued by the Audit Commission in October 2013. We have considered the results of the following:

- our review of the Governance Statement ; and

- the work of other relevant regulatory bodies or inspectorates , to the extent that the results of this work impact on our responsibilities at the CCG.

As a result, we have concluded that there are no matters to report.

Certificate

We certify that we have completed the audit of the accounts of NHS Lewisham CCG in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice issued by the Audit Commission.

Susan M. Exton
Director
for and on behalf of Grant Thornton UK LLP, Appointed Auditor

Grant Thornton House
Melton Street Euston Square London
NW1 2EP
5 June 2014

Statement of Comprehensive Net Expenditure for the year ended 31 March 2014

	Note	2013-14 £000
Administration Costs and Programme Expenditure		
Gross employee benefits	4.1	**3,961**
Other costs	5	**375,454**
Other operating revenue	2	**(3,747)**
Net operating costs before interest		**375,668**
Other operating revenue		**-**
Other (gains)/losses		**-**
Finance costs		**-**
Net operating costs for the financial year		**375,668**
Net (gain)/loss on transfers by absorption		
Net operating costs for the financial year including absorption transfers		**375,668**
Of which:		
Administration Costs		
Gross employee benefits	4.1	**2,886**
Other costs	5	**3,624**
Other operating revenue	2	**(115)**
Net administration costs before interest		**6,395**
Programme Expenditure		
Gross employee benefits	4.1	**1,075**
Other costs	5	**371,830**
Other operating revenue	2	**(3,632)**
Net programme expenditure before interest		**369,273**

Other Comprehensive Net Expenditure	2013-14 £000
Impairments and reversals	**-**
Net gain/(loss) on revaluation of property, plant & equipment	**-**
Net gain/(loss) on revaluation of intangibles	**-**
Net gain/(loss) on revaluation of financial assets	**-**
Movements in other reserves	**-**
Net gain/(loss) on available for sale financial assets	**-**
Net gain/(loss) on assets held for sale	**-**
Net actuarial gain/(loss) on pension schemes	**-**
Share of (profit)/loss of associates and joint ventures	**-**
Reclassification Adjustments	
On disposal of available for sale financial assets	**-**
Total comprehensive net expenditure for the year	**375,668**

Reconciliation of Cash Drawings to Parliamentary Funding	2013-14 £000
Total cash received from DH (Gross)	**325,878**
Less: Trade revenue from DH	
Less:/(Plus): movement in DH working balances	**(372)**
Sub total: net advances	**325,506**
(Less)/plus: transfers (to)/from other resource account bodies	
Plus: cost of Home Oxygen Therapy	**320**
Plus: cost of drugs reimbursement (central charge to cash limits)	**29,135**
Parliamentary funding credited to General Fund	**354,961**
Adjustment for Partially Completed Spells	**(1,618)**
Net Funding	**353,343**

Statement of Financial Position as at 31 March 2014

	Note	31 March 2014 £000
Non-current assets:		
Property, plant and equipment		-
Intangible assets		-
Investment property		-
Trade and other receivables		-
Other financial assets		-
Total non-current assets		-
Current assets:		
Inventories		-
Trade and other receivables	17	**6,516**
Other financial assets		-
Other current assets		-
Cash and cash equivalents	20	**38**
Total current assets		**6,554**
Non-current assets held for sale		-
Total current assets		**6,554**
Total assets		**6,554**
Current liabilities		
Trade and other payables	23	**(27,264)**
Other financial liabilities		-
Other liabilities		-
Borrowings		-
Provisions	30	**(1,162)**
Total current liabilities		**(28,426)**
Total Assets less Current Liabilities		**(21,872)**
Non-current liabilities		
Trade and other payables		-
Other financial liabilities		-
Other liabilities		-
Borrowings		-
Provisions	30	**(453)**
Total non-current liabilities		**(453)**
Total Assets Employed		**(22,325)**
Financed by Taxpayers' Equity		
General fund		**(22,325)**
Revaluation reserve		-
Other reserves		-
Charitable Reserves		-
Total taxpayers' equity:		**(22,325)**

The notes on pages 5 to 40 form part of this statement

The financial statements on pages 1 to 40 were approved by the Governing Body on 3 June 2014 and signed on its behalf by:

Accountable Officer
Martin Wilkinson

Statement of Changes In Taxpayers Equity for the year ended 31 March 2014

	Note	General fund	Revaluation reserve	Other reserves	Total reserves
		£000	£000	£000	£000
Changes in taxpayers' equity for 2013-14					
Balance at 1 April 2013		**-**	**-**	**-**	**-**
Transfer of assets and liabilities from closed NHS Bodies as a result of the 1 April 2013 transition		-	-	-	-
Transfer between reserves in respect of assets transferred from closed NHS bodies		-	-	-	-
Adjusted CCG balance at 1 April 2013		**-**	**-**	**-**	**-**
Changes in CCG taxpayers' equity for 2013-14					
Net operating costs for the financial year		(375,668)	-	-	**(375,668)**
Net gain/(loss) on revaluation of property, plant and equipment		-	-	-	**-**
Net gain/(loss) on revaluation of intangible assets		-	-	-	**-**
Net gain/(loss) on revaluation of financial assets		-	-	-	**-**
Total revaluations against revaluation reserve		**-**	**-**	**-**	**-**
Net gain (loss) on available for sale financial assets		-	-	-	**-**
Net gain (loss) on revaluation of assets held for sale		-	-	-	**-**
Impairments and reversals		-	-	-	**-**
Net actuarial gain (loss) on pensions		-	-	-	**-**
Movements in other reserves		-	-	-	**-**
Transfers between reserves		-	-	-	**-**
Release of reserves to the Statement of Comprehensive Net Expenditure		-	-	-	**-**
Reclassification adjustment on disposal of available for sale financial		-	-	-	**-**
Transfers by absorption to (from) other bodies		-	-	-	**-**
Transfer between reserves in respect of assets transferred under absorption		-	-	-	**-**
Reserves eliminated on dissolution		-	-	-	**-**
Net Recognised CCG Expenditure for the Financial Year		(375,668)	-	-	**(375,668)**
Net funding		353,343	-	-	**353,343**
Balance at 31 March 2014		**(22,325)**	**-**	**-**	**(22,325)**

Statement of Cash Flows for the year ended 31 March 2014

	Note	2013-14 £000
Cash Flows from Operating Activities		
Net operating costs for the financial year		**(375,668)**
Depreciation and amortisation		**-**
Impairments and reversals		**-**
Other gains (losses) on foreign exchange		**-**
Donated assets received credited to revenue but non-cash		**-**
Government granted assets received credited to revenue but non-cash		**-**
Interest paid		**-**
Release of PFI deferred credit		**-**
(Increase)/decrease in inventories		**-**
(Increase)/decrease in trade & other receivables	**17**	**(6,516)**
(Increase)/decrease in other current assets		**-**
Increase/(decrease) in trade & other payables	**23**	**27,264**
Increase/(decrease) in other current liabilities		**-**
Provisions utilised		**-**
Increase/(decrease) in provisions	**30**	**1,615**
Net Cash Inflow (Outflow) from Operating Activities		**(353,305)**
Cash Flows from Investing Activities		
Interest received		**-**
(Payments) for property, plant and equipment		**-**
(Payments) for intangible assets		**-**
(Payments) for investments with the Department of Health		**-**
(Payments) for other financial assets		**-**
(Payments) for financial assets (LIFT)		**-**
Proceeds from disposal of assets held for sale: property, plant and equipment		**-**
Proceeds from disposal of assets held for sale: intangible assets		**-**
Proceeds from disposal of investments with the Department of Health		**-**
Proceeds from disposal of other financial assets		**-**
Proceeds from disposal of financial assets (LIFT)		**-**
Loans made in respect of LIFT		**-**
Loans repaid in respect of LIFT		**-**
Rental revenue		**-**
Net Cash Inflow (Outflow) from Investing Activities		**-**
Net Cash Inflow (Outflow) before Financing		**(353,305)**
Cash Flows from Financing Activities		
Net funding received		**353,343**
Other loans received		**-**
Other loans repaid		**-**
Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT		**-**
Capital grants and other capital receipts		**-**
Capital receipts surrendered		**-**
Net Cash Inflow (Outflow) from Financing Activities		**353,343**
Net Increase (Decrease) in Cash & Cash Equivalents	**20**	**38**
Cash & Cash Equivalents at the Beginning of the Financial Year		**-**
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		**-**
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**38**

Notes to the financial statements

NHS Lewisham Clinical Commissioning Group was constituted under the Health and Social Care Act 2012, and came into being on 1 April 2014.

This is a new organisation. Previous assets and liabilities of Lewisham Primary Care Trust transferred to other organisations under a Transfer Order on behalf of the Secretary of State for Health from that date. Under the terms of the Act our principal activities are the commissioning and monitoring of health services, for the population of Lewisham, defined as patients registered with GPs who are on Lewisham's performers list.

We carry out our operations from Cantilever House, Eltham Road, London SE12 8RN.
All references to the "Clinical Commissioning Group" and the "CCG" means NHS Lewisham Clinical Commissioning Group.

1 Accounting Policies

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the *Manual for Accounts* issued by the Department of Health. Consequently, the following financial statements have been prepared in accordance with the *Manual for Accounts 2013-14* issued by the Department of Health. The accounting policies contained in the *Manual for Accounts* follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the *Manual for Accounts* permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group (NHS Lewisham CCG) are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

In accordance with the Directions issued by NHS England comparative information is not provided in these Financial Statements.

1.1 Going Concern

These accounts have been prepared on the going concern basis.
Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.
Where a clinical commissioning group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of Financial Statements. If services will continue to be provided the financial statements are prepared on the going concern basis.

1.2 Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.3 Acquisitions & Discontinued Operations

Activities are considered to be ‘acquired’ only if they are taken on from outside the public sector. Activities are considered to be ‘discontinued’ only if they cease entirely. They are not considered to be ‘discontinued’ if they transfer from one public sector body to another.

1.4 Movement of Assets within the Department of Health Group

Transfers as part of reorganisation fall to be accounted for by use of absorption accounting in line with the Government Financial Reporting Manual, issued by HM Treasury. The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Department of Health Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.
For transfers of assets and liabilities from those NHS bodies that closed on 1 April 2013, HM Treasury has agreed that a modified absorption approach should be applied. For these transactions only, gains and losses are recognised in reserves rather than the Statement of Comprehensive Net Expenditure.

1.5 Critical Accounting Judgements & Key Sources of Estimation Uncertainty

Notes to the financial statements

In the application of the clinical commissioning group's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.5.1 Critical Judgements in Applying Accounting Policies

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the clinical commissioning group's accounting policies that have the most significant effect on the amounts recognised in the financial statements:

NHS Lewisham CCG exercised critical judgement in respect of prescribing accruals (see Note 23).

1.5.2 Key Sources of Estimation Uncertainty

The following are the key estimations that management has made in the process of applying the clinical commissioning group's accounting policies that have the most significant effect on the amounts recognised in the financial statements:

NHS Lewisham CCG had no material key sources of estimation uncertainty.

1.6 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

1.7 Employee Benefits

1.7.1 Short-term Employee Benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.7.2 Retirement Benefit Costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to NHS Lewisham CCG of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time NHS Lewisham CCG commits itself to the retirement, regardless of the method of payment.

Some employees are members of the Local Government Superannuation Scheme, which is a defined benefit pension scheme. The scheme assets and liabilities attributable to those employees can be identified and are recognised in NHS Lewisham CCG's accounts. The assets are measured at fair value and the liabilities at the present value of the future obligations. The increase in the liability arising from pensionable service earned during the year is recognised within operating expenses. The expected gain during the year from scheme assets is recognised within finance income. The interest cost during the year arising from the unwinding of the discount on the scheme liabilities is recognised within finance costs. Actuarial gains and losses during the year are recognised in the General Reserve and reported as an item of other comprehensive net expenditure.

1.8 Other Expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

Expenses and liabilities in respect of grants are recognised when NHS Lewisham CCG has a present legal or constructive obligation, which occurs when all of the conditions attached to the payment have been met.

1.9 Property, Plant & Equipment

Notes to the financial statements

NHS Lewisham CCG had no Property, Plant and Equipment in 2013-14.

1.10 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

1.10.1 The Clinical Commissioning Group as Lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the clinical commissioning group's surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.
Contingent rentals are recognised as an expense in the period in which they are incurred.
Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

1.10.2 The Clinical Commissioning Group as Lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the clinical commissioning group's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the clinical commissioning group's net investment outstanding in respect of the leases.
Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.11 Cash & Cash Equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of NHS Lewisham CCG's cash management.

1.12 Provisions

Provisions are recognised when NHS Lewisham CCG has a present legal or constructive obligation as a result of a past event, it is probable that the clinical commissioning group will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:

- Timing of cash flows (0 to 5 years inclusive): Minus 1.90%
- Timing of cash flows (6 to 10 years inclusive): Minus 0.65%
- Timing of cash flows (over 10 years): Plus 2.20%
- All employee early departures: 1.80%

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.
A restructuring provision is recognised when NHS Lewisham CCG has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.13 Clinical Negligence Costs

Notes to the financial statements

The NHS Litigation Authority operates a risk pooling scheme under which the clinical commissioning group pays an annual contribution to the NHS Litigation Authority which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHS Litigation Authority is administratively responsible for all clinical negligence cases the legal liability remains with the clinical commissioning group.

1.14 Non-clinical Risk Pooling

NHS Lewisham CCG participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the clinical commissioning group pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.15 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the clinical commissioning group. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1.16 Financial Assets

Financial assets are recognised when the clinical commissioning group becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories:

- Financial assets at fair value through profit and loss;
- Held to maturity investments;
- Available for sale financial assets; and,
- Loans and receivables.

The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

1.16.1 Loans & Receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the clinical commissioning group assesses whether any financial assets, other than those held at ‘fair value through profit and loss’ are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset’s carrying amount and the present value of the revised future cash flows discounted at the asset’s original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced through a provision for impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

Notes to the financial statements

1.17 Financial Liabilities

Financial liabilities are recognised on the statement of financial position when the clinical commissioning group becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

1.18 Value Added Tax

Most of the activities of NHS Lewisham CCG are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.19 Foreign Currencies

NHS Lewisham CCG's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the clinical commissioning group's surplus/deficit in the period in which they arise.

1.20 Losses & Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the clinical commissioning group not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.21 Accounting Standards That Have Been Issued But Have Not Yet Been Adopted

The Government Financial Reporting Manual does not require the following Standards and Interpretations to be applied in 2013-14, all of which are subject to consultation:

- IAS 27: Separate Financial Statements
- IAS 28: Investments in Associates & Joint Ventures
- IAS 32: Financial Instruments – Presentation (amendment)
- IFRS 9: Financial Instruments
- IFRS 10: Consolidated Financial Statements
- IFRS 11: Joint Arrangements
- IFRS 12: Disclosure of Interests in Other Entities
- IFRS 13: Fair Value Measurement

The application of the Standards as revised would not have a material impact on the accounts for 2013-14, were they applied in that year.

1.22 The accounting arrangements for balances transferred from predecessor PCTs ("legacy" balances) are determined by the Accounts Direction issued by NHS England on 12 February 2014. The Accounts Directions state that the only legacy balances to be accounted for by the CCG are in respect of property, plant and equipment (and related liabilities) and inventories. All other legacy balances in respect of assets or liabilities arising from transactions or delivery of care prior to 31 March 2013 are accounted for by NHS England. The impact of the legacy balances accounted for by the CCG is disclosed in note 1.2 to these financial statements. The CCG's arrangements in respect of settling NHS Continuing Healthcare claims are disclosed in note 30 to these financial statements."

2 Other Operating Revenue

	2013-14 Total £000	2013-14 Admin £000	2013-14 Programme £000
Recoveries in respect of employee benefits	**-**	-	-
Patient transport services	**-**	-	-
Prescription fees and charges	**548**	-	548
Dental fees and charges	**-**	-	-
Education, training and research	**357**	49	308
Charitable and other contributions to revenue expenditure: NHS	**-**	-	-
Charitable and other contributions to revenue expenditure: non-NHS	**-**	-	-
Receipt of donations for capital acquisitions: NHS Charity	**-**	-	-
Receipt of Government grants for capital acquisitions	**-**	-	-
Non-patient care services to other bodies	**2,842**	66	2,776
Income generation	**-**	-	-
Rental revenue from finance leases	**-**	-	-
Rental revenue from operating leases	**-**	-	-
Other revenue	**0**	-	0
Total other operating revenue	**3,747**	**115**	**3,632**

Admin revenue is revenue received that is not directly attributable to the provision of healthcare or healthcare services.

Revenue in this note does not include cash received from NHS England, which is drawn down directly into the bank account of the CCG and credited to the General Fund.

3 Revenue

	2013-14 Total £000	2013-14 Admin £000	2013-14 Programme £000
From rendering of services	**3,747**	**115**	**3,632**
From sale of goods	**-**	**-**	**-**
Total	**3,747**	**115**	**3,632**

Revenue is totally from the supply of services. The clinical commissioning group receives no revenue from the sale of goods.

4. Employee benefits and staff numbers

4.1.1 Employee benefits

	2013-14 Total	Total Permanent Employees	Other	Total	Admin Permanent Employees	Other	Total	Programme Permanent Employees	Other
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Employee Benefits									
Salaries and wages	**3,125**	2,768	357	**2,186**	2,104	82	**939**	664	275
Social security costs	**325**	325	-	**266**	266	-	**59**	59	-
Employer Contributions to NHS Pension scheme	**406**	406	-	**329**	329	-	**77**	77	-
Other pension costs	**-**	-	-	**-**	-	-	**-**	-	-
Other post-employment benefits	**-**	-	-	**-**	-	-	**-**	-	-
Other employment benefits	**-**	-	-	**-**	-	-	**-**	-	-
Termination benefits	**105**	105	-	**105**	105	-	**-**	-	-
Gross employee benefits expenditure	**3,961**	**3,604**	**357**	**2,886**	**2,804**	**82**	**1,075**	**800**	**275**
Less recoveries in respect of employee benefits (note 4.1.2)	**-**	-	-	**-**	**-**	**-**	**-**	**-**	**-**
Total - Net admin employee benefits including capitalised costs	**3,961**	**3,604**	**357**	**2,886**	**2,804**	**82**	**1,075**	**800**	**275**
Less: Employee costs capitalised	**-**	-	-	**-**	-	-	**-**	-	-
Net employee benefits excluding capitalised costs	**3,961**	**3,604**	**357**	**2,886**	**2,804**	**82**	**1,075**	**800**	**275**

4.1.2 Recoveries in respect of employee benefits

	2013-14 Total	Permanent Employees	Other
	£000	£000	£000
Employee Benefits - Revenue			
Salaries and wages	-	-	-
Social security costs	-	-	-
Employer contributions to the NHS Pension Scheme	-	-	-
Other pension costs	-	-	-
Other post-employment benefits	-	-	-
Other employment benefits	-	-	-
Termination benefits	-	-	-
Total recoveries in respect of employee benefits	**-**	**-**	**-**

4.2 Average number of people employed

	2013-14 Total	Permanently employed	Other
	Number	Number	Number
Total	**53**	48	5
Of the above:			
Number of whole time equivalent people engaged on capital projects	**-**	-	-

4.3 Staff sickness absence and ill health retirements

	2013-14 Number
Total Days Lost	162
Total Staff Years	53
Average working Days Lost	3

	2013-14 Number
Number of persons retired early on ill health grounds	**-**
Total additional Pensions liabilities accrued in the year	**-**

Ill health retirement costs are met by the NHS Pension Scheme

Where the clinical commissioning group has agreed early retirements, the additional costs are met by the clinical commissioning group and not by the NHS Pension Scheme.

4.4 Exit packages agreed in the financial year

2013-14	Compulsory redundancies		Other agreed departures		Total	
	Number	£	Number	£	Number	£
Less than £10,000	-	-	1	818	**1**	**818**
£10,001 to £25,000	-	-	-	-	**-**	**-**
£25,001 to £50,000	-	-	-	-	**-**	**-**
£50,001 to £100,000	-	-	-	-	**-**	**-**
£100,001 to £150,000	-	-	-	-	**-**	**-**
£150,001 to £200,000	-	-	-	-	**-**	**-**
Over £200,001	-	-	-	-	**-**	**-**
Total	**-**	**-**	**1**	**818**	**1**	**818**

	Departures where special payments have been made	
	Number	£
Less than £10,000	-	-
£10,001 to £25,000	-	-
£25,001 to £50,000	-	-
£50,001 to £100,000	-	-
£100,001 to £150,000	-	-
£150,001 to £200,000	-	-
Over £200,001	-	-
Total	**-**	**-**

Analysis of Other Agreed Departures

	Other agreed departures	
	Number	£
Voluntary redundancies including early retirement contractual costs	-	-
Mutually agreed resignations (MARS) contractual costs	-	-
Early retirements in the efficiency of the service contractual costs	-	-
Contractual payments in lieu of notice	1	818
Exit payments following Employment Tribunals or court orders	-	-
Non-contractual payments requiring HMT approval*	-	-
Total	**1**	**818**

Contractual payments in lieu of notice relates to one payment of £818 for annual leave due at date of termination.
These tables report the number and value of exit packages agreed in the financial year. The expense associated with these departures may have been recognised in part or in full in a previous period.

Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.
The Remuneration Report includes the disclosure of exit payments payable to individuals named in that Report.

4.5 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/Pensions.

The Scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The Scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities.

Therefore, the Scheme is accounted for as if it were a defined contribution scheme: the cost to the clinical commissioning group of participating in the Scheme is taken as equal to the contributions payable to the Scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of these follows:

a) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2014, is based on valuation data as 31 March 2013, updated to 31 March 2014 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes were suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision due in 2015.

The Scheme Regulations were changed to allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next formal valuation to be used for funding purposes will be carried out at as at March 2012 and will be used to inform the contribution rates to be used from 1 April 2015.

4.5 Pension costs

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a “final salary” scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as “pension commutation”.

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year’s pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.
Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC’s run by the Scheme’s approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

• Members can purchase additional service in the Scheme and contribute to money purchase AVC’s run by the Scheme’s approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

5. Operating expenses

	2013-14 Total £000	2013-14 Admin £000	2013-14 Programme £000
Gross employee benefits			
Employee benefits excluding governing body members	3,437	2,362	1,075
Executive governing body members	524	524	-
Total gross employee benefits	**3,961**	**2,886**	**1,075**
Other costs			
Services from other CCGs and NHS England	**7,746**	2,631	5,115
Services from foundation trusts	**134,126**	-	134,126
Services from other NHS trusts	**165,434**	-	165,434
Services from other NHS bodies	**19**	-	19
Purchase of healthcare from non-NHS bodies	**23,773**	-	23,773
Chair and lay membership body and governing body members	**103**	103	-
Supplies and services – clinical	**-**	-	-
Supplies and services – general	**669**	389	280
Consultancy services	**374**	32	342
Establishment	**1,117**	76	1,041
Transport	**5**	4	1
Premises	**3,251**	154	3,097
Impairments and reversals of receivables	**-**	-	-
Inventories written down	**-**	-	-
Depreciation	**-**	-	-
Amortisation	**-**	-	-
Impairments and reversals of property, plant and equipment	**-**	-	-
Impairments and reversals of intangible assets	**-**	-	-
Impairments and reversals of financial assets	**-**	-	-
· Assets carried at amortised cost	**-**	-	-
· Assets carried at cost	**-**	-	-
· Available for sale financial assets	**-**	-	-
Impairments and reversals of non-current assets held for sale	**-**	-	-
Impairments and reversals of investment properties	**-**	-	-
Audit fees	**103**	103	-
Other auditor's remuneration			
· Internal audit services	**-**	-	-
· Other services	**-**	-	-
General dental services and personal dental services	**-**	-	-
Prescribing costs	**35,956**	-	35,956
Pharmaceutical services	**-**	-	-
General ophthalmic services	**-**	-	-
GPMS/APMS and PCTMS	**728**	-	728
Other professional fees excl. audit	**399**	98	301
Grants to other public bodies	**-**	-	-
Clinical negligence	**-**	-	-
Research and development (excluding staff costs)	**-**	-	-
Education and training	**142**	34	108
Change in discount rate	**-**	-	-
Other expenditure	**1,509**	-	1,509
Total other costs	**375,454**	3,624	371,830
Total operating expenses	**379,415**	**6,510**	**372,905**

Admin expenditure is expenditure incurred that is not a direct payment for the provision of healthcare or healthcare services.

6.1 Better Payment Practice Code

Measure of compliance	2013-14 Number	2013-14 £000
Non-NHS Payables		
Total Non-NHS Trade invoices paid in the Year	4,336	21,879
Total Non-NHS Trade Invoices paid within target	4,123	21,263
Percentage of Non-NHS Trade invoices paid within target	95.09%	97.18%
NHS Payables		
Total NHS Trade Invoices Paid in the Year	2,225	313,940
Total NHS Trade Invoices Paid within target	2,136	310,897
Percentage of NHS Trade Invoices paid within target	96.00%	99.03%

The Better Payment Practice Code requires the CCG to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

6.2 The Late Payment of Commercial Debts (Interest) Act 1998

	2013-14 £000
Amounts included in finance costs from claims made under this legislation	-
Compensation paid to cover debt recovery costs under this legislation	-
Total	-

7 Income Generation Activities

The Clinical Commissioning Group does not undertake any income generation activities.

8. Investment revenue

The clinical commissioning group had no investment revenue as at 31 March 2014.

9. Other gains and losses

The clinical commissioning group had no other gains or losses as at 31 March 2014.

10. Finance costs

The clinical commissioning group had no finance costs as at 31 March 2014.

11. Net gain/(loss) on transfer by absorption

The clinical commissioning group had no net gains or losses on transfer by absorption as at 31 March 2014.

12. Operating Leases

Following the Health and Social Care Act 2012, all leases were transferred to NHS Property Services or Lewisham and Greenwich NHS Trust.

Lewisham CCG is recharged by NHS Property Services and Community Health Partners for the costs of its staff accommodation at Cantilever house and running costs of some buildings from which community health services are provided.

There are no formal agreements in place between NHS Property Services and the CCG or Community Health Partners and the CCG. Recharges in 2013-14 were based on the budget transfers to those organisations from the former Lewisham PCT, which were agreed by the CCG's officers. In 2013-14 Lewisham CCG paid NHS Property Services £1,479K and Community Health Partnership £1,679k. As there are no contracts in place there are no defined future contractual payment obligations.

13 Property, plant and equipment

NHS Lewisham CCG had no property, plant and equipment as at 31 March 2014 or during 2013-14.

14 Intangible non-current assets

NHS Lewisham CCG had no intangible non-current as at 31 March 2014 or during 2013-14.

15 Investment property

The Clinical Commissioning Group had no investment property as at 31 March 2014.

16 Inventories

The Clinical Commissioning Group had no inventories as at 31 March 2014

17 Trade and other receivables

	Current	Non-current
	2013-14	2013-14
	£000	£000
NHS receivables: Revenue	**4,025**	**-**
NHS receivables: Capital	**-**	**-**
NHS prepayments and accrued income	**2,315**	**-**
Non-NHS receivables: Revenue	**58**	**-**
Non-NHS receivables: Capital	**-**	**-**
Non-NHS prepayments and accrued income	**99**	**-**
Provision for the impairment of receivables	**-**	**-**
VAT	**19**	**-**
Private finance initiative and other public private partnership arrangement prepayments and accrued income	**-**	**-**
Interest receivables	**-**	**-**
Finance lease receivables	**-**	**-**
Operating lease receivables	**-**	**-**
Other receivables	**(0)**	**-**
Total	**6,516**	**-**
Total current and non current	**6,516**	
Included above:		
Prepaid pensions contributions	**-**	

The great majority of trade is with NHS England. As NHS England is funded by Government to provide funding to clinical commissioning groups to commission services, no credit scoring of them is considered necessary.

17.1 Receivables past their due date but not impaired

	2013-14
	£000
By up to three months	**278**
By three to six months	**17**
By more than six months	**268**
Total	**563**

£399k of the amount above has subsequently been recovered post the statement of financial position date.

The clinical commissioning group did not hold any collateral against receivables outstanding at 31 March 2014.

17.2 Provision for impairment of receivables

	2013-14
	£000
Balance at 1 April 2013	**-**
Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition	**-**
Adjusted balance at 1 April 2013	**-**
Amounts written off during the year	**-**
Amounts recovered during the year	**-**
(Increase) decrease in receivables impaired	**-**
Transfer (to) from other public sector body	**-**
Balance at 31 March 2014	**-**

18 Other financial assets

The clinical commissioning group had no other financial assets as at 31 March 2014.

19 Other current assets

The clinical commissioning group had no other current assets as at 31 March 2014.

20 Cash and cash equivalents

	2013-14 £000
Balance at 1 April 2013	**-**
Net change in year	**38**
Balance at 31 March 2014	**38**
Made up of:	
Cash with the Government Banking Service	**38**
Cash with Commercial banks	**-**
Cash in hand	**-**
Current investments	**-**
Cash and cash equivalents as in statement of financial position	**38**
Bank overdraft: Government Banking Service	**-**
Bank overdraft: Commercial banks	**-**
Total bank overdrafts	**-**
Balance at 31 March 2014	**38**
Patients' money held by the clinical commissioning group, not included above	**-**

21 Non-current assets held for sale

The clinical commissioning group had no non-current assets held for sale as at 31 March 2014.

22 Analysis of impairments and reversals

The clinical commissioning group had no impairments or reversals of impairments recognised in expenditure during 2013-14.

23 Trade and other payables

	Current 2013-14 £000	Non-current 2013-14 £000
Interest payable	-	-
NHS payables: revenue	10,559	-
NHS payables: capital	-	-
NHS accruals and deferred income	2,336	-
Non-NHS payables: revenue	1,437	-
Non-NHS payables: capital	-	-
Non-NHS accruals and deferred income	12,428	-
Social security costs	44	-
VAT	-	-
Tax	56	-
Payments received on account	-	-
Other payables	404	-
Total	27,264	-
Total payables (current and non-current)	27,264	

Non NHS accruals includes a sum of £6,218k in respect of prescribing for two months outstanding invoices from the Prescription Pricing Authority, due to the time lags in their processing of this information. This is in common with other CCG's treatment of this issue.

24 Other financial liabilities

The clinical commissioning group had no other financial liabilities as at 31 March 2014.

25 Other liabilities

The clinical commissioning group had no other liabilities as at 31 March 2014.

26 Borrowings

The clinical commissioning group had no borrowings as at 31 March 2014.

27 Private finance initiative, LIFT and other service concession arrangements

The clinical commissioning group had no private finance initiative, LIFT or other service concession arrangements that were excluded from the Statement of Financial Position as at 31 March 2014.

28 Finance lease obligations

The clinical commissioning group had no finance lease obligations as at 31 March 2014.

29 Finance lease receivables

The clinical commissioning group had no finance lease receivables as at 31 March 2014.

30 Provisions

	Current 2013-14 £000	Non-current 2013-14 £000
Pensions relating to former directors	-	-
Pensions relating to other staff	-	-
Restructuring	151	453
Redundancy	106	-
Agenda for change	-	-
Equal pay	-	-
Legal claims	-	-
Continuing care	870	-
Other	35	-
Total	1,162	453

Total current and non-current

	Pensions Relating to Former Directors £000s	Pensions Relating to Other Staff £000s	Restructuring £000s	Redundancy £000s	Agenda for Change £000s	Equal Pay £000s	Legal Claims £000s	Continuing Care £000s	Other £000s	Total £000s
Balance at 1 April 2013	-	-	-	-	-	-	-	-	-	-
Transfer of assets from closed NHS bodies as a result of the 1 April 2013 transition	-	-	-	-	-	-	-	-	-	-
Adjusted balance at 1 April 2013	-	-	-	-	-	-	-	-	-	-
Arising during the year	-	-	604	106	-	-	-	870	35	1,615
Utilised during the year	-	-	-	-	-	-	-	-	-	-
Reversed unused	-	-	-	-	-	-	-	-	-	-
Unwinding of discount	-	-	-	-	-	-	-	-	-	-
Change in discount rate	-	-	-	-	-	-	-	-	-	-
Transfer (to) from other public sector body	-	-	-	-	-	-	-	-	-	-
Balance at 31 March 2014	-	-	604	106	-	-	-	870	35	1,615
Expected timing of cash flows:										
Within one year	-	-	151	106	-	-	-	870	35	1,162
Between one and five years	-	-	453	-	-	-	-	-	-	453
After five years	-	-	-	-	-	-	-	-	-	-
Balance at 31 March 2014	-	-	604	106	-	-	-	870	35	1,615

Restructuring provisions relate to the costs of the formation of new NHS organisations following the dissolution of South London Healthcare NHS Trust, payable over 4 years.

Redundancy provisions relate to employees under notice of redundancy at 31 March 2014. These will be payable in 2014/15 unless alternative NHS employment is confirmed and commences prior to the termination dates.

Continuing care provisions (£870k) relate to new continuing care claims in 2014/15 (£717k) and claims relating to periods of care before the establishment of the CCG (£153k) that are excluded from the £1561k that has been accounted for by NHS England. NHS Lewisham Clinical Commissioning Group retains legal responsibility for all NHS continuing healthcare payments relating to Lewisham patients accounted for by NHS Lewisham Clinical Commissioning Group and NHS England

Under the Accounts Direction issued by NHS England on 12 February 2014, NHS England is responsible for accounting for liabilities relating to NHS Continuing Healthcare claims relating to periods of care before establishment of the clinical commissioning group. However, the legal liability remains with Lewisham CCG. The total value of legacy NHS Continuing Healthcare provisions accounted for by NHS England on behalf of Lewisham CCG at 31 March 2014 is £1,561k.

Other provisions include NHS Lewisham Clinical Commissioning Group's share of potential redundancy liabilities relating to an employee of NHS Southwark Clinical Commissioning Group, engaged on work on behalf of all South East London CCGs.

There are no legal claims currently lodged with the NHS Litigation Authority.

31 Contingencies

The clinical commissioning group had no contingent liabilities or contingent assets as at 31 March 2014.

32 Commitments

32.1 Capital commitments

The clinical commissioning group had no contracted capital commitments not otherwise included in these financial statements as at 31 March 2014.

32.2 Other financial commitments

The clinical commissioning group had no non-cancellable contract (which were not leases, private finance initiative contracts or other service concession arrangements) as at 31 March 2014.

33 Financial instruments

33.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because the clinical commissioning group is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The clinical commissioning group has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the clinical commissioning group in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the clinical commissioning group’s standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the clinical commissioning group’s internal auditors.

33.1.1 Currency risk

The clinical commissioning group is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The clinical commissioning group has no overseas operations. The clinical commissioning group therefore has low exposure to currency rate fluctuations.

33.1.2 Interest rate risk

The clinical commissioning group borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The clinical commissioning group therefore has low exposure to interest rate fluctuations.

33.1.3 Credit risk

Because the majority of the clinical commissioning group’s revenue comes parliamentary funding, the clinical commissioning group has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

33.1.3 Liquidity risk

The clinical commissioning group is required to operate within revenue and capital resource limits agreed with NHS England, which are financed from resources voted annually by Parliament. The clinical commissioning group draws down cash to cover expenditure, from NHS England, as the need arises. The clinical commissioning group is not, therefore, exposed to significant liquidity risks.

33 Financial instruments cont'd

33.2 Financial assets

	At 'fair value through profit and loss'	Loans and Receivables	Available for Sale	Total
	2013-14 £000	2013-14 £000	2013-14 £000	2013-14 £000
Embedded derivatives	-	-	-	-
Receivables:	-	-	-	-
· NHS	-	4,025	-	4,025
· Non-NHS	-	58	-	58
Cash at bank and in hand	-	38	-	38
Other financial assets	-	(0)	-	(0)
Total at 31 March 2014	-	4,121	-	4,121

33.3 Financial liabilities

	At 'fair value through profit and loss'	Other	Total
	2013-14 £000	2013-14 £000	2013-14 £000
Embedded derivatives	-	-	-
Payables:	-	-	-
· NHS	-	12,895	12,895
· Non-NHS	-	13,865	13,865
Private finance initiative, LIFT and finance lease obligations	-	-	-
Other borrowings	-	-	-
Other financial liabilities	-	-	-
Total at 31 March 2014	-	26,760	26,760

34 Operating segments

The clinical commissioning group and consolidated group consider they have only one segment: commissioning of healthcare services.

35 Pooled budgets

The clinical commissioning group was not party to any pooled budget arrangements during 2013-14.

36 NHS Lift investments

The clinical commissioning group had no NHS LIFT investments as at 31 March 2014.

37 Intra-government and other balances

	Current Receivables 2013-14 £000	Non-current Receivables 2013-14 £000	Current Payables 2013-14 £000	Non-current Payables 2013-14 £000
Balances with:				
· Other Central Government bodies	19	-	101	-
· Local Authorities	-	-	-	-
Balances with NHS bodies:				
· NHS bodies outside the Departmental Group	236	-	500	-
· NHS Trusts and Foundation Trusts	6,104	-	12,395	-
Total of balances with NHS bodies:	6,340	-	12,895	-
· Public corporations and trading funds	-	-	-	-
· Bodies external to Government	157	-	14,268	-
Total balances at 31 March 2014	6,516	-	27,264	-

38 Related party transactions

Details of related party transactions with individuals are as follows. Each individual was a member of the CCG's Governing Body for part or all of the year 2013-14 and is either a partner or a salaried GP within a Lewisham GP practice.
The table below records payments to and amounts owed to the GP practice for the provision of healthcare services.

	Payments to Related Party £000	Receipts from Related Party £000	Amounts owed to Related Party £000	Amounts due from Related Party £000
Oakview Family Practice (Dr Helen Tattersfield - CCG Chair April to September 2013)	55		0	
Jenner Practice (Dr Marc Rowland - CCG Clinical Director April to August 2013; CCG Chair from September 2013)	78		0	
Morden Hill Surgery (Dr David Abraham -CCG Senior Clinical Director)	148		3	
Hilly Fields Medical Centre (Dr Faruk Majid -CCG Senior-Clinical Director)	30		0	
Rushey Green Group Practice (Dr Judy Chen -CCG Clinical Director)	142		10	
Woolstone Medical Centre (Dr Hilary Entwistle - CCG Clinical Director)	32		5	
South Lewisham Group Practice (Dr Arun Gupta - CCG Clinical Director and Dr Simon Parton - CCG Advisory Governing Body Member)	99		11	
Vale Medical Centre (Dr Jacqueline McLeod - CCG Clinical Director from October 2013)	36		0	

The Department of Health is regarded as a related party. During the year the clinical commissioning group has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. For example:

• NHS England;
• NHS Foundation Trusts (e.g. Guy's and St. Thomas' NHS Foundation Trust, King's College Hospital NHS Foundation Trust, South London and Maudsley NHS Foundation Trust);
• NHS Trusts (e.g. Lewisham and Greenwich NHS Trust);
• NHS Litigation Authority; and,
• NHS Business Services Authority.

In addition, the clinical commissioning group has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with the London Borough of Lewisham in respect of services for people with learning disabilities.

39 Events after the end of the reporting period

There are no post balance sheet events which will have a material effect on the financial statements of the clinical commissioning group.

40 Losses and special payments

The clinical commissioning group had no losses and special payments cases during 2013-14.

41 Third party assets

The clinical commissioning group held no third party assets as at 31 March 2014.

42 Financial performance targets

Clinical commissioning groups have a number of financial duties under the NHS Act 2006 (as amended). The clinical commissioning group's performance against those duties was as follows:

	2013-14 Maximum	2013-14 Performance	Duty Achieved?
Expenditure not to exceed income	383,159	379,416	Yes
Capital resource use does not exceed the amount specified in Directions	-	-	Yes
Revenue resource use does not exceed the amount specified in Directions	379,410	375,668	Yes
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	Yes
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	Yes
Revenue administration resource use does not exceed the amount specified in Directions	7,160	6,395	Yes

43 Impact of IFRS

Accounting under IFRS had no impact on the results of the clinical commissioning group during the 2013-14 financial year.