# CCG Governing Body

**Thursday 14 September 2017, 14:00–17:30**  
**Room G02A&B, 160 Tooley Street, London SE1 2QH**

## AGENDA

<table>
<thead>
<tr>
<th>Time</th>
<th>Item</th>
<th>ENC</th>
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<tbody>
<tr>
<td>14.00</td>
<td>Chair’s Welcome</td>
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<td>Dr. Heaversedge</td>
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<tr>
<td>14.10</td>
<td><strong>OPEN: Southwark CCG Governing Body – Meeting in Public</strong></td>
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<tr>
<td>14.10</td>
<td>2 Introductions and apologies for absence</td>
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<td>Dr. Heaversedge</td>
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<tr>
<td>14.15</td>
<td><strong>Provider presentation and question and answers</strong></td>
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<td>14.15</td>
<td>3 Guy’s &amp; St. Thomas’ NHS Foundation Trust</td>
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<td>Amanda Pritchard, Chief Executive</td>
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<tr>
<td>15.00</td>
<td><strong>Patient story / Southwark ‘showcase’</strong></td>
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<tr>
<td>15.00</td>
<td>4 Southwark Showcase: Transforming Care Programme</td>
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<td>Smriti Singh, Kate Moriarty-Baker</td>
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<tr>
<td>15.25</td>
<td><strong>Items for Assurance</strong></td>
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<tr>
<td>15.25</td>
<td>5 Minutes and action log from the meeting on 13 July 2017</td>
<td>A (i, ii)</td>
<td>Dr Heaversedge</td>
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<tr>
<td>15.30</td>
<td>6 Chief Officer’s Report</td>
<td>B</td>
<td>Andrew Bland</td>
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<tr>
<td>15.45</td>
<td>7 Director of Health and Wellbeing Report</td>
<td>C</td>
<td>Prof Kevin Fenton</td>
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<tr>
<td>16.00</td>
<td><strong>Items Recommended to the Governing Body for decision</strong></td>
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<tr>
<td>16.00</td>
<td>8 Report of the CCG’s prime committees: May, June, July, August, September 2017</td>
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<td></td>
<td>Items referred to the Governing Body for decision:</td>
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<tr>
<td></td>
<td>i. Scheme of Delegation</td>
<td>D (i)</td>
<td>Dr Heaversedge</td>
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<td></td>
<td>ii. Revision of prescribing guidance for general practice</td>
<td>D (ii, iii)</td>
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<td><strong>Items for decision</strong></td>
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Chair: Dr Jonty Heaversedge  
Chief Officer: Andrew Bland  

*The best possible health outcomes for Southwark people*
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<th>Time</th>
<th>Duration</th>
<th>Agenda Item</th>
<th>Presenter(s)</th>
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<tbody>
<tr>
<td>16.20</td>
<td>9</td>
<td>SEL CCG commissioning review</td>
<td>E Andrew Bland</td>
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**Standing Items for Assurance**

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<thead>
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<th>Time</th>
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<tr>
<td>16.40</td>
<td>10</td>
<td>Update on the latest CCG position:</td>
<td>Presentation and discussion Andrew Bland &amp; Kate Moriarty-Baker Julian Westcott &amp; Jonty Heaversedge</td>
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<tr>
<td></td>
<td></td>
<td>i. Performance and quality</td>
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<td>ii. Finance and risk</td>
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**Appended documents for reference:**

- CCG Finance Report (M4)

**Items for Reference and Information**

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<tr>
<td>16.20</td>
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<td>Minutes of CCG committees</td>
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<td>Integrated Governance &amp; Performance Committee (June; July 2017)</td>
<td>G (i, ii)</td>
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<td>Commissioning Strategy Committee (June; July; 2017)</td>
<td>H (i, ii)</td>
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<td>SCCG Primary Care Commissioning Committee (June 2017)</td>
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<td>Engagement &amp; Patient Experience Committee (July 2017)</td>
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<td></td>
<td></td>
<td>Joint Commissioning Strategy Committee Meeting summary (Feb; May 2017)</td>
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**Closing Items**

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<tr>
<td>17.20</td>
<td>12</td>
<td>Any Other Business: Items to be notified to the secretary at least 48 hours before the meeting in accordance with Standing Orders</td>
<td>Dr. Heaversedge</td>
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<tr>
<td>17.25</td>
<td>13</td>
<td>Public Open Space</td>
<td>Dr. Heaversedge</td>
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<td>17:30</td>
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Note: Extended Public Open Space to be held 17:30-18:30, Room 132ab

Date of Next Meeting: 2.00pm to 5.30 pm, 9 November 2017
CCG GOVERNING BODY

13 July 2017

Southwark CCG, 160 Tooley Street, SE1 2QH

Minutes

GOVERNING BODY MEMBERS PRESENT:
Dr Jonty Heaversedge (JH) CCG Chair (Meeting Chair)
Dr Richard Gibbs (RG) Lay Member, (Deputy Chair)
Andrew Bland (AB) Chief Officer
Joy Ellery (JE) Lay member
Malcolm Hines (MH) Chief Financial Officer
Dr Noel Baxter (NB) Clinical Lead
Dr Yvonneke Roe (YR) Clinical Lead
Dr Michael Khan (MKh) Secondary Care Doctor Member
Dr Emily Gibbs (EG) Clinical Lead
Mark Kewley (MK) Director of Transformation and Performance
Dr Nancy Kuchemann (NK) Clinical Lead
Linda Drake (LD) Practice Nurse Member
Professor Ami David (AD) Governing Body Nurse Member
Stephen Whittle (SW) Healthwatch Southwark
Kate Moriarty-Baker (KMB) Acting Director of Quality and Nursing
Andrew Nebel (AN) Lay Member
Dr Robert Davidson (RD) Clinical Lead
Robert Park (RP) Lay Member

IN ATTENDANCE:
Richard Whitfield (RW) Assurance Manager (minutes)
Nick Moberly (NM) Chief Executive, King's College Hospital
Helen Williams (HW) Clinical Associate for Cardiology

APOLOGIES:
Dr Jane Cliffe (JC) Local Medical Committee Representative
Dr Penny Ackland (PA) Local Medical Committee Representative
Caroline Gilmartin (CG) Director of Integrated Commissioning
Chair: Dr Jonty Heaversedge
Chief Officer: Andrew Bland

The best possible health outcomes for Southwark people

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<tr>
<th>Chair’s Welcome</th>
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<tr>
<td>JH welcomed attendees to the meeting. JH reminded members of some of the work that has been undertaken by the CCG leadership team to develop the principles that should run through all aspects of the CCG; to be caring, attentive and positive which are fundamental to the way we work.</td>
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<td>In particular, JH stressed the importance of being positive and supportive. JH recorded his thanks to local organisations for delivering care through a very difficult time.</td>
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<td>JH announced the outcome of the recent Governing Body elections, congratulating YR and NB for being elected to the Governing Body for a second term.</td>
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<td>JH stated that MH will be leaving for a short period of time to undergo a planned procedure. Christine Caton (Lambeth CFO) will provide additional support to the Southwark finance team during this period. JH thanked MH and wished him a speedy recovery.</td>
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<td>JH stated that the CCG are trialling an extended public open space after the governing body. This will be more informal and give the public an opportunity for a more detailed conversation with a small group.</td>
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<td>All members were asked to declare any change in conflicts of interests and raise any conflicts relating to items on the agenda. No conflict relating to agenda items were declared. The register was circulated for update and signing.</td>
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<th>Public Opening Space</th>
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<td>JH invited questions from members of the public, advising that questions can also be asked at the open space at the end of the meeting.</td>
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<td>Steve Lancashire asked for details about plans to improve mental health in the borough.</td>
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<td>JH stated that he had recently corresponded with Elizabeth Rylance-Watson regarding specific questions she had about mental health services and plans for Southwark. He also acknowledged how important mental health and parity of esteem is.</td>
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<td>Regarding support to people who are in crisis, JH stated that two mental health suites have recently been opened in KCH A&amp;E, with an additional three to follow soon. JH also referenced arrangements made with LAS to ensure that mental health specialists are available and will see patients when they arrive at A&amp;E. JH emphasised the importance of not all people being treated in the same way at A&amp;E, but that there is a need to recognise that people with mental health needs may also...</td>
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have physical health needs. JH thanked Steve, as well as Tom White and Elizabeth Rylance-Watson for their campaigning which has ensured this approach is taken. JH asked for consideration of his recent correspondence to ensure that this addresses the concerns which have been raised previously.

Steve Lancashire asked what was being done to ensure that STP process was not just a cost cutting exercise.

MK stated that the STP is based on projecting forward the amount of money in the system. There will be an increase of approximately 8 billion over the next five years but due to changes in demographics and population there will be a gap if care continues to be delivered in the same fashion as now. MK stated that everything in the STP is about finding new ways of doing things that improves the value and quality of care provided. MK highlighted that even if there was not a gap in funding we would still be setting out plans to change the way that care is provided and ensure that quality and value improves.

MH added that the work locally which is now under the heading of STP, begun some years ago as OHSEL and that the focus on value and quality of care (rather than cost cutting) has continued. Collaboration across 12 health organisations and councils has provided a vehicle for making the changes at a south east London scale.

Trevor Arnold (of Siemens Healthineers) asked how the CCG and federations are coordinating best use of point of care testing in the context of the STP and ambitions for transformational care.

JH stated that he provided leadership on the planned care group for Bromley, Lambeth and Southwark. He stated that there has been a focus to date on optimising the value of referrals but that access to diagnostics, including point of care testing are likely to become more of focus going forward. JH said that he would consider next steps with colleagues at the CCG.
**Provider presentation and questions:**

JH introduced NM, chief executive of KCH, to the governing body. JH stated that the data and information from the trust is considered monthly at IGP but it is also very useful to have a conversation with NM.

NM said that it is a pleasure and privilege to work for KCH. It is grounded in the local community serving as a DGH while also being a large specialist centre.

NM stated that there has been a focus on clinical quality which has resulted in an overall improvement across a large number of outcome measures but that there is work to be done, particularly regarding patient experience.

NM highlighted that they are anticipating a further CQC inspection. KCH are currently rated as requires improvement but have been working very hard to ensure that standards are met and demonstrate delivery.

NM highlighted the challenges in delivering the constitution standards, and the partnership working with the CCG. Progress has been made at Bromley to improve the delivery of the 4 hour A&E target and there is a significant change programme being undertaken at Denmark Hill, but this represents a more complex challenge. Regarding elective access, he said that KCH has one of the largest backlogs in the country but additional capacity has been purchased which should enable a return to the 18 week standard in the next 18 months. He said that there is a significant underlying deficit with challenging levels of savings required but that work is ongoing with partners in the system to support this.

NM identified three systematic areas of focus as: delivery of care within and outside the hospital walls, structural and leadership changes at the organisation and staff morale (there are early signs of improvement).

NM identified the big strategic development areas as: Delivery of integrated care in partnership with the wider system and CCG, and work across KHP identifying where closer partnership can develop more powerful tertiary areas of specialist care.

JH thanked NM for his candour and welcomed question

SW asked NM for more details about staff morale and why he thinks the results for staff recommending the care and KCH as a place to work was poor.

NM stated that staff engagement is fundamental to delivering high quality care. It is the single lead indicator of an organisation being able to deliver. Rich feedback has been come from staff survey on morale, engagement, care, place to work which are all quite disturbing.

NM said that KCH have been doing further reviews and gathering feedback – and there is some indication of a bit of a bounce back.
Five to six themes have been identified, each with executive director leadership and he has confidence that this will start to pay dividends.

JE asked if there are any areas of particular concern regarding high vacancy rates and the impact this can have on quality and cost of care.

NM stated that hiring, retention and vacancies is an issue across the NHS. He highlighted public sector pay and uncertainty about the EU as factors influencing this. He identified the work of HR on targeted recruitment as having the potential to reduce vacancy rates.

RG asked about the role of KCH within the LCNs.

NM reiterated his commitment to this work and that he is closely personally involved. Acute trusts do have an important role in thinking through how best to risk stratify, support and case manage complex patients. At the heart of this is ensuring there is seamless joined up care between the community and more specialist care in the acute hospital. Providing specialist expertise into MDTs is absolutely part of this.

AN asked about the achievability of the financial and performance challenges.

NM said that high quality, consistent care goes hand in hand with efficient delivery of services. Quality outcomes are linked to efficiency. He stated that early work on pathways indicates that improvements in outcomes and savings can be made.

MK asked for details of what actions have been taken following the loss of trainee doctors from radiology and whether this is a unique situation at the trust.

NM stated that the situation was extremely concerning. He stated that the trust is working very hard to address specific concerns raised, including increasing the number of consultants and remote monitoring. He said that the dialogue with HEE was positive and they are hopeful of a return of trainees soon. They are looking very closely to ensure there is not a similar issue elsewhere. This also forms part of the approach to recruitment and retention.

JH thanked NM for the candid answers provided.

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<th>Introduction and apologies for absence</th>
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<tr>
<td>Introductions were made and apologies received.</td>
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<th>Southwark Showcase: CCG Medicines Optimisation Team</th>
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<td>HW presented the recent work on AF led by the medicines optimisation team. This has involved the delivery by KCH pharmacists of virtual clinics at GP practices across Southwark. This has fed into the Pan London toolkit.</td>
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<td>This work has led to a pronounced increase in the number of people being anticoagulated in Southwark. This has risen from approximately 62% to 83%, which means that Southwark has one of the highest rates of anticoagulation in the country.</td>
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<td>HW stated that AF is a disease of aging so the number of people with AF is likely to increase. A focus on identification is required now.</td>
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<td>JH offered his congratulations to Helen personally on the leadership she has shown on this and across cardiology more generally at Southwark for a number of years, and to the wider team for the real impact that this work has had, saving a large number of fatal and disabling strokes from occurring.</td>
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<th>Minutes and action log from the last meeting on 11 May 2017</th>
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<td>The minutes were agreed to be an accurate record of the meeting on 11 May.</td>
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<td>JH highlighted that information on mental health spend had been provided following a request at the previous meeting. He noted that this had been provided previously by Lambeth CCF as part of a particular item about alliance contract, rather than as part of their regular reporting. It was agreed that this action would be noted as closed.</td>
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<td>All other actions were noted as closed.</td>
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<th>Chief Officer’s Report</th>
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<td>AB presented the Chief Officer’s report which provides the Governing Body with an</td>
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update on major developments in local health system and within the commissioning portfolio. Each area of the report has been overseen by the relevant committee of the Governing Body including the Senior Management Team of the CCG. Clinical lead portfolio holders have been involved in each area.

AB highlighted the following items for specific focus in discussion:
- New part-time role – London Medical Director for Primary Care & Digital Transformation for Jonty Heaversedge, Chair of Southwark CCG.
- The ongoing discussions across South East London regarding collaborative working. He highlighted that there will be a series of further conversations across August.
- System resilience and performance would be addressed in more detail under the performance agenda item.

JH welcomed questions from the board.

SW asked when the Deloitte report on EPCS would be available.

MK stated that the report will come through the primary care committee which meets in public in August. It will also be available on the Southwark CCG website.

AB said that it may warrant discussion at the Governing Body and is likely to be a strong contender for a show case agenda item.

The Governing Body noted the contents of the report

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<th>Report of the CCG’s prime committees: December, January, February 2017</th>
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<td>JH introduced the report, explaining the format for reporting the work of the CCG’s prime committees. JH reminded members that the papers being referred to the Governing Body for decision had been thoroughly reviewed and discussed at committee stage.</td>
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JH welcomed questions on the report or decisions made by delegated committees.

JH highlighted the item recommended to the Governing Body for decision:
- Terms of Reference for Audit Committee

The Governing Body reviewed and approved the audit committee ToR.

The Governing Body noted the content of the prime committee report and the decisions that have been made by the delegated committees.
Update on the latest CCG position:

i) Performance

AB presented information on the latest key issues, highlighting:

A&E - 4 hours target

- Improved performance at the PRUH site
- A recovery plan for the Denmark Hill site will come to IGP following meeting with regional directors
- Estates issues at the Denmark Hill site are progressing
- Both sites are suffering from staffing issues which is impacting on patient flow
- There was spike in demand in June

Referral to Treatment within 18 weeks

- Sufficient capacity has been bought by the CCG but backlog is the rate limiting factor
- There have also been on the day cancellations
- KCH are considering an insourcing approach and GST an outsourcing approach.
- The CCG have provided significant investment beyond a single year’s activity in order to address the backlog.
- Safety and clinical risk around long waiters is being

Diagnostics within 6 weeks

- Following a downward trend in performance, KCH have taken swift action at the Denmark Hill site to increase capacity. This is reflected in the most recent month’s performance

Cancer waits

- Numbers are very small which results in large fluctuations in monthly performance.
- The CCG’s position is good compared to the rest of London.
- There are challenges for the 2 week standard across the GI pathway
- GST 62 day is due to interhospital transfer
London Ambulance Services response times

- Performance remains a challenge in London
- Southwark remains one of the two boroughs in London where the target is consistently being delivered.

JH welcomed questions.

SW asked about the reference to administrative issues causing cancer waits.

AB stated that the cancer pathway is tracked in detail and route cause analysis is made for each breach. The reasons for breaches are considered by the cancer group and administrative issues are often due to complexity of process including the processing of information, booking times being missed or timing of testing.

SW asked about the recent news about the three new categories being used to stratify ambulance waits based on severity of patients.

AB stated that CCGs commission and pay for LAS services but do not set the targets. Brent CCG commission on our behalf and part of their responsibility is for them to respond to changes. **Action: AB/CG to test with Brent the background to the changes in standards and provide update to the governing body.**

The updated position as set out above and in the accompanying assurance report was noted by the Governing Body.

ii) Quality

KMB provided highlights of the quality work being undertaken by the CCG in partnership with neighbouring organisations, and main quality issues affecting the CCG. These include:

- CQRG has recently undertaken a stocktake to ensure that all quality issues are being tracked and triangulated at KCH and that the right escalation with senior managers is in place.
- There has been a slight increase in SIs possibly due to a delay in notification
- There have been three never events
- Clear protocols are in place for route cause analysis
- In the recent CQC inspection, LAS received outstanding in the caring domain.
- There is review of the process for assessing harm due to people waiting >52 weeks

JH welcomed questions.
JE asked about learning that could be taken from well-functioning teams to support those performing less well.

NB responded that at a recent QSC, Toby Stone presented on the significant improvement in fractured neck of femur delivered by a project at PRUH. Part of the learning from this was the importance of reporting positive outcomes about teams.

KMB stated that increasingly the quality team is working across organisations and sharing lessons learnt. This is an opportunity which should be taken advantage of.

KMB said that her team could consider how to take a more systematic approach to sharing learning about teams.

JH stated that he would invite Toby Stone to present under the showcase item

The updated position as set out above was noted by the Governing Body.

iii) Finance

MH presented the current and projected financial position for the CCG, drawing particular attention to the following:

- It is still very early in the financial year
- There is a target surplus of £9.6 million with a planned drawdown of 700K for the year
- Targets are less flexible than in recent years
- Trajectories are on track but there are potential pressures around primary care
- The majority of reserves are non-recurrent but cost pressures are recurrent
- A paper outlining plans for 18/19 and 19/20 will be available soon

JH welcomed comments and questions.

RG highlighted the recurrent risks vs the non-recurrent reserves, and that the CEP process adds additional pressures

JH emphasised the importance of clinical involvement in identifying and developing QIPP opportunities.

MH highlighted that the CEP process is identifying QIPP opportunities over and above what has already been agreed. There are various ways that this work is being taken forward, including the Lambeth and Southwark QIPP group.

AB highlighted that benchmarking has highlighted areas where savings can be made including a recovery of out of area payments, meds optimisation savings.
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<thead>
<tr>
<th>The updated position as set out above and in the accompanying finance report was noted by the Governing Body.</th>
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<td>iv) Risks</td>
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<td>JH presented the key points from the Board Assurance Framework and recent reviews of risk.</td>
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<td>JH highlighted the extreme risks and the robust processes in place to review risks. The Integrated Governance and Performance Committee meetings in May and June were provided Risk Reports updating it on the progress made on mitigating actions for risks on the BAF and directorate risk registers.</td>
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<tr>
<td>The Governing Body noted:</td>
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<td>• One new risk was added to the BAF on London-wide re-commissioning of GUM and RSH services under a new integrated tariff. This risk is expected to be closed soon.</td>
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<td>• Two risks were closed: 1. Risk that there is no formal transformation programme in place which reduces our ability to systematically support commissioner and provider development and 2. Risk that there is no robust Southwark and Lambeth transformation programme which undermines our ability to engage providers in systematic development of new integrated working and/or new organisational and contractual relationships.</td>
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<td>• Risk reviews are being conducted on a monthly basis by teams and their directors. Continuous risk monitoring ensures that risks and controls are current and the most up to date information is provided to the Governing Body.</td>
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<tr>
<td>• Integrated Governance &amp; Performance Committee (April &amp; May 2017)</td>
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<td>• Commissioning Strategy Committee (April 2017)</td>
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<td>• Primary Care Joint Committee (February 2017)</td>
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<td>• Engagement &amp; Patient Experience Committee (May 2017)</td>
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<td>• Audit Committee (April 2017)</td>
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<td>• SCCG Primary Care Commissioning Committee (April 2017)</td>
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<td>• South East London Commity in Common (Nov 2016)</td>
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<th>Any other Business</th>
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| 15 | **Public Open Space**  
JH invited questions from the public and welcomed them to an extended session to be held immediately after the meeting. |

|    | **Date of the next Governing Body Meeting:**  
14 September 2017, 2.00pm to 5.30pm, 160 Tooley Street. |
# Action Log: Governing Body Meeting July 2017

## Outstanding action from last Governing Body meeting

<table>
<thead>
<tr>
<th>Meeting Date</th>
<th>Agenda item</th>
<th>Action Point</th>
<th>Update</th>
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<td>Update on the latest CCG position</td>
<td>Provide background to the recent changes to ambulance wait standards</td>
<td>CG will verbally provide an overview of changes at the September GB</td>
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## Actions closed since the last Governing Body meeting

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## ITEM FOR DISCUSSION / ASSURANCE

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**Item title:** Chief Officer’s Report – 14 September 2017

**Enclosure number:** B

**Any known conflict of interest:** No

**The item is being presented to the committee for (select only one):**

- [x] Assurance
- [ ] Discussion
1. Purpose of the paper (why does the committee need to discuss / receive assurance?)

The Chief Officer report provides the Governing Body with an update on major developments in local health system and within the commissioning portfolio.

2. Describe the issue being presented to the committee for discussion or assurance

This report gives focus to:

- Chief (Accountable) Officer arrangements
- NHS England – Directions for NHS Southwark CCG
- Partnership commissioning
- Better Care Fund (BCF) in Southwark
- System wide transformation
- Our Healthier South East London (OHSEL)
- System Resilience
- NHS Continuing Healthcare Discharge to Assess (CHCD2A)
- General Practice Forward View - 2017/18 Resilience Funding
- CQC Inspections
- Medicines Optimisation
3. What stakeholder engagement has taken place?

Each area of the report has been overseen by the relevant committee of the Governing Body including the Senior Management Team of the CCG. Clinical lead portfolio holders have been involved in each area.

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<td>CCG Chief Officer’s Report – September 2017</td>
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| Date paper completed | Monday, 11 September 2017 |
Chief Officer’s Report
14 September 2017

1. Chief (Accountable) Officer arrangements

In August 2017 I wrote to all staff, members and stakeholders to inform them that, upon the planned departure of the current Chief Officer at NHS Greenwich CCG on 11 September, I would take up the role of Chief Officer for that CCG on an interim basis (for at least the next six months). I will hold this position in addition to my current role as Chief Officer of NHS Southwark CCG.

This interim arrangement is being made ahead, and in the context of the south east London CCG review proposals that the Governing Body is receiving today - that will, if approved, establish a different and long term arrangement for the leadership of south east London’s CCGs. During the period for which I will hold these two positions, both Greenwich and Southwark CCGs will each appoint interim Managing Directors on a full time basis to provide the requisite capacity to each local area to deliver on commissioning objectives. These Director roles will manage the CCGs’ senior management teams and will report to me. The Governing Body considered and supported this development in July 2017.

2. NHS England – Directions for NHS Southwark CCG

On 1 September 2017 NHS England wrote to the CCG to confirm the use of their powers under the NHS Act 2006 (as amended) to direct NHS Southwark CCG to support acute commissioning at Greenwich CCG and Lewisham CCG by taking on that function for each CCG for a period of time. In order to do this, legal directions have been applied to all three CCGs.

This action follows a period of concern around the performance of urgent and emergency care services and as a CCG we look forward to working in full partnership with the leadership of both those CCGs to strengthen this area over the coming months. Full details of the Directions to all three organisations can be found on the NHS England website.

In order to secure the required capacity to fulfill this additional responsibility the CCG has worked with all CCGs in south east London to expand its Integrated Contracts and Delivery Team, that will now work across all six boroughs rather than its current portfolio relating to Bromley, Lambeth and Southwark.

3. Partnership commissioning update

The Partnership Commissioning team is now close to full staffing levels following a successful recruitment campaign and is in a position to increasingly influence the development of the population based commissioning approaches. The team is currently working on a number of key commissioning work streams, including developing the detail of
the agreed population segmentation model, developing joint commissioning intentions for 2018/19 and more generally supporting the commissioning development groups to deliver their challenging agendas. The team has also led on the BCF plan and is undertaking a major procurement for care at home services.

4. Better Care Fund (BCF) in Southwark

I am pleased to report that the Integrated Governance and Performance Committee (IGP) agreed the draft Integration and Better Care Fund (BCF) Plan at its meeting on 24 August 2017. The Health and Wellbeing Board is scheduled to hold a special meeting on 11 September 2017 to agree the plan.

Following agreement by the Board, the Local Authority and the CCG, it is due to be submitted to the national assurance process immediately after that meeting. Approval of the plan by NHS England and the national BCF team, or any direction on required changes for approval to be granted, is expected in early October 2017.

A key feature of the 2017-2019 BCF plan is the additional resource provided by the iBCF (Improved Better Care Fund) which is a council grant of £9.1m in 2017/18 rising to £12.6m in 2018/19 which is to be included within the total BCF pooled budget and applied to social care cost pressures. Locally we have agreed that this funding should be applied predominantly to home care and nursing care which were otherwise facing critical cost pressures in 2017/18. This additional resource has been warmly welcomed but still does not fully address the resource gap facing the local social care system. Detailed plans for the 2018/19 iBCF growth will be discussed in alignment with the council’s budget process.

The core BCF plan of £22.3m continues to support the range of community based health and social care services around hospital discharge, admissions avoidance and support to live at home, protecting social services of value to health. Although this represents a two-year plan, there will be a review of services during 2017/18 as we seek to further align the BCF approach with strategic priorities around integration and population based commissioning.

The much delayed planning conditions introduced a much stronger focus on delayed transfers of care. An action plan on the High Impact Change model for delayed transfers is included within the plan. The plan also contains new targets reflecting Southwark’s contribution to the national reduction target, with separate targets for council and NHS delays as well as overall delays. Although challenging, the target has been met locally for quarter one of this year.

The development of the plan has been led by the Partnership Commissioning team, working with the CCG and council to establish an agreed approach to this complex pooled budget arrangement, and provides a platform for further progress on integrated approaches to funding services.
5. Taking forward system wide transformation

Transformation activities across the CCG are about putting our Five Year Forward View into action, by taking steps to reduce fragmentation in commissioning, by strengthening the way local providers work together, and by activating and empowering local communities. To help us to transform commissioning we have agreed to use the ‘Bridges to Health’ population segmentation framework; this is a way of thinking about how resources and services are organised based on people and their needs, rather than thinking purely about healthcare institutions.

This is a new way of approaching commissioning and, whilst we are following in the footsteps of others, we are taking time to fully understand this new approach and to consider how we use it to improve value for local people. We have arranged workshops and discussions within the CCG and Council to create the time and space for commissioning leads and the Partnership Commissioning team to explore the model in more depth. These discussions and workshops will continue throughout September, particularly in order to set out some practical first steps towards implementation as part of our communications around commissioning intentions.

Our work to support provider development also continues, with a range of important actions to build resilience within individual general practices, to create sustainable collaboration between practices, and to transform the way that all community-based services work together within primary care. In all of this work the CCG is partnering with the borough’s two GP federations (Quay Health Solutions and Improving Health Limited) to provide funding and to support practical ‘on-the-ground’ changes including:

- **Focused support** has been provided to practices through QHS’s Improvement Leaders Programme to improve stability and resilience in general practice. This has involved improvement leads from each practice coming together to receive practical support, facilitation and training; and in doing so they are able to identify practice-based improvement projects which are then delivered over the course of several months. We have also been working closely with IHL to develop cluster-based improvement projects in the south of the borough. This is about bringing practices together to get to know one another and to identify opportunities for better collaboration, with facilitation and peer-support to help make those changes happen.

- **We are mobilising our Clinical Effectiveness Group**: this is a three-way collaboration with the federations to establish a clinically-led expert resource that can provide tools and training to practices so that ‘the right thing to do, is the easy thing to do’ - for example by making sure that templates support clinical guidance and is easy to fill in. We have applied to the Health Foundation for additional support in delivering the CEG, and we have been shortlisted for the final round selection interview.

- **We are about to launch the fourth of a series of Protected Learning Time events focusing on care coordination for people with complex health and care needs.** This has been a very successful example of local providers, commissioners and patients working together and learning together, for example: hearing from experts about the recent NICE guidelines on managing multi-morbidity, refreshing motivational interviewing techniques and discussing with patients what effective care planning looks like. The final PLT event will be an immersive learning event with facilitators and role-play, and it is scheduled to coincide with the launch and mobilisation of a new care pathway for people living with 3+
long-term conditions. This development of these new pathways of care have helped to formalise some of the working practices between different parts of our local health and care system, and in doing so it has helped to establish the relationships and processes that give rise to Local Care Networks (LCNs) in practice.

Our five year forward view also highlights the need for a ‘more than medical’ approach, built upon much stronger partnerships with local community organisations. To help us to understand this in more detail, and to help foster the new relationships between GP practices and local community ‘anchor’ organisations, we have established learning partnerships within Walworth and Canada Water. This work – in partnership with Community Southwark, Pembroke House and Time & Talents – will help us to link health partners with the energy and activities that already happen within our communities all the time, and to develop new ideas that help GP practices, IAPT services and community groups to work more closely together.

These are the sort of transformative relationships that the Governing Body heard about through the Pembroke House presentation given at the Annual General Meeting. This overall approach follows other successful examples from around the country, for example: in Robin Lane Surgery in Leeds this type of community action helped the GP practice to connect some of its most frequent attenders to interesting community activities in a way that helped empower and entertain those patients, whilst also freeing up significant time for doctors to care for patients who needed medical care.

6. Our Healthier South East London (OHSEL) update

OHSEL receives ‘advanced’ rating

NHS England and the Department of Health recently announced the first ratings for STPs. I am pleased to report that OHSEL has been rated as ‘advanced’ – the second highest category. This is good recognition of the work we have done since 2013 in bringing health and social care together to plan the best ways to deal with the financial, quality and capacity challenges we have. Our collective leadership has been rated “advanced” - the highest grade.

Regulators have been clear that STP ratings should not be taken as a comment on the performance of STPs to date. Rather, it indicates the relative starting points on the road to better care, often driven by a range of historical factors.

Update from the Strategic Planning Group

Our Strategic Planning Group (SPG) – the senior governance group of the STP - held its second meeting in public on 4 September 2017. The meeting covered updates on a range of activity from across the programme, which are summarised below.

- **Finance back office** - all five providers have signed up to a proposal to develop a single ledger system, and they are currently in the design phase and potentially effected staff are being engaged.

- **Delivery plans** - have been developed for four priority areas set out in NHS England’s recent Five Year Forward View delivery update (mental health, cancer, urgent and
emergency care and primary care). Alongside these nationally prioritised areas it is important the STP does not lose focus on longer term transformation and the STP is using both its clinical and enabler programmes – digital, estates and workforce - to make sure that the programme remains transformation focussed.

- **Accountable care** - A paper was considered on the development of accountable care systems, in line with the Next Steps in the Five Year Forward View. Experts in the development of integrated organisations, Credo, have been appointed following a competitive procurement for a two-month role to look at the complex organisational and care structures in south east London, speak to stakeholders, and make some recommendations on the options available for moving this forward. It was emphasised that this is about how we can work in a more integrated way, building on existing good work, and that it was likely to be more about a "system of systems and networks", rather than involving organisational change.

- **Financial Strategy** - south east London is one of the STP footprints that are part of the capped expenditure process. This is because we have not so far been able to submit plans which confirm that all organisations will meet their financial targets this year. As a result, regulators have requested OHSEL to provide a consolidated financial forecast up to 2020/21 for all organisations within the footprint (including Specialised Commissioning). The STP is working with each of the partner organisations to develop their own forecasts to ensure that there is a consistent approach taken across the system. This exercise will allow OHSEL to demonstrate the normalised financial position of the south east London footprint up to and including 2020/21. There are no proposals as part of either the capped expenditure process or the sustainability and transformation partnership to close or downgrade services.

### 7. System Resilience

**Accident and Emergency 4 Hour Wait Standard**

Performance at both St Thomas’ and Denmark Hill departments, has remained below the national standard of 95% of patients being treated, admitted, transferred or discharge within 4 hours - with St Thomas’ achieving performance of 90.7% in August 2017 and Denmark Hill achieving performance of 85.67% in the same time period. This represents an improved position for both sites, which whilst slightly behind trajectory, represents progress in our overarching aim of returning to national compliance by the end of March 2018. Both Trusts have full recovery plans in place which are subject to continued scrutiny by both the CCG, and NHS England and NHS Improvement at Regional Director level.

As previously noted, both sites are affected by estates issues. For Guy’s and St Thomas’ Hospitals NHS FT (GSTT), the rebuilding of their Emergency Department (ED) has proven to be particularly problematic with majors and resuscitation areas now separated and a number of key supporting services no longer co-located with the rest of the ED. As a result, the ED department is operating in sub-optimal conditions, but with arrangements that ensure quality and safety is maintained, although performance has been impacted upon. These works will not be fully completed until 2018, but a number of key milestones are due to be met over the next few months which will see additional facilities start to come on-line. Staffing has also been a key issue for GSTT’s ED department, but a number of consultant and middles grade
posts have now been appointed to, with the ED expected to be at full establishment by the end of quarter three.

In relation to Denmark Hill, capacity constraints have been cited as a key driver to underperformance against the 4-hour target. However, Charles Polkey, a 23 bedded ward, opened in early July which will ultimately allow for a greater number of beds to be allocated to acute medicine. However, a series of site moves are now underway to expand surgical and medical assessment units, thus the full benefit of the additional capacity is unlikely to be felt until October this year. Whilst this will not fully close the projected bed deficit at the site, it is expected to help reduce flow issues and delays in transferring patients from ED and the acute medical unit.

We are pleased to report that the re-specified 24/7 Urgent Care Centre is now operational with dedicated space and staffing which should significantly improve waiting times for patients with minor conditions as well as providing space for three mental health suites. The service is still in the process of fully mobilising and work is continuing to recruit additional staffing and optimise pathways and flow.

The A&E Delivery Board has also been working to review winter plans and allocate winter pressure funds which will support all system partners to increase resilience ahead of winter. These will be finalised in the next 2 weeks, but will put strong emphasis on developing our Discharge to Assess model which aims to ensure that the majority of assessments for patient’s long term health or care needs can be undertaken out of hospital – in care homes, step down community beds, or in the patient’s own home. Where previously piloted, there is strong evidence that this approach can support more timely, personalised and accurate assessments, whilst also reducing hospital occupancy levels. This, along with the other initiatives currently being developed, aim to ensure that the system is equipped and able to manage winter pressures whilst continuing to improve waiting times within local emergency departments.

Referral to Treatment (RTT) Standard

Overall RTT performance for NHS Southwark CCG did not meet the 84.2% trajectory for June 2017, reaching 82.8%, although this was an improvement from 81.8% in May 2017. RTT performance for our CCG at King’s College Hospital NHS FT (KCH) was 76.9%, where all specialties with the exceptions of Rheumatology, General, Geriatric, and Thoracic Medicines were non-compliant. In July 2017, ‘18 Week Support’ were contracted to provide additional capacity for KCH via insourcing, and outpatient clinics began with the Ophthalmology service on 22nd July. Other services currently planned to be insourced are outpatient appointments and day cases for Dermatology and General Surgery. Although insourcing will provide additional capacity and improve RTT performance, KCH are not expecting to be compliant with the RTT standard until March 2019.

Formal feedback has been received by KCH following the NHS Improvement (NHSI) investigation into RTT, confirming that no enforcement action would be undertaken in relation to the Trust. It did require the trust to have a fully integrated recovery plan for RTT. This was submitted to NHSI at the end of June 2017, and the plan is currently being revised to reflect feedback, but has not yet been formally board approved. Additional support from NHSI has also been given to the trust with the placement of an RTT Improvement Director working on site.
RTT performance for NHS Southwark CCG at GSTT was 88.0%. GSTT are continuing to work with local commissioners on demand management for growth, including working with GPs to develop a screening process at point of referral for ENT patients on the ‘Balance pathway’, which would enable these patients to be identified and be given access to physiotherapy earlier on in the pathway. Although previous plans to outsource Orthopaedic hip and knee patients to BMI are no longer going ahead, additional capacity will be provided with the appointment of two substantive Orthopaedic consultants to the Trust, one of which is a hip and knee surgeon who starts in August.

The number of Southwark patients waiting over 52 weeks in June 2017 was 41. Of these 41 breaches, 38 occurred at KCH and the remaining three breaches occurred at GSTT.

Cancer Waits

NHS Southwark CCG did not meet the trajectory of 85.7 % for Cancer 62 Day performance in June 2017, reaching 72.2% (10 out of 36 patients breached). However, this was an improvement from 70.4% in May 2017. The breaches were allocated to the following providers: GSTT (5), KCH (4), and Barts Health NHS Trust (1).

Cancer performance continues to be monitored through the 62 Day Leadership Group, and a south east London cancer delivery plan has been developed to ensure that the providers can improve performance and improve treatment times for tertiary referrals. KCH, GSTT, and Lewisham and Greenwich NHS Trust (LGT) all submitted refreshed cancer performance trajectories to regulators in June 2017 as part of the update to the south east London cancer delivery plan. The revised trajectories were formally signed off in August 2017. As part of that cancer delivery plan, bids to support short term cancer diagnostic performance improvement were also invited. As a result of this, KCH were allocated funding for additional Endoscopy capacity to support the Upper and Lower GI pathways, and LGT were allocated funding to support the implementation of straight to test for the Lung pathway. A bid was not submitted for GSTT as it was thought that improved diagnostic access in LGT and KCH would improve ITT times to GSTT.

Additional funding was made available to bid for by the STP from NHS England under STP Transformational Funding. Bids were submitted to NHS England in January 2017, focusing on key themes of early detection, stratified follow-up, and recovery packages. The Early Diagnosis Transformation bid has been approved for quarter one. The other two bids (Recovery Package and Stratified Follow up) which are London-wide are still waiting confirmation.

NHS Southwark CCG met the 93% national two week wait (2WW) standard for all cancers in June 2017, achieving 94.0%. As well as an improvement from 91.1% in May 2017, performance was also compliant with the 93.0% trajectory for June 2017.

Electronic Referral System (e-RS)

The CCG’s June e-RS utilisation was at 28%. This ranks Southwark at 24th out of 32 in London and 170th out of 209 nationally. NHS Southwark CCG has improved from 22% in December.

GSTT currently have 92% of services linked to e-RS. The Trust have been chosen as early adopters of paper switch off and will close to non e-RS referrals for all specialties by April.
2018. Phase 1 of the paper switch off began on 1 September. KCH have not yet submitted a clear breakdown of services currently available. KCH Trust are working to a plan to have all services available on e-RS by April 2018 and to have paper switch off by October 2018.

In primary care a large number of services are currently available on e-RS however, utilisation has not improved dramatically. All practices in Southwark have self-certified that they will be able to use e-RS for referrals to the phase one GSTT specialties and this is expected to increase utilisation. The CCG has given regular communications to primary care on the developments in e-RS. An IT facilitator is offering training to any practices in need and group training sessions have been arranged. The CCG has agreed to review and sign of the finalised Directory of Services proposed by both Trusts prior to any paper switch off to ensure the system is usable from a GP perspective.

8. **NHS Continuing Healthcare Discharge to Assess (CHCD2A)**

As part of the eight High Impact Actions stipulated nationally for improving emergency care performance, CCGs are required to reduce the number of continuing healthcare assessment undertaken in an acute setting. By March 2018 less than 15% of CHC assessment should be undertaken in an acute setting. The SEL CHCD2A Review Group, which is led by the CCG Interim Director of Quality and Chief Nurse, has agreed a SEL STP trajectory for the achievement of this target as part of the Urgent and Emergency Care Improvement Plan.

In addition, individual CCGs are required to report on progress in achieving this target to NHS England with the first assurance return due on 11 September 2017. As at end of quarter one 60% of CHC assessments in Southwark took place in an acute setting, a monthly trajectory has been set which shows achievement of this target by end March 2018. NHS Southwark CCG in partnership with NHS Lambeth CCG, has established a CHC Discharge to Assess (CHCD2A) Board to oversee the development and implementation of a discharge to assess pathway. This pathway has been developed in partnership with acute and community providers and is supported by additional resources from winter pressure monies and a phased implementation of this pathway will go live on 11 September 2017.

Regular updates on the CCGs achievement of the trajectory will be provided to Integrated Governance and Performance and via the bi monthly Quality Report to the Governing Body.

9. **Primary care updates**

**General Practice Forward View - 2017/18 Resilience Funding**

I am pleased to confirm that NHS Southwark CCG will receive £38k in 2017/18 to support the resilience of general practice in 2017/18 on a South East London allocation. Six practices in Southwark have been identified using the heat-map, which was developed at a London level and locally held information. No practices in Southwark self-nominated themselves for inclusion in the 2017/18 programme.

The CCG has made contact with all practices to discuss the type of support the practices may wish benefit from. This will be agreed between the CCG and practices by the end of September 2017. This is in addition to the offer of RCGP support which is provided to
practices rated as inadequate and placed in special measures following a CQC inspection. This will be considered on a case by case basis.

**CQC Inspections**

To date all but two of Southwark’s GP practices have been inspected by the CQC and had their reports published. Queens Road Surgery and Sir John Kirk Close have not been inspected, but will be inspected prior to the 1 October 2018. From 1 October 2018 the CQC will implement a new process for prioritising practices for inspection. The outcomes of inspection confirmed 24 practices as ‘Good’, six as ‘Requires improvement’ and five as ‘Inadequate’. The CCG has directed its support to practices in the final two categories.

**10. Medicines Optimisation**

Devika Sennik, Senior Pharmaceutical Adviser at NHS Southwark CCG has been appointed as one of three CCG representatives at the London Regional Medicines Optimisation Committee (RMOC). She was successful in this appointment having drawn from her commissioning role at Southwark and her Area Prescribing Committee role hosted by Lambeth on behalf of all six CCGs.

RMOCs will provide advice and make recommendations on the optimal use of medicines for the benefit of patients and the NHS. They will bring together decision makers and clinicians across the four regions of England, to share best practice, understand the evidence base, coordinate action and so reduce variation thus improving outcomes and value.

**11. London Leadership changes**

In July 2017 Dr Anne Rainsberry announced that she would be leaving her role of as NHS England, Regional Director for London. I am sure you will join me in wishing Anne the very best in the future and in recognising the huge contribution Anne has made to health and care in the Capital. We were delighted that Anne’s final interview with BBC London News in late August featured Southwark’s Extended Primary Care Service. Jane Cummings, NHS England’s national Chief Nursing Officer, will undertake the Regional Director role going forward, on an interim basis. We equally welcome Jane to our system.

Finally, as outlined in the first section of this report, Jo Murfitt left her position as Chief Officer at NHS Greenwich CCG on 8 September 2017 and will take up her new post as Director of Specialised Commissioning for NHS England (London Region) on 11 September. Again I am sure you will join me in wishing Jo well and thanking her for her contribution to both Greenwich and south east London.
ITEM FOR DISCUSSION / ASSURANCE

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Item title: Director of Health and Wellbeing Report

Enclosure number: C

Any known conflict of interest: N/A

The item is being presented to the committee for (select only one):

- Discussion: ☐
- Assurance: ✓
1. Purpose of the paper (why does the committee need to discuss / receive assurance?)

The Director of Health and Wellbeing report provides a high-level overview of recent developments in public health policy and practice from the London Borough of Southwark, London-wide public health developments as well as national initiatives of relevance to our work in Southwark.

2. Describe the issue being presented to the committee for discussion or assurance

This report gives focus to:

**Updates from Southwark Public Health:**
- Response to the London Bridge Terror Attacks
- Social regeneration in Southwark
- Southwark Joint Mental Health and Wellbeing Consultation
- Health Profiles for Southwark
- Sexual Health
- HIV PrEP Impact Trial update
- Joint Strategic Needs Assessments in Southwark
- Arts and Health in Southwark: The Peckham Experiment

**Pan-London Public Health Developments of Significance:**
- London Smoking Cessation Transformation Programme (LSCTP) helpline campaign.
- London drug and alcohol blog
- London intelligence summaries from the London Knowledge and Intelligence Service
- Thrive LDN event

**National Public Health Developments of Significance**
- Prevention concordat for better mental health and suite of documents
- Better care for people with co-occurring mental health and alcohol/drug use conditions
- Reducing Health Inequalities: System, Scale and Sustainability
- Sexual health commissioners survey report
- Heart Age Test relaunch
- Improving clinical responses to drug-related deaths: a summary of best practice and innovations from drug treatment providers
- Update on Business Rate Retention
- NHS England publishes new help for ‘acid attack’ victims following recent rise in demand for NHS help

**Funding, education and collaboration opportunities:**
- PHE invites expressions of interest to participate in an Individual Placement and Support (IPS) drug and alcohol dependency trial
- Letter on metrics and outcome measures for healthy child programme 0-5 years: data collection
- Public Health England seeking five local authority-Clinical Commissioning Group partnerships to participate in Physical Activity Clinical Advice Pad pilot
- Empowering Parents Empowering Communities (EPEC) programme
- Refresh for the Health Inequalities e-learning programme
- PHE annual conference 2017

3. **What stakeholder engagement has taken place?**

N/A

**Supporting information / documents**

Please append any relevant documents including detailed reports; options appraisals; background documents; national guidance etc.

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Director of Health and Wellbeing Report

13 July 2017

Introduction

1. Southwark is a place of growth, development and opportunity. It is a borough with a rich and proud history, a strong sense of community and a great ability to transform and renew, at times against the odds. The Council’s ambition (as expressed through the Council Plan) is of “a fairer future for all” where everyone can achieve their potential, and be more than the sum of our parts in a borough that is proud if its place in the world.

2. The ambition is underpinned by plain speaking principles that guide everything that we do. These include making Southwark a place to be proud of and treating residents as if they were a valued member of our own family. It is this ambition and fairer future values that provide the twin basis for developing a social regeneration policy framework, a draft of which is set out in this report.

3. In addressing the wider determinants of health, Southwark’s urban regeneration has been a key strategy to revitalise communities by transforming the built environment and injecting enhanced economic opportunities. However changing the built and social environment will only be part of the solution. We need to engage our everyone who lives, works and plays in the borough to be more engaged in their healthy and wellbeing. Getting this message out to people is more important than ever, with new analysis from PHE showing that 8 out of 10 people aged 40 to 60 either weigh too much, drink too much or don’t exercise enough. It’s understandable that when people are busy with work, with families and with the daily grind, sometimes their own health is the least of their priorities. The Global Burden of Disease study revealed that more than 60% of the top four health conditions contributing to premature death and ill health (heart disease, stroke, lung cancer and breast cancer) can be attributed to behavioural or a combination of behavioural and non-behavioural risks.

4. This update report provides a high-level overview of recent developments in public health policy and practice from the London Borough of Southwark, London-wide public health developments as well as national initiatives of relevance to our work in Southwark. The final section outlines emerging opportunities for collaboration, education and funding from Public Health England and other sources.
Updates from Southwark Public Health

Response to the London Bridge Terror Attacks

5. Following the Saturday 3 June 2017, London Bridge and Borough Market terror attacks, Southwark Public Health team have been working closely with Healthy London Partnership, PHE, NHSE and other stakeholders via the Humanitarian Assistance Steering Group and Mental Health and Wellbeing Sub-Group which were established to coordinate the response and help mitigate the negative impacts on mental health and wellbeing, economic activity and community cohesion. Following the incident, a Humanitarian Assistance Impact Assessment (HAIA) was completed by a number of organisations involved in the response to better understand the impact on communities and what humanitarian assistance is required. Thematic analysis of the HAIA revealed three key areas of focus for this needs assessment: Mental health and wellbeing; Economic activity; and Community cohesion.

6. Working with Healthy London Partnership colleagues we have developed (1) a multi-agency stepped model of care that is holistic and personalised; (2) an evidence based and proportional, flexible and timely programme of activities to respond to needs as they emerge; (3) provided clear and consistent messaging to general population and target populations affected; (4) and monitored the system response and overall utility of care in providing additional support as necessary. More specifically, the Public Health team have supported the humanitarian response through: coordination of psychological first aid across health, care and community partners; undertaken humanitarian assistance impact assessments; completed a health needs assessment; supported the development of data and information sharing protocols and practice; informed evidence-based and timely communications to general and priority populations; supported the community cohesion and engagement activities; and have commenced structured reviews and assessments of our response to date. Additional information on the role and lessons learned available from kevin.fenton@southwark.gov.uk

Social regeneration in Southwark

7. Social regeneration is not something new to Southwark. The borough has always been a place of visionary change. It was home to Ada and Alfred Salter, pioneering MPs in the early 20th century, who brought one of the first public health services to this corner of London. More recently, Southwark has led successful urban regeneration, working to boost local economic growth, revitalise neighbourhoods and create opportunities for all. In the 10 years prior to 2015, Southwark fell from being the 10th most deprived borough in the UK to the 41st. More so, with children’s services rated ‘good’ by Ofsted and schools performing among the best in the country and more Southwark residents in work than at any time this century, this is a borough where families want to raise their children so they too can take up the opportunities from the borough’s place at the centre of London. Working with residents, development partners and the community, Southwark is delivering some of Europe’s most exciting and complex regeneration schemes. This is helping to shape future neighbourhoods at Elephant and Castle, Aylesbury, Canada Water and the London Bridge Quarter among others.
8. Work continues with colleagues across the Council to develop our approach to social regeneration alongside renewed and proactive community and partner engagement. An emerging area of interest for many colleagues is ensuring that the benefits of social regeneration are linked to a wider cross-section of local communities, not just the areas undergoing targeted investment. Capturing and expanding these collateral benefits are a key contribution of social regeneration efforts. In addition, we have begun to think about how the principles and approaches of social regeneration may be applied to areas that might not have large-scale urban regeneration planned but would still benefit from better coordination of social services including health, education, housing, social care, environment and leisure services, and community engagement and cohesion programmes. There are no easy answers to these questions but the good news is that our work and exploration of these issues provide new opportunities for public health to contribute to these emerging agendas. Further information on social regeneration is available from kevin.fenton@southwark.gov.uk

Southwark Joint Mental Health and Wellbeing Consultation

9. Mental ill health is a major priority in Southwark. We know that 3,800 people in the borough have a serious mental illness and they are most likely to be male, older and from a black ethnic background. Almost 1,200 people over 65 years old in Southwark have been diagnosed with dementia, and 47,600 people are currently experiencing a common mental disorder in Southwark, affecting more women than men. Responding effectively to this challenge will require more than providing high quality services. We need to move upstream to do more on promoting good mental health and resilience, expand community based care and activating communities, improve clinical and care services, improve recovery pathways, and work towards improved quality and outcomes across the entire system. That’s why I’m delighted that we have been working with NHS Southwark Clinical Commissioning Group (CCG), other NHS organisations, the voluntary and community sector, users of services, carers, and local residents to launch a consultation on our revised Southwark joint mental health and wellbeing strategy. We want to support everyone in Southwark to live healthy, happy and longer lives, stop people from becoming unwell and support more people in the community and at home. Please share with your partners and encourage everyone to give their feedback using this link to the Consultation Hub and complete our online form before 10 September 2017.

Health Profiles for Southwark 2016

10. Having a robust understanding of the health and wellbeing status of our local population is the cornerstone for effective policies, programmes and action. The Public Health England Health Profile reports provide a snapshot overview of health for each local authority in England. They provide a broad overview of the health and wellbeing of the population, highlighting issues that can affect health in each locality. Public Health England has recently released an overarching Local Health Profile and a Child Health Profile which focuses specifically on children and young people. Chris Williamson and our health intelligence team have further analysed the data for Southwark and provided additional insights on where we are doing well, consistent or poorly compared to other London boroughs and those nationally. Even in these challenging times, we should be proud that
there are many areas where we are doing well compared to others. However, the health profiles are only the beginning of the conversation – we will work with our partners in the year ahead to focus on securing improvements in some of the more challenging areas including immunisations, STIs, violent crime, childhood obesity and emergency admissions. Further information from chris.williamson@southwark.gov.uk

Sexual Health

11. Southwark has a young, mobile and international population. Much work has been undertaken over the last decade to improve the sexual health of our borough and there have been considerable successes. However, we know that some Southwark residents are still engaging in risky activities and sexually transmitted infections (STIs) remain prevalent in our borough. We also know that there is an unacceptable correlation between deprivation and STIs, teenage conceptions and abortions, and that the highest rates of STIs in our borough are found in men who have sex with men (MSM), young people and black and minority ethnic groups. Through commissioning and providing our services, we must continue to strive to ensure that no community is being left behind and that regardless of age, ethnicity or financial means, everyone in Southwark has whatever they need to stay healthy and achieve wellbeing.

12. Open access sexual health services, based in clinics in Camberwell, Streatham, Burrell Street and Walworth, are hugely important part of what we do. Providing these open access clinics is a requirement by statute, and they are well used by our residents. Specialist open access clinics do, however, come at a substantial cost. In response to significant cuts in national government funding to local government – in particular to the ring fenced public health grant – it is critical that we find lower cost and more efficient ways of providing our residents with high quality sexual health services, that will meet the sexual and reproductive health needs of residents in the coming years. Innovations such as our e-service, channel shifting, innovative partnership for sexual health promotion, scaling up HIV testing and linkage to care, and improved use of data for action are all part of the Southwark response. In addition, Southwark Council is approaching the final approval of the use of the new open access pan-London contracts with Kings College Hospital NHS Foundation Trust (KCH) and Guy’s and St Thomas’ NHS Foundation Trust (GSTT) – our two clinic providers in the borough. These contracts form part of a matrix of measures designed to modernise rationalise and reduce the cost of our sexual health service provision in Southwark. Further information from Kirsten.Watters@southwark.gov.uk

HIV PrEP Impact Trial update

13. Pre-exposure prophylaxis, or PrEP, is a way for people who do not have HIV but who are at substantial risk of getting it to prevent HIV infection by taking a pill every day. The pill (brand name Truvada) contains two medicines (tenofovir and emtricitabine) that are used in combination with other medicines to treat HIV. When someone is exposed to HIV through sex or injection drug use, these medicines can work to keep the virus from establishing a permanent infection. When taken consistently, PrEP has been shown to reduce the risk of HIV infection in people who are at high risk by up to 92%. PrEP is much less effective if it is not taken consistently. As part of ongoing communications regarding
the PrEP Impact Trial, NHS England and PHE have recently shared a series of public and commissioner Q&As with stakeholders. A stakeholder update has also been posted on the PHE PrEP update page here. The public Q&As is now available online also. Commissioner Q&As will be shared on the Sexual Health Commissioners Forum and via the English Sexual Health Commissioners Group. Southwark sexual health providers will be participating in the PrEP Impact Trial. Further information on the HIV PrEP trial available from Kevin.Fenton@southwark.gov.uk

14. There remains very good reason to be excited about the contribution of HIV PrEP to reducing HIV incidence, with very encouraging recent data just published from the Australian EPIC-NSW PrEP Trial. The Australians have reported that the 101 MSM newly diagnosed in January to June 2017 is 31% less than the average of 147 for the same period in each of the previous six years and is the lowest on record for any Jan-Jun period since 1985 (see page 7 of: http://www.health.nsw.gov.au/endinghiv/Documents/q2-2017-nsw-hiv-data-report.pdf). Moreover, of these 101 new HIV diagnoses in MSM, 46 were in early stage infection, which is 39% less compared with an average number of 76 MSM in January to June 2011-2016 (page 9). Beginning March 2016 to June 2017, the EPIV-NSW Trial has enrolled 6336 participants across 24 clinics and none who has commenced PrEP has tested HIV positive during follow-up to date. The companion statement from the Kirby Institute concluded that these NSW results ‘provide strong evidence to support wide availability of PrEP to prevent HIV transmission’ (https://kirby.unsw.edu.au/news/hiv-diagnoses-nsw-lowest-record-1985). These Australian data are very impressive and increase the urgency to get our PrEP trial underway in England.

Joint Strategic Needs Assessments in Southwark

15. Joint Strategic Needs Assessment (JSNA) is a process designed to inform and underpin the Joint Health and Wellbeing Strategy (JHWS) by identifying areas of unmet need, both now and into the future. It is a statutory requirement for Local Authorities and their partners (under both the Health and Social Care Act 2012 and the Local Government and Public Involvement in Health Act 2007 s116 and s116A). An annual work programme for the JSNA was signed off by the Health and Social Care Partnership Board on 4 April 2017. The programme was aligned to the four themes of the JSNA: Theme 1 - population groups; Theme 2 - behaviours and risk factors; Theme 3 - wider determinants of health; Theme 4 - health conditions and healthcare. Table 1 outlines the range of JSNA projects that have either been completed or are currently underway since the 2017-18 work programme was agreed in April. The projects span the four themes outlined above and have involved partners from across both the local authority and the CCG.

Table 1: Project update

<table>
<thead>
<tr>
<th>Topic</th>
<th>Project Leads</th>
<th>Partners</th>
<th>Project Sponsors</th>
<th>Status</th>
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<tr>
<td>Cross cutting: JSNA website redevelopment (phase 1)</td>
<td>Diana Divajeva</td>
<td>LBS web team</td>
<td>Richard Pinder</td>
<td>Complete</td>
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<tr>
<td>Wider determinants: Active Travel</td>
<td>Melinda Chau</td>
<td></td>
<td>Jin Lim</td>
<td>Complete</td>
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</tbody>
</table>
16. In addition to the projects outlined in table 1 that are either completed or underway, the Public Health team have also completed a number of additional JSNA projects, including: Female genital mutilation; Suicide and self-harm; Drug-related deaths. To support those leading on JSNA projects, and to raise awareness and understanding of the JSNA a masterclass was held in April with over 20 partners from across the local authority and CCG in attendance. An evaluation framework will be developed to identify areas where projects have worked well and supported change, and where there are opportunities for further improvement. Scoping for the future projects agreed as part of the 2017-18 work programme will be conducted over the coming months, with authors and project sponsors. Additional JSNA masterclasses will be held over the autumn to support future project leads and raise awareness and understanding of the JSNA. Engagement with partners across the local authority and CCG will take place through the autumn to identify potential areas of focus for the 2018-19 work programme. The membership of the JSNA steering group will be revised to ensure the development of the JSNA work programme for 2018-19 continues to reflect priorities from across the system.

**Arts and Health in Southwark: The Peckham Experiment**

17. I recently had the pleasure of discussing a new project - *The Peckham Experiment: A Centre for Self-Organisation* - a Heritage Lottery funded project led by the Art Assassins, the South London Gallery’s (SLG) youth group for 14-21 year olds, working with the Pioneer Health Foundation (PHF), the Wellcome Library and the Science Gallery at Kings College, as well as Peckham Vision and the Wilderness Wood. In this programme, young people will work alongside an historian-in-residence, heritage experts and artists to investigate the Peckham Experiment – a pioneering health movement which was founded by doctors George Scott Williamson and Innes Hope Pearse, who established the Pioneer Health Centre (1925-1950), located 1.5 miles from the South London Gallery. The founders believed that through a holistic approach to healthy living, well-being and social interaction, disease and illness would be reduced. Initiated twenty-three years before the establishment of the NHS, the Peckham Experiment offered bespoke on-the-doorstep...
healthcare and support for the whole family. The project will help young people gain new skills in heritage research, exhibition curation, running workshops and intergenerational activities, and aims to bring stories of the early development of mass healthcare to a wider audience. This is a great opportunity to connect the Arts and Health locally and I will be collaborating with SLG to support this year long programme.

Pan-London Public Health Developments of Significance

London Smoking Cessation Transformation Programme (LSCTP) helpline campaign.

18. The Association of Directors of Public Health London (ADPH) has been exploring ways we can work together to support and reach more people who want to quit smoking. One of the methods we’ve been trialling is a new Stop Smoking London helpline service, providing regular telephone support from a specialist advisor. We know that roughly 1.3 million people in London smoke. And we also know that one in three adults want to quit. In addition to its existing advice line, NHS Smokefree now provides bespoke telephone support for Londoners who call the national helpline number. Currently funded by 31 participating London Boroughs, it forms a new part of the suite of options already available to people who want to quit. When someone calls the national number - 0300 123 0044 - they’re asked a series of questions to determine the level of stop smoking support they need. If they’re from London and meet the eligibility criteria, they’re offered the opportunity to sign up to the specialist telephone-based service. This gives the individual regular phone calls from a stop smoking advisor who will support and motivate them throughout their quit attempt. This is part of a London-wide six month pilot which was launched in late May 2017. There was an initial a soft-launch to allow for a short testing period. We’d now like to work with you to increase callers to the helpline number and therefore uptake in the service. To be eligible for the service, you need to be over 18 and living in a participating borough (currently all London boroughs excluding Harrow and Hillingdon). You’ll need to be a smoker who wishes to set quit date within the forthcoming week, or has stopped within last 48 hours, and not already using local, specialist stop-smoking services. It’s not aimed at pregnant women.

London drug and alcohol blog

19. PHE London have recently published a Public Health Matters blog on tackling drug misuse and harm in London, authored by Alison Keating, PHE London Drug and Alcohol lead. The blog follows the publication of the new Government Drug Strategy and looks at what PHE London specifically is doing, how we support and work with partners, and why it’s worth investing in this area. Please do read and share the blog with colleagues. https://publichealthmatters.blog.gov.uk/2017/07/26/tackling-drug-misuse-and-harm-in-london/

London intelligence summaries from the London Knowledge and Intelligence Service

20. The London Knowledge and Intelligence Service supports stakeholders by producing high quality public health intelligence and insight. The team regularly prepare short briefings on
health in London and these can be found on their website. The London Knowledge and Intelligence Service also provide shorter intelligence summaries of key health outputs. These are provided to PHE London to give a rapid indication of what new data releases mean for London. These summaries are not added to the website, but are circulated to Directors of Public Health.

Thrive LDN event

21. On Friday 8 September, Thrive LDN worked with partners to raise awareness of mental health in light of World Suicide Prevention Day on 10 September. Following the international suicide prevention campaign’s theme of ‘Take a Minute, Change a Life’, Thrive LDN is looking to carry out Problem Solving Booths with volunteers from partners such as the MET, British Transport Police, Samaritans, London Ambulance Service and the National Suicide Prevention Alliance in Lincoln’s Inn Fields from 12.30-2.30pm. Problem Solving Booths give Londoners the opportunity to have a conversation with those they wouldn’t normally otherwise, and to recognise that it is not necessary to reach a crisis point before asking for help. Problem Solving Booths were recently held on the Piccadilly Line with members of the MET and BTP, and following this success, Thrive LDN is hoping to expand this conversation with the public.

National Public Health Developments of Significance

Prevention concordat for better mental health and suite of documents

22. At the beginning of September, PHE launched a new national prevention concordat for better mental health, focussed on preventing mental health problems and promoting good mental health. The aim is to galvanise cross-sector action to secure the adoption of effective prevention planning arrangements in all local areas (a Five Year Forward View for Mental Health commitment). To underpin the concordat we have also published a series of documents including; a Return on Investment tool and commissioning guidance, a guide to the mental health JSNA, a prevention planning resource for local areas and a report on psychosocial pathways and health equity. These documents will be of use to Commissioners, Providers, Directors of Public Health and local public health teams to create systems that are able to prevent mental ill health as well as treat it. The work is underpinned by evidence that prevention focused approaches to improving the public’s mental health make a valuable contribution to achieving a fairer and more equitable society. If you have any queries please contact Lily.Makurah@phe.gov.uk.

Better care for people with co-occurring mental health and alcohol/drug use conditions

23. Public Health England has published new national guidance ‘Better care for people with co-occurring mental health and alcohol/drug use conditions’ for commissioners and all providers of mental health and alcohol and drug treatment services, as well as being relevant for all support services that have contact with people with co-occurring conditions. The new guidance supports implementation of the Five Year Forward View for Mental Health, encouraging commissioners and providers to work together to improve access to services which can reduce harm, improve health and enhance recovery.
Reducing Health Inequalities: System, Scale and Sustainability

24. PHE’s Health Equity Unit has launched “Reducing Health Inequalities: System, Scale and Sustainability”. Published in response to demand from across the public health system, the guidance is an update of the Health Inequalities National Support Team (HINST) background document “Systematically reducing health inequalities”. This originated from the work done between 2006 and 2010, by HINST. The revised publication and supporting slide deck were developed under the expert eye of Professor Chris Bentley, who led the original HINST. In turn, we were supported by a large stakeholder group of colleagues from across the public health and local government. As a result the guidance provides broad scope for application, taking you through different levels of intervention on health inequalities. It explores risk, impact of interventions over time and across the life course, emphasising the importance of acting at scale to reach large sections of the population and have real effect. PHE South West’s webinar on 25 September will demonstrate application of this health inequalities approach.

Sexual health commissioners survey report

25. On Wednesday 30 August PHE published a response to the sexual health commissioners survey. This includes findings and an action plan from a national survey of commissioning arrangements for sexual health, reproductive health and HIV. It is available online here.

Heart Age Test relaunch

26. PHE has relaunched its Heart Age Test as part of the One You brand, which supports adults in making simple changes towards a longer, happier life. The online test is for anyone aged 30+ and provides an estimation of their Heart Age based on basic physical and lifestyle-related information - having a heart age older than your actual age means you are at a higher risk of having a heart attack or stroke. In total, 1.3 million people have taken the test so far.

Improving clinical responses to drug-related deaths: a summary of best practice and innovations from drug treatment providers

27. Collective Voice and the NHS Substance Misuse Provider Alliance have published a set of recommendations for drug treatment providers to help improve clinical responses to drug-related deaths. Practice points covered include: the identification of risk of drug-related death; the delivery of safe, recovery-orientated drug treatment; preventing overdose in people who use drugs; meeting physical and mental health needs; and reducing the risk of drug-related death for people outside drug treatment.

Update on Business Rate Retention

28. In response to requests for information and with there being no explicit legislation in the Queen’s Speech on local government finance, PHE understands that the government is still committed to delivering the manifesto pledge to help local authorities to control more of the money they raise and will work closely with local government to agree the best way to achieve this.
NHS England publishes new help for ‘acid attack’ victims following recent rise in demand for NHS help

29. NHS England, in partnership with the British Association of Plastic, Reconstructive and Aesthetic Surgeons (BAPRAS) has published new advice for anyone falling victim to acid attacks, including new online guidance and support to victims as well as friends or family of people affected by burns. The guidance – Report, Remove, Rinse – has been developed with specialist BAPRAS burns and trauma surgeons, who have treated victims of these attacks.

Funding, education and collaboration opportunities

PHE invites expressions of interest to participate in an Individual Placement and Support (IPS) drug and alcohol dependency trial

30. The Alcohol Drugs and Tobacco Division in PHE are inviting expressions of interest from areas who are interested in partnering with us in a drug and alcohol dependency Individual Placement and Support (IPS) randomised control trial. This is an exciting opportunity to contribute to building the evidence base around employment and drug and alcohol recovery, and PHE are seeking 5 – 7 areas to participate in a trial to test the effectiveness of the IPS employment support approach in drug and alcohol community treatment settings. The trial will be live from April 2018 – March 2020, and will be followed by a 12 month evaluation period. PHE will work closely with selected trial sites between November 2017 and March 2018 in preparation for going live, and for the duration of the trial. Queries and applications should be submitted to IPSdependencytrials@phe.gov.uk. Two expression of interest events are being held in London and Leeds, later in September and further information about these is available in the letter. The deadline for applications is 5pm on 31st October.

Letter on metrics and outcome measures for healthy child programme 0-5 years: data collection

31. Public Health England is seeking support from local authorities to extend the collection of the healthy child programme 0-5 (including health visitor service delivery) metrics and outcome indicators which it has been collecting since 2015. In the longer term the data source for these metrics will be the NHS Digital Children and Young Peoples Health Services Dataset. Whilst the dataset is operational and reporting has begun, providers are at different stages of maturity with their submissions or readiness to flow record level data to NHS Digital. Therefore, it is expected to take some additional time for this data set to reach sufficient coverage for reporting purposes.

Public Health England seeking five local authority-Clinical Commissioning Group partnerships to participate in Physical Activity Clinical Advice Pad pilot

32. The Adult Health and Wellbeing team at Public Health England, in partnership with Sport England, are seeking to partner with up to five local authorities and Clinical Commissioning Groups (as partnerships) to pilot a clinical advice pad to aid clinicians in
promoting physical activity as part of routine care. Each partnership area will be provided with a package of support and will test the Physical Activity Clinical Advice Pad in 20-25 clinical care settings between October 2017 and August 2018. The deadline for application is 5pm on the 22nd September. For any further information please contact the Physical Activity Programme Manager, Nick Clarke, at Nick.Clarke@phe.gov.uk

Empowering Parents Empowering Communities (EPEC) programme

33. The Centre for Parent and Child Support (CPCS) are looking for expressions of interest to work in partnership with local authorities or health providers on the EPEC programme to improve early parenting and child outcomes for vulnerable groups. EPEC is a parenting support, peer led programme aimed at vulnerable communities in England (parents of children 0- end of primary school; children at risk of exclusion; parents with mental health problems including personality disorder; families from the 10% most economically disadvantaged communities). CPCS have secured 2 years funding from NESTA (The Innovation Foundation) to work with 16 sites to increase the scale of the peer based delivery programme. CPCS would like to work with these sites to develop the programme to ensure that the model is contextualised to the needs of local communities.

Refresh for the Health Inequalities e learning programme

34. The Health Inequalities e-learning programme has been updated to include the revised Health Equity Assessment Tool (HEAT) together with updated charts on life expectancy and healthy life expectancy. Nearly 400 colleagues from across public health and local authorities have completed this e-learning and their feedback has been overwhelmingly positive. Reducing health inequalities is at the heart of PHE’s priorities and there is also a legal duty on PHE to have due regard to reducing health inequalities. Completing this e-learning is an important first step to meeting that legal duty.

PHE annual conference 2017

35. The PHE annual conference takes place at the University of Warwick on Tuesday and Wednesday (12/13 September 2017). The PHE annual conference brings together more than 1,400 participants from a wide range of organisations, to learn, share their knowledge and experiences to help improve public health. This year’s conference focuses on three key themes: promoting world-class science and evidence, making the economic case for prevention, working towards a healthier, fairer society.

Prepared by:

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ITEM FOR DISCUSSION / ASSURANCE

<table>
<thead>
<tr>
<th>CCG Committee</th>
<th>Governing Body</th>
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</thead>
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<tr>
<td>Month</td>
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</tr>
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<td>Year</td>
<td>2017</td>
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**Item title:** Report of the CCG’s prime committees

**Enclosure number:** D

**Any know conflict of interest:** N/A

The item is being presented to the committee for (select only one):

- [ ] Discussion
- [x] Assurance
1. **Purpose of the paper (why does the committee need to discuss / receive assurance?)**

The enclosed report of the activities of the CCG’s prime committees summarises the activities of the CCG’s main committees for the period stated. This report supports the Governing Body to receive assurance that its prime committees are functioning effectively within the governance structure of the CCG and are fully exercising their duties as described in the CCG Constitution and scheme of delegation.

The most recent minutes of CCG prime committee are also included in Governing Body papers where they have been signed-off by that committee. All minutes and agendas are also available at: http://www.southwarkccg.nhs.uk/news-and-publications/meeting-papers/Pages/default.aspx.

2. **Describe the issue being presented to the committee for discussion or assurance**

The standard report records the following for each of the prime committee meetings:

1. Action taken under delegation by CCG prime committees. The Governing Body should note these actions, which are provided for information.

2. Recommendations made by a committee to the Governing Body for decision. Accompanying documents will be referenced as part of the report. The Governing Body will be asked to agree the recommendation received from the prime committee.

3. Items of committee business may also be flagged to the Governing Body to note and to further discuss.

The Governing Body is asked to approve the following item following committee recommendation to do so:
• D (ii): Additions to the Scheme of Delegation relating to the additional duties falling to the CCG as a result of Delegated Primary Care should be approved.

• D (iii): the proposal for changes to prescription for OTC, malaria and travel vaccines. The committee recommends that governing body also notes the following:
  o CSC Re-iterated the need for ongoing evaluation, with the outcome of this to be reviewed by CSC in 18 months to 2 years to monitor any impact of the changes to the prescription of malaria and travel vaccines.
  o CSC recommended that as part of implementation, the public campaign is utilised fully in particular as a means to address health inequalities
  o CSC endorsed, in particular, the effective communication out to practices which supports them with consistent messaging to patients as part of a coordinated approach with other parties including schools.

The Governing Body may wish to seek additional assurance or discuss pertinent issues relating to the business of the CCG for the following committee agenda items, which are included in the Standing items for Assurance agenda item:

• CCG Assurance Report (M3)
• CCG Finance Report (M4)
• CCG Risk Report & Board Assurance Framework (BAF) (August)

3. What stakeholder engagement has taken place?

All minutes have been circulated and signed off by the committees. Membership of these committees are noted at the start of each set of minutes

Supporting information / documents

Please append any relevant documents including detailed reports; options appraisals; background documents; national guidance etc.

<table>
<thead>
<tr>
<th>Appendix #</th>
<th>Name of document</th>
</tr>
</thead>
<tbody>
<tr>
<td>i</td>
<td>Prime Committee Report – September 2017</td>
</tr>
<tr>
<td>ii</td>
<td>Southwark CCG – Schemes of delegation</td>
</tr>
<tr>
<td>iii-a</td>
<td>GB briefing consultation report on proposed revisions to prescribing guidelines</td>
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<tr>
<td>iii-b</td>
<td>Consultation report NHS prescriptions Aug 2017 v 1 5 FINAL</td>
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<td>iii-ci</td>
<td>Equality Analysis- OTC</td>
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<tr>
<td>iii-cii</td>
<td>Equality Analysis - Antimalarials</td>
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<tr>
<td>iii-ciii</td>
<td>Equality Analysis - Travel Vaccines</td>
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<tr>
<td>d</td>
<td>PH Options Summary of Malaria Chemoprophylaxis</td>
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**Date paper completed**  
Thursday, 14 September 2017
1. **Summary of prime committee meetings since the last Governing Body**

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<tr>
<th>Meeting Date</th>
<th>Integrated Governance &amp; Performance Committee</th>
<th>Commissioning Strategy Committee</th>
<th>Joint Commissioning Strategy Committee</th>
<th>Engagement and Patient Experience Committee</th>
<th>South East London Committee in Common</th>
<th>SCCG Primary Care Commissioning Committee</th>
<th>Remuneration Committee</th>
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<td>6 July 2017</td>
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2. **Summary of the principal role of CCG prime committees**

<table>
<thead>
<tr>
<th>Committee</th>
<th>Principal role of the committee</th>
<th>Chair</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrated Governance &amp; Performance Committee</td>
<td>Overarching duty of the committee is to act to oversee governance in an integrated way, with all aspects of commissioning and provider activities are scrutinised using an approach that considers finance, quality, safety and performance together. Assurance of the effective functioning of the CCG and its main contracted providers. Provision of assurance to the CCG Governing Body for safeguarding; information governance; health and safety and equality and diversity management. Responsible for assuring the Governing Body on the monitoring of the CCG’s risk management and Board Assurance Framework.</td>
<td>Andrew Nebel, Lay Member, NHS Southwark CCG</td>
</tr>
<tr>
<td>Commissioning Strategy Committee</td>
<td>Oversees the development and implementation of the CCG’s strategic plans and commissioning intentions, taking into account information received from Localities and the Council of Members on commissioning strategy and priorities; scrutinises the on-going efficacy of commissioned services where service developments are identified; works with Member Practices to implement plans and undertake designated actions in the localities; receives reports from strategic programme boards charged with overseeing major commissioning programmes</td>
<td>Dr. Jonty Heaversedge, Chair, NHS Southwark CCG</td>
</tr>
<tr>
<td>Joint Commissioning Strategy Committee</td>
<td>Sets direction and provides guidance on the development of strategic plans that are shared between NHS Southwark Clinical Commissioning Group and Southwark Council. Provides a joint forum for the senior leadership of the two organisations to discuss the local approach to strategic issues and oversee the key partnership strategies for children and young people, mental health, and older adults and complex needs, within the overarching Joint Southwark Five Year Forward View for Health and Social Care.</td>
<td>Dr. Jonty Heaversedge, Chair, NHS Southwark CCG &amp; David Quirke-Thornton, Strategic Director, Children's and Adults Services, Southwark Council</td>
</tr>
<tr>
<td>Engagement and Patient Experience Committee</td>
<td>Responsible for monitoring, advising and providing assurance on patient engagement ensuring statutory duties are met and building on local good practice and report to the Governing Body on progress in implementing the engagement strategy and advising of any major deviation from engagement plans.</td>
<td>Joy Ellery, Lay Member, NHS Southwark CCG</td>
</tr>
<tr>
<td>Committee</td>
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<td>Chair</td>
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</tr>
<tr>
<td>South East London Committee in Common for Strategic Decision Making</td>
<td>The Committee in Common will perform the functions delegated to its members by their CCGs in relation to any healthcare service changes (either in hospital or out of hospital) proposed as part of the Our Healthier South East London programme or subsequent programmes, as agreed by the CCGs, which involve public consultation and which have not already or will not be consulted on as part of a separate process.</td>
<td>Paul Minton, independent chair</td>
</tr>
<tr>
<td>Southwark CCG Primary Care Commissioning Committee</td>
<td>The Primary Care Commissioning Committee makes collective decisions on the review, planning and procurement of primary care services in Southwark, under delegated authority from NHS England</td>
<td>Robert Park, Lay Member, NHS Southwark CCG</td>
</tr>
<tr>
<td>Remuneration Committee</td>
<td>Remuneration Committee is a decision-making committee of the Governing Body, makes determinations about the remuneration, fees, payments and other allowances for employees and for people who provide services to the CCG</td>
<td>Richard Gibbs, Lay Member, NHS Southwark CCG</td>
</tr>
<tr>
<td>Audit Committee</td>
<td>Audit Committee provides the Governing Body with an independent and objective view of the CCG’s financial systems, financial information and compliance with laws, regulations and directions governing the CCG in so far as they relate to finance, and assurance on risk and fraud issues;</td>
<td>Richard Gibbs, Lay Member, NHS Southwark CCG</td>
</tr>
</tbody>
</table>
3. Recommendations to the Governing Body for decision/approval

The Governing Body should review the papers referenced and formally approve the recommendation made by the stated committee. This decision will be recorded in the minutes of the Governing Body meeting.

<table>
<thead>
<tr>
<th>No.</th>
<th>Committee name</th>
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<th>Recommendation for decision</th>
<th>Associated documents</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Integrated Governance and Performance</td>
<td>24 August 2017</td>
<td>Procurement Policy and Scheme of Delegation</td>
<td>The Committee recommended to the Governing Body that the suggested additions to the Scheme of Delegation relating to the additional duties falling to the CCG as a result of Delegated Primary Care should be approved.</td>
<td>D (ii)</td>
</tr>
</tbody>
</table>
| 2.  | Commissioning Strategy Committee      | 7 September 2017  | Proposals to revise prescribing guidelines for general practice: consultation response and recommendations | The Committee recommended to the Governing Body the proposal for changes to prescription for OTC, malaria and travel vaccines should be approved for implementation. The committee recommends that governing body also notes the following:  
- CSC re-iterated the need for ongoing evaluation, with the outcome of this to be reviewed by CSC in 18 months to 2 years to monitor any impact of the changes to the prescription of malaria and travel vaccines.  
- CSC recommended that as part of implementation, the public campaign is utilised fully in particular as a means to address health inequalities  
- CSC endorsed, in particular, the effective communication out to practices which supports them with consistent messaging to patients as part of a coordinated approach with other parties including schools.                                                                 | D (iii a-d)          |
4. **Action taken under delegation: Governing Body to note for assurance**

The Governing Body should note the below items, where a prime committee made a decision under the scheme of delegation as set out in the CCG Constitution.

<table>
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<tr>
<th>No.</th>
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<tbody>
<tr>
<td>1.</td>
<td>Integrated Governance &amp; Performance Committee</td>
<td>27 July 2017</td>
<td>CCG Quality Update</td>
<td>The committee noted the contents of the quality report and the activities undertaken by the quality directorate, and received assurance that issues identified are being fully addressed.</td>
</tr>
<tr>
<td>2.</td>
<td>Integrated Governance &amp; Performance Committee</td>
<td>27 July 2017</td>
<td>Annual Looked After Children Commissioning Report</td>
<td>The committee noted that feedback from the recent OFSTED inspection of the local authority is integrated into the action plan for 2017/2018.</td>
</tr>
<tr>
<td>3.</td>
<td>Integrated Governance &amp; Performance Committee</td>
<td>27 July 2017</td>
<td>Annual Looked After Children Commissioning Report</td>
<td>The committee noted the overall statutory performance is satisfactory.</td>
</tr>
<tr>
<td>4.</td>
<td>Integrated Governance &amp; Performance Committee</td>
<td>27 July 2017</td>
<td>Annual Looked After Children Commissioning Report</td>
<td>The committee noted that further work is required to improve the timeliness of initial health assessments.</td>
</tr>
<tr>
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<tr>
<td>5.</td>
<td>Integrated Governance &amp; Performance Committee</td>
<td>27 July 2017</td>
<td>Annual Looked After Children Commissioning Report</td>
<td>The committee noted that the issues reflected in overall performance of the provider service (Southwark LAC Health Service) have been noted by the CCG. They are being monitored via provider assurance pathways and the CCG has committed additional resource.</td>
</tr>
<tr>
<td>6.</td>
<td>Integrated Governance &amp; Performance Committee</td>
<td>27 July 2017</td>
<td>Annual Looked After Children Commissioning Report</td>
<td>The committee noted that the CCG is engaged in robust scrutiny of issues pertinent to the health of looked after children in partnership with the local authority and the wider health economy.</td>
</tr>
<tr>
<td>7.</td>
<td>Integrated Governance &amp; Performance Committee</td>
<td>27 July 2017</td>
<td>Dulwich – Stage 2 business case – strategic, finance and management cases</td>
<td>The committee agreed that the project is affordable to the CCG and therefore the local health economy, subject to further confirmations being provided.</td>
</tr>
<tr>
<td>8.</td>
<td>Integrated Governance &amp; Performance Committee</td>
<td>27 July 2017</td>
<td>Dulwich – Stage 2 business case – strategic, finance and management cases</td>
<td>The committee confirmed delegated authority to the CFO, Programme Board Chair and IGP Chair to approve and submit the final completed business case when ready, to NHSE.</td>
</tr>
<tr>
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<tr>
<td>9.</td>
<td>Integrated Governance &amp; Performance Committee</td>
<td>27 July 2017</td>
<td>Policies: Lone Working, Security, Avoiding Violence &amp; Aggression, Maternity, paternity and adoption; COI; Gifts and Hospitality.</td>
<td>The committee agreed the following policies: Lone Working, Security, Avoiding Violence &amp; Aggression, Maternity, paternity and adoption; COI; Gifts and Hospitality.</td>
</tr>
<tr>
<td>10.</td>
<td>Integrated Governance &amp; Performance Committee</td>
<td>27 July 2017</td>
<td>Community dermatology procurement business case</td>
<td>The committee accepted and approved the recommendation of this business case that the CCG procure a mandated single point of referral for dermatology referrals on a three year contract with an option to extend for two years.</td>
</tr>
<tr>
<td>11.</td>
<td>Integrated Governance &amp; Performance Committee</td>
<td>27 July 2017</td>
<td>Community dermatology procurement business case</td>
<td>The committee agreed to allow Chair’s action for changes to the specification in line with feedback at the locality meetings.</td>
</tr>
<tr>
<td>12.</td>
<td>Integrated Governance &amp; Performance Committee</td>
<td>27 July 2017</td>
<td>Minutes – Quality and Safety Sub-Committee (April 2017)</td>
<td>The committee reviewed and noted the minutes</td>
</tr>
<tr>
<td>13.</td>
<td>Integrated Governance &amp; Performance Committee</td>
<td>27 July 2017</td>
<td>Minutes – Medicines Management Committee (Jan; Apr; Jun 2017)</td>
<td>The committee reviewed and noted the minutes</td>
</tr>
<tr>
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<tr>
<td>14.</td>
<td>Integrated Governance &amp; Performance Committee</td>
<td>24 August 2017</td>
<td>Asthma Digital Project</td>
<td>The committee noted the project and associated documents.</td>
</tr>
<tr>
<td>15.</td>
<td>Integrated Governance &amp; Performance Committee</td>
<td>24 August 2017</td>
<td>Asthma Digital Project</td>
<td>The committee was assured that the correct processes are being followed and governance safeguards are being put in place.</td>
</tr>
<tr>
<td>16.</td>
<td>Integrated Governance &amp; Performance Committee</td>
<td>24 August 2017</td>
<td>Primary Care Peer Review Scheme</td>
<td>The committee approved the implementation of a local incentive scheme for GP peer review which will run from September 2017 to March 2018.</td>
</tr>
<tr>
<td>17.</td>
<td>Integrated Governance &amp; Performance Committee</td>
<td>24 August 2017</td>
<td>CCG Quality Update</td>
<td>The committee noted the contents of the quality report and the activities undertaken by the quality directorate, and received assurance that issues identified are being fully addressed.</td>
</tr>
<tr>
<td>18.</td>
<td>Integrated Governance &amp; Performance Committee</td>
<td>24 August 2017</td>
<td>Restoration of RTT Compliance at KCH and CCG Referral Optimisation</td>
<td>The committee noted the current iteration of the plan KCH has in place to restore RTT to compliance.</td>
</tr>
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<tr>
<td>19.</td>
<td>Integrated Governance &amp; Performance Committee</td>
<td>24 August 2017</td>
<td>Restoration of RTT Compliance at KCH and CCG Referral Optimisation</td>
<td>The committee took assurance that the CCG is taking appropriate steps to optimise referrals to the acute sector including KCH and therefore support the Trust in its delivery of a compliant RTT position.</td>
</tr>
<tr>
<td>20.</td>
<td>Integrated Governance &amp; Performance Committee</td>
<td>24 August 2017</td>
<td>Southwark Better Care Fund</td>
<td>The committee reviewed the BCF plan and planning template.</td>
</tr>
<tr>
<td>21.</td>
<td>Integrated Governance &amp; Performance Committee</td>
<td>24 August 2017</td>
<td>Southwark Better Care Fund</td>
<td>The committee agreed the BCF plan and template and recommended it to the HWB for sign off.</td>
</tr>
<tr>
<td>22.</td>
<td>Integrated Governance &amp; Performance Committee</td>
<td>24 August 2017</td>
<td>Procurement Policy and Scheme of Delegation</td>
<td>The committee approved the Procurement Policy changes to ensure that additional information is available to CCG employees with regard to the requirements of procurement and contract management and also the assistance that is available to them.</td>
</tr>
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<tr>
<td>24.</td>
<td>Integrated Governance &amp; Performance Committee</td>
<td>24 August 2017</td>
<td>Quality and Safety Sub-Committee Terms of Reference</td>
<td>The committee approved the QSC Terms for Reference</td>
</tr>
<tr>
<td>25.</td>
<td>Integrated Governance &amp; Performance Committee</td>
<td>24 August 2017</td>
<td>Minutes – Quality and Safety Sub-Committee (May 2017)</td>
<td>The committee reviewed and noted the minutes.</td>
</tr>
<tr>
<td>26.</td>
<td>Integrated Governance &amp; Performance Committee</td>
<td>24 August 2017</td>
<td>Minutes – Medicines Management Committee (Jun 2017)</td>
<td>The committee reviewed and noted the minutes.</td>
</tr>
<tr>
<td>27.</td>
<td>Commissioning Strategy Committee</td>
<td>6 July 2017</td>
<td>Locality Reports: June 2017</td>
<td>The committee reviewed and noted the content of the June 2017 locality reports for North and South Southwark.</td>
</tr>
<tr>
<td>28.</td>
<td>Commissioning Strategy Committee</td>
<td>6 July 2017</td>
<td>SELTCP Year 1 progress report</td>
<td>The committee approved the recommendations included in the report.</td>
</tr>
<tr>
<td>29.</td>
<td>Commissioning Strategy Committee</td>
<td>6 July 2017</td>
<td>IAPT service redesign</td>
<td>The committee agreed to support the proposal.</td>
</tr>
<tr>
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<tr>
<td>30.</td>
<td>Commissioning Strategy Committee</td>
<td>7 September 2017</td>
<td>Locality Reports: July 2017</td>
<td>The committee reviewed and noted the content of the June 2017 locality reports for North and South Southwark.</td>
</tr>
<tr>
<td>31.</td>
<td>Joint Commissioning Strategy Committee</td>
<td>4 May 2017</td>
<td>Joint Commissioning Strategy Committee</td>
<td>The committee received and reviewed updates on the financial positions of the CCG and Council.</td>
</tr>
<tr>
<td>32.</td>
<td>Joint Commissioning Strategy Committee</td>
<td>4 May 2017</td>
<td>Our Joint Southwark Forward View (Health and Wellbeing Report)</td>
<td>The committee considered the report from the health and wellbeing board on a joint approach.</td>
</tr>
<tr>
<td>33.</td>
<td>Joint Commissioning Strategy Committee</td>
<td>4 May 2017</td>
<td>Report back from Commissioning Development Groups (CDGs)—progress and next steps</td>
<td>The committee received a report on the first year of the CDGs and advised on direction of travel.</td>
</tr>
<tr>
<td>34.</td>
<td>Joint Commissioning Strategy Committee</td>
<td>4 May 2017</td>
<td>Primary Health Care Model and Mental Health Strategy</td>
<td>The committee received an update on the development of the mental health strategy.</td>
</tr>
<tr>
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<tr>
<td>35.</td>
<td>Joint Commissioning Strategy Committee</td>
<td>4 May 2017</td>
<td>Primary Health Care Model and Mental Health Strategy</td>
<td>The committee received an update on the primary health care model for mental health.</td>
</tr>
<tr>
<td>36.</td>
<td>Joint Commissioning Strategy Committee</td>
<td>4 May 2017</td>
<td>Better Care Fund update</td>
<td>The committee received an update on the Better Care Fund.</td>
</tr>
<tr>
<td>37.</td>
<td>Joint Commissioning Strategy Committee</td>
<td>4 May 2017</td>
<td>Urgent Response and Re-ablement Review</td>
<td>The committee received the review of urgent response and re-ablement towards a more integrated approach.</td>
</tr>
<tr>
<td>38.</td>
<td>Southwark Primary Care Commissioning Committee</td>
<td>7 June 2017</td>
<td>Grange Road Surgery: contract commissioning decision</td>
<td>The voting members of the Primary Care Commissioning Committee made an urgent planned decision to ask patients of Grange Road Surgery to register with another practice by 30 June 2017.</td>
</tr>
<tr>
<td>39.</td>
<td>Southwark Primary Care Commissioning Committee</td>
<td>29 June 2017</td>
<td>Avicenna Health Centre: contract commissioning decision</td>
<td>The committee received notice that the voting members of the then Primary Care Joint Committee had made the decision (on 17 March 2017) to procure a caretaker provider to deliver services to patients from the Avicenna Health Centre from 14 July 2017 until 31 March 2018.</td>
</tr>
<tr>
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<tr>
<td>40.</td>
<td>Southwark Primary Care Commissioning Committee</td>
<td>29 June 2017</td>
<td>Requires improvement potential contract remedial notices and breaches – Lordship Lane Surgery</td>
<td>The committee approved the issuing of the remedial and breach notices.</td>
</tr>
<tr>
<td>41.</td>
<td>Southwark Primary Care Commissioning Committee</td>
<td>26 July 2017</td>
<td>Acorn and Gaumont Surgery Breach and Remedial Notice</td>
<td>The committee agreed with the recommendation to issue the practice with a formal letter which confirms that commissioners are satisfied that all CQC related action have been addressed.</td>
</tr>
<tr>
<td>42.</td>
<td>Southwark Primary Care Commissioning Committee</td>
<td>26 July 2017</td>
<td>Extended Primary Care Service Evaluation and Management Response</td>
<td>The committee approved the management response and evaluation report.</td>
</tr>
<tr>
<td>43.</td>
<td>Remuneration Committee</td>
<td>13 July 2017</td>
<td>CFO three month secondment</td>
<td>The committee agreed the three month 0.5 WTE secondment of the CFO from Lambeth CCG.</td>
</tr>
<tr>
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<tr>
<td>44.</td>
<td>Remuneration Committee</td>
<td>10 August 2017</td>
<td>Interim Managing Director for Southwark</td>
<td>The committee approved the recruitment and the proposed salary range.</td>
</tr>
<tr>
<td>45.</td>
<td>Remuneration Committee</td>
<td>10 August 2017</td>
<td>1% pay uplift for CCG VSM staff</td>
<td>The committee agreed to uplift the pay of VSM staff members by 1% for the financial year from April 2016 and again from the financial year beginning April 2017. This is following a pay freeze and is in line with uplifts for 2016/17 and 2017/18 in neighbouring CCGs.</td>
</tr>
<tr>
<td>46.</td>
<td>Remuneration Committee</td>
<td>10 August 2017</td>
<td>Accountable Officer secondment agreement</td>
<td>The committee approved the secondment agreement.</td>
</tr>
<tr>
<td>47.</td>
<td>Remuneration Committee</td>
<td>10 August 2017</td>
<td>Interim Shared Accountable Officer post (terms and pay)</td>
<td>The committee approved the salary subject to its agreement by the Greenwich Remuneration Committee and further engagement with other south east London CCGs.</td>
</tr>
<tr>
<td>48.</td>
<td>Remuneration Committee</td>
<td>10 August 2017</td>
<td>Interim Shared Accountable Officer post (terms and pay)</td>
<td>The committee agreed to allow for a chair’s action to decide the precise salary consistent with the guidance set out in the paper and following consultation with Greenwich CCG and consultation between the Chairs of the six south east London CCGs.</td>
</tr>
<tr>
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<tr>
<td>49.</td>
<td>Engagement and Patient Experience Committee</td>
<td>20 July 2017</td>
<td>GP Patient Survey Result July 2017</td>
<td>The committee discussed the GPPS survey results and noted the variation in findings and the comparison with Lambeth.</td>
</tr>
<tr>
<td>50.</td>
<td>Engagement and Patient Experience Committee</td>
<td>20 July 2017</td>
<td>Role of EPEC in assuring good practice engagement</td>
<td>The committee discussed the knowledge, skills and experience required to assure the governing body for good practice engagement, using the ten principles for participation in the new NHS England guidance that was published in 2017.</td>
</tr>
</tbody>
</table>
5. **Committee items for the Governing Body to discuss**

The Governing Body should note and discuss the below items. These are items where assurance has been received at a prime committee, but where the Governing Body may wish to seek additional assurance or discuss pertinent issues relating to the business of the CCG.

<table>
<thead>
<tr>
<th>No.</th>
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<th>Meeting date</th>
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<th>Recommendation for discussion / to note</th>
<th>Associated Documents</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Integrated Governance &amp; Performance Committee</td>
<td>24 August 2017</td>
<td>CCG Assurance Report (M3)</td>
<td>Recommended to the Governing Body for review and approval.</td>
<td>ENC F (i)</td>
</tr>
<tr>
<td>2.</td>
<td>Integrated Governance &amp; Performance Committee</td>
<td>22 August 2017</td>
<td>CCG Finance Report (M4)</td>
<td>Recommended to the Governing Body for review and approval.</td>
<td>ENC F (ii)</td>
</tr>
<tr>
<td>3.</td>
<td>Integrated Governance &amp; Performance Committee</td>
<td>22 August 2017</td>
<td>CCG Risk Report &amp; Board Assurance Framework (BAF) (M4)</td>
<td>Recommended to the Governing Body for review and approval.</td>
<td>ENC F (iii a-b)</td>
</tr>
</tbody>
</table>
Scheme of Delegation:
Schedule of Matters Delegated to Officers

V1.1

This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of the document are not controlled.
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<th><strong>Approved by</strong></th>
<th>Governing Body</th>
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<tbody>
<tr>
<td><strong>Date approved</strong></td>
<td>11 May 2017</td>
</tr>
<tr>
<td><strong>Name and title of originator/author</strong></td>
<td>Julian Westcott, Head of Finance</td>
</tr>
<tr>
<td><strong>Name and title of sponsor</strong></td>
<td>Malcolm Hines, Chief Financial Officer</td>
</tr>
<tr>
<td><strong>Name of responsible committee/individual</strong></td>
<td>Integrated Governance and Performance Committee, Audit Committee</td>
</tr>
<tr>
<td><strong>Review date</strong></td>
<td>May 2018</td>
</tr>
<tr>
<td><strong>Policy description (Max 50 words)</strong></td>
<td>This Schedule of Matters has been developed in conjunction with NHS Southwark Clinical Commissioning Group’s (the CCG) Standing Financial Instructions (Detailed Financial Policies), Prime Financial Policies, and Standing Orders. All items concerning Finance must be carried out in accordance with the CCG’s Standing Financial Instructions (Detailed Financial Policies) and Standing Orders. Where delegated matters or decisions are believed to have a far-reaching (novel, contentious or repercussive) implication, this must be reported to the Chief Officer. All financial limits in this Scheme of Delegation are subject to sufficient budget being available.</td>
</tr>
<tr>
<td><strong>Target audience</strong></td>
<td>CCG directors, designated budget holders,</td>
</tr>
<tr>
<td><strong>Stakeholders engaged in development or review</strong></td>
<td>CFO, Integrated Governance and Performance Committee, Audit Committee</td>
</tr>
</tbody>
</table>

**Version Control**

| **Version number** | 1.1 |
| **Supersedes** | - |

**Implementation**

| **Implementation plan in place?** | Yes |
| **Method and date of dissemination** | Members and Staff Zone, Staff newsletter, SMT email |

**Monitoring**

| **Monitoring method** | |
| **Frequency** | |
| **Responsibility** | |
| **Reporting** | |
The best possible health outcomes for Southwark people

### Detailed Scheme of Delegation v. 1.1

Date approved: 11 May 2017

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Reviewer Name(s) and Job title</th>
<th>Change/amendment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>09/08/2017</td>
<td>Julian Westcott, Head of Finance</td>
<td>Addition of delegated authority for staff managing the Delegated Primary Care budgets</td>
</tr>
</tbody>
</table>
This Schedule of Matters has been developed in conjunction with NHS Southwark Clinical Commissioning Group’s (the CCG) Standing Financial Instructions (Detailed Financial Policies), Prime Financial Policies, and Standing Orders. All items concerning Finance must be carried out in accordance with the CCG’s Standing Financial Instructions (Detailed Financial Policies) and Standing Orders.

Where delegated matters or decisions are believed to have a far-reaching (novel, contentious or repercussive) implication, this must be reported to the Chief Officer. All financial limits in this Scheme of Delegation are subject to sufficient budget being available.

The delegations set out in this detailed scheme of delegation represent the lowest level to which authority for that specific issue has been delegated. Authority can be delegated/referred upwards (with agreement between delegator and delegate) with no further approval required.

In the absence of the delegated officer, approval is required from either the officer officially acting on to that role or the next level up in the hierarchy. Where the unavailable officer is the Chief Officer (CO), and where the matter cannot wait until their return, the Scheme of Delegation shall read Deputy Chief Officer.

1. **Delegation of authority**
   1.1. The Chief Officer and/or Chief Finance Officer will approve the level of non-pay expenditure on an annual basis and the Chief Officer and/or Chief Finance Officer will determine the level of delegation to budget managers.
   1.2. The Council of Members will formally approve the annual budget in March of each year.
   1.3. The Chief Officer will set out:
       a) the list of managers authorised to place requisitions for the supply of goods and services;
       b) the maximum level of each requisition and the system for authorisation above that level.
   1.4. The Chief Finance Officer shall set out procedures on the seeking of professional advice regarding the supply of goods and services.
1.5. The table below shows a summary of the current delegation hierarchy for authorisation limits for officers:

<table>
<thead>
<tr>
<th>Delegated to, or reserved for</th>
<th>Revenue Budgetary Delegation and Invoice Authorisation</th>
<th>Capital Budgetary Delegation and Invoice Authorisation</th>
<th>Approval of Quotes &amp; Tenders</th>
<th>Approval of Sales Order Requests (invoices to other organisations)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governing Body</td>
<td>Unlimited (within resource limits)</td>
<td>£1,000,000 or above</td>
<td>£1,000,000 or above</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Integrated Governance &amp; Performance Committee</td>
<td>Nil</td>
<td>Nil</td>
<td>£250,000 or above, but less than £1,000,000</td>
<td></td>
</tr>
<tr>
<td>A - Chief Officer</td>
<td>£15,000,000</td>
<td>£500,000 or above, but less than £1,000,000</td>
<td>Less than £250,000</td>
<td>Less than £15,000,000</td>
</tr>
<tr>
<td>A - Chief Finance Officer</td>
<td>£15,000,000</td>
<td>Less than £500,000</td>
<td>Less than £250,000</td>
<td>Less than £15,000,000</td>
</tr>
<tr>
<td>B – Other Directors</td>
<td>£5,000,000*</td>
<td>Nil</td>
<td>Less than £100,000</td>
<td>Less than £7,500,000</td>
</tr>
<tr>
<td>C – Head of Finance</td>
<td>£500,000</td>
<td>Nil</td>
<td>Less than £100,000 (in absence of Directors)</td>
<td>Less than £5,000,000</td>
</tr>
<tr>
<td>D – Designated Budget Holders</td>
<td>£100,000</td>
<td>Nil</td>
<td>Less than £50,000</td>
<td>Less than £1,000,000 (including Senior Finance Manager and Finance Manager)</td>
</tr>
<tr>
<td>E – Other managers (authorised by CO or CFO)</td>
<td>Less than £20,000</td>
<td>Nil</td>
<td>Less than £50,000</td>
<td>Less than £500,000</td>
</tr>
</tbody>
</table>

* The CFO and Director of Integrated Commissioning have delegated invoice authorisation approval of £1,000,000 for Delegated Primary Care to the Head of Primary Care, SE London Primary Care Team, and £500,000 to the Assistant Head of Primary Care, SE London Primary Care Team.
1.6. The list of specific posts in each category in the table on the previous page is:

<table>
<thead>
<tr>
<th>Category</th>
<th>Category Title</th>
<th>Post Title</th>
</tr>
</thead>
</table>
| A        | Chief Officer & Chief Finance Officer               | ➢ Chief Officer  
            |                                                     | ➢ Chief Finance Officer                                                  |
| B        | Other Directors                                     | ➢ Director of Quality & Chief Nurse  
            |                                                     | ➢ Director of Integrated Commissioning  
            |                                                     | ➢ Director of Transformation  
            |                                                     | ➢ Director of Integrated Contracting (ICDT)        |
| C        | Head Of Finance                                     | ➢ Head of Finance                                                         |
| D        | Designated Budget Holders                           | ➢ Head of Nursing & Safeguarding  
            |                                                     | ➢ Head of Quality                                                        |
            |                                                     | ➢ Chief Pharmacist / Lead for Medicines Optimisation                      |
            |                                                     | ➢ Head of System Performance                                              |
            |                                                     | ➢ Joint Head of Partnership Commissioning                                 |
            |                                                     | ➢ Head of Children & Young People Commissioning                           |
            |                                                     | ➢ Head of Demand Management                                               |
            |                                                     | ➢ Head of Primary Care Commissioning                                      |
            |                                                     | ➢ Head of Assurance and Governance                                        |
            |                                                     | ➢ Head of Transformation - Population Health                              |
            |                                                     | ➢ Head of Transformation - Local Care Networks                            |
            |                                                     | ➢ Head of Membership, Engagement& Equalities                              |
            |                                                     | ➢ Asst Director of Integrated Commissioning (ICDT)                        |
            |                                                     | ➢ Head of Finance & Planning (ICDT)                                       |
            |                                                     | ➢ Head of Performance (ICDT)                                              |
| E        | Other Managers (authorised by CO or CFO)            | List to be held electronically within the Finance ledger system and maintained on a monthly basis |

The best possible health outcomes for Southwark people
## 2. NHS Southwark CCG Delegated Matters

- **●** = Individual Delegated Authority/Responsibility
- **○** = Combined Authority/Responsibility

### Reference Table

<table>
<thead>
<tr>
<th>Ref</th>
<th>Delegated Matter</th>
<th>Council of Members</th>
<th>Committee</th>
<th>Chief Officer</th>
<th>Head of Finance</th>
<th>Designated Budget Holder (Head of Service)</th>
<th>Approved Other Mngs/Line Mngr (or HR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Management of budgets (limits for budget approval and agreement of virements)</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>1.1</td>
<td>Approval of Annual Budget</td>
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<td>Approve Annual Budget</td>
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<tr>
<td>1.2</td>
<td>Responsibility of keeping expenditure within budgets</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>a)</td>
<td>At individual budget level (pay and non-pay)</td>
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<tr>
<td>b)</td>
<td>At service level</td>
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<td>For totality of programme costs within the CCG</td>
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<td>d)</td>
<td>For totality of running costs within the CCG</td>
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<tr>
<td>e)</td>
<td>For all other areas</td>
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<td>1.3</td>
<td>Virement within budgets</td>
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<td>Within directorates</td>
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<td>£50,000 or above</td>
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<td></td>
<td>Between directorates</td>
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<td>1.4</td>
<td>Reserves or Additional Income</td>
<td>Reserves or Additional Income</td>
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<td>2</td>
<td>Management of capital spend (limits for budget approval and agreement of virements)</td>
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<td>Responsibility of keeping expenditure within allowance</td>
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<tr>
<td>a)</td>
<td>At individual capital project level</td>
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<tr>
<td>b)</td>
<td>For totality of capital projects</td>
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</tbody>
</table>

Detailed Scheme of Delegation v. 1.1

Date approved: 11 May 2017

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The best possible health outcomes for Southwark people
<table>
<thead>
<tr>
<th>Ref</th>
<th>Delegated Matter</th>
<th>Council of Members</th>
<th>Chief Officer</th>
<th>Director</th>
<th>Head of Finance</th>
<th>Designated Budget Holder (Head of Service)</th>
<th>Approved Other Mngs/Line Mngrs (for HR)</th>
</tr>
</thead>
</table>

### Capital Schemes

a) Appointment of architects, quantity surveyors, consultant engineer and other professional advisors within EU regulations

b) Financial monitoring and reporting on all capital scheme expenditure

c) Granting and termination of leases with annual rent

d) Capital works orders:
   
   - Up to £500,000
   - Between £500,000 and £1,000,000
   - £1,000,000 or above

### Expenditure/requisitioning/ordering/invoices/payment of goods and services

#### Revenue

- Up to £1,000 (reserved for specific Commissioning Support Unit staff in order to carry out services contracted out)
- Up to £20,000
- Up to £100,000
- Up to £100,000 (reserved for specific Commissioning Support Unit staff in order to carry out services contracted out)
- Up to £500,000
- Up to £5,000,000

---

Detailed Scheme of Delegation v. 1.1
Date approved: 11 May 2017

The best possible health outcomes for Southwark people
## Delegated Matter

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<tr>
<th>Ref</th>
<th>Council of Members</th>
<th>Chief Officer</th>
<th>Head of Finance</th>
<th>Designated Budget Holder (Head of Service)</th>
<th>Approved Other Mngrs/Line Mngrs (for HR)</th>
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<tbody>
<tr>
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<tr>
<td>Up to £15,000,000</td>
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<tr>
<td>Unlimited (within resource limits)</td>
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<td>GB</td>
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</tbody>
</table>

*The CFO and Director of Integrated Commissioning have delegated invoice authorisation approval of £1,000,000 for Delegated Primary Care to the Head of Primary Care, SE London Primary Care Team, and £500,000 to the Assistant Head of Primary Care, SE London Primary Care Team.

### Sales Orders Requests (raising invoices to other organisations)

<table>
<thead>
<tr>
<th>Category</th>
<th>Up to £500,000</th>
<th>Category E (Section 1.6)</th>
<th>Up to £1,000,000</th>
<th>Category D (Section 1.6), Senior Finance Manager and Finance Manager</th>
<th>Up to £5,000,000</th>
<th>Category C (Section 1.6)</th>
<th>Up to £7,500,000</th>
<th>Category B (Section 1.6)</th>
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### Capital

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<thead>
<tr>
<th>Category</th>
<th>Up to £500,000</th>
<th>GB</th>
<th>Up to £1,000,000</th>
<th>GB</th>
<th>£1,000,000 or above</th>
<th>GB</th>
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</table>

### Quotation, Tendering & Contract procedures

<table>
<thead>
<tr>
<th>Category</th>
<th>Tender/quote limits</th>
<th>GB</th>
<th>1 written quote</th>
<th>GB</th>
<th>At least 3 written quotes</th>
<th>GB</th>
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<td></td>
<td></td>
</tr>
<tr>
<td>Ref</td>
<td>Delegated Matter</td>
<td>Council of Members</td>
<td>Chief Finance Officer</td>
<td>Director</td>
<td>Head of Finance</td>
<td>Designated Budget Holder (Head of Service)</td>
</tr>
<tr>
<td>-----</td>
<td>-----------------</td>
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<td>----------------</td>
<td>------------------------------------------</td>
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<tr>
<td></td>
<td>(presented below is the lowest level of delegation allowed across the CCG. Authority can be referred higher, but never lower)</td>
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</tr>
<tr>
<td></td>
<td>Above 50,000, less than £100,000</td>
<td>3 competitive tenders</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Above £100,000, less than £200,000</td>
<td>4 competitive tenders</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Above £200,000</td>
<td>6 competitive tenders</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Approving expenditure greater than tender price</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Waiving of quotations and tenders subject to SFIs (needs to be reported to Audit Committee at next available meeting)</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Contract Authorisation and Award Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to £50,000</td>
</tr>
<tr>
<td>Up to £50,000</td>
</tr>
<tr>
<td>Up to £100,000</td>
</tr>
<tr>
<td>Up to £250,000</td>
</tr>
<tr>
<td>Above £250,000, less than £1m</td>
</tr>
<tr>
<td>£1m or above</td>
</tr>
</tbody>
</table>

*For Primary Care, authority is delegated to the Chief Officer and approved contracts are reported to IG&P or the Governing Body based on value

NHS Service Agreements and Contracts

a) For the commissioning of healthcare services with: NHS bodies, NHS Trusts, NHS Foundation Trusts

<table>
<thead>
<tr>
<th></th>
<th>Council of Members</th>
<th>Chief Finance Officer</th>
<th>Director</th>
<th>Head of Finance</th>
<th>Designated Budget Holder (Head of Service)</th>
<th>Approved Other Mngs/Line Mngs (for HR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to £15,000,000</td>
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<tr>
<td>£15,000,000 and above</td>
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</tbody>
</table>
### Delegated Matter

(presented below is the lowest level of delegation allowed across the CCG. Authority can be referred higher, but never lower)

<table>
<thead>
<tr>
<th>Ref</th>
<th>Delegated Matter</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Council of Members</th>
<th>Chief Officer</th>
<th>Chief Finance Officer</th>
<th>Director</th>
<th>Head of Finance</th>
<th>Designated Budget Holder (Head of Service)</th>
<th>Approved Other Mgrs/Line Mgrs (for HR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>b) For the purchase of all other services</td>
<td>As per the contract authorisation and award values above</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Setting of Fees and charges</td>
<td>Price of NHS Contracts</td>
<td>*Director of Integrated Commissioning, Director of Integrated Contracting (ICDT)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Agreements/licences</td>
<td>a) Preparation and signature of all tenancy agreements/licences for all staff subject to policy on accommodation for staff</td>
<td>*</td>
<td></td>
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<td></td>
<td>b) Extensions to existing leases</td>
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</tr>
<tr>
<td></td>
<td>c) Letting of premises to outside organisations</td>
<td>○ ○</td>
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</tr>
<tr>
<td></td>
<td>d) Approval of rent based on professional assessment</td>
<td>○ ○</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>e) Engagement of solicitors</td>
<td>○ ○</td>
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</tr>
</tbody>
</table>

**Agreements/licences**

a) Preparation and signature of all tenancy agreements/licences for all staff subject to policy on accommodation for staff

b) Extensions to existing leases

c) Letting of premises to outside organisations

d) Approval of rent based on professional assessment

e) Engagement of solicitors

**Maintenance/operation of bank accounts** (authorisation of banking transactions and management of accounts)

All banking administered by CSU, but must be managed in accordance with organisational Prime Financial Policies (PFPs), Standing Financial Instructions (SFIs) and Standing Orders (SOs). Maintenance and Operation in accordance with mandates approved by the CCG Governing Body.

**Personnel & Pay**

**Funding/approving posts**

a) authority to fill funded post in establishment with permanent staff

b) authority to appoint staff to post not in

---

Detailed Scheme of Delegation v. 1.1
Date approved: 11 May 2017
Review date: May 2018

The best possible health outcomes for Southwark people
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<th>Chief Officer</th>
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<th>Designated Budget Holder (Head of Service)</th>
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<tbody>
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<td>establishment</td>
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<tr>
<td></td>
<td>i) with specifically allocated funding</td>
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<tr>
<td></td>
<td>ii) without specifically allocated funding</td>
<td>SMT1</td>
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<tr>
<td></td>
<td>c) authority to appoint fixed-term or temporary staff</td>
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<tr>
<td></td>
<td>d) renewal of contract for fixed-term or temporary staff</td>
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<td></td>
<td>Additional increments/regrading</td>
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<td></td>
<td>Additional increments to staff</td>
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<td>* must follow appropriate HR policy</td>
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<td>Pay</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>a) Standing data forms affecting pay, comprising new starters, variations and leavers</td>
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<td>●</td>
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<td></td>
<td>b) Overtime</td>
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<td></td>
<td>●</td>
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<tr>
<td></td>
<td>c) Travel &amp; subsistence expenses</td>
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<tr>
<td></td>
<td>d) Performance related pay assessment</td>
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<td>RC</td>
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<td></td>
<td>e) Executive pay level</td>
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<td>Leave</td>
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<tr>
<td></td>
<td>a) Annual leave (including carry forward leave up to max 5 days)</td>
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<td>●</td>
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<tr>
<td></td>
<td>b) Annual leave carry over in excess of 5 days</td>
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<td></td>
<td>c) Compassionate/special leave (e.g carer's leave)</td>
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<td></td>
<td>d) Paid special leave in excess of 5 days</td>
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<td>●</td>
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</tbody>
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The best possible health outcomes for Southwark people
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<tbody>
<tr>
<td>e) Leave without pay</td>
<td>●</td>
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<tr>
<td>f) Parental Leave (Maternity &amp; Paternity)</td>
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</tbody>
</table>

**Sickness Absence (Sick Leave)**

| a) Extension of occupational sick pay (full and half pay) beyond the terms set out in Agenda for Change/ terms and conditions of employment | | | ○ | ○ | ○ | ○ | ○ |
| b) Return to work part-time on full pay to assist recovery | | | | | ● | ● | ● |

* based on Occupational Health recommendation

**Study Leave/Study Funding**

| a) Approval of course with single day time and /or financial commitment under £500 | | | ○ | | | ○ | ○ |
| b) Approval of course / study leave with a requirement for more than one day, or costing £500 or more | | | | | | | ● |

**Removal expenses, excess rent and house purchases**

Payment of removal expenses incurred by officers taking up new appointments, up to £5,000 | ○ | ○ | ○ | ○ | ● | ● |

**Grievance**

All grievances must be dealt with strictly in accordance with the appropriate policy and the HR department must be informed when a formal grievance is lodged.
<table>
<thead>
<tr>
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<th>Delegated Matter</th>
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<th>Director</th>
<th>Head of Finance</th>
<th>Designated Budget Holder (Head of Service)</th>
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<tr>
<td></td>
<td><strong>Authorised car, mobile phone, laptop or tablet (such as iPad or Microsoft Surface) users</strong></td>
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<tr>
<td></td>
<td>New posts to be authorised as car users</td>
<td>RC</td>
<td>O</td>
<td>O</td>
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<tr>
<td></td>
<td>New posts to be authorised as mobile telephone, laptop or tablet users</td>
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<tr>
<td></td>
<td><strong>Other Personnel &amp; Pay related items</strong></td>
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<tr>
<td></td>
<td>Extensions of contract beyond normal retirement age in exceptional circumstances</td>
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<tr>
<td></td>
<td>Redundancy</td>
<td>RC</td>
<td>O</td>
<td>O</td>
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<td></td>
<td>Premature retirement</td>
<td>RC</td>
<td>O</td>
<td>O</td>
<td>O</td>
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<td></td>
<td>Ill health retirement</td>
<td>RC</td>
<td>O</td>
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<td>O</td>
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<tr>
<td></td>
<td>Dismissal (following appropriate policy)</td>
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<tr>
<td></td>
<td><strong>Losses, write-offs &amp; special payments</strong></td>
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<tr>
<td></td>
<td><strong>Losses</strong></td>
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<tr>
<td></td>
<td>Losses due to theft, fraud, overpayment etc – up to £50,000</td>
<td>AC</td>
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<tr>
<td></td>
<td>Losses due to theft, fraud, overpayment etc – over £50,000</td>
<td>GB</td>
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</tr>
<tr>
<td></td>
<td><strong>Fruitless payments, crediting of debtors and write-offs</strong></td>
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<td></td>
<td>Fruitless payments (including abandoned capital schemes – up to £250,000)</td>
<td>AC</td>
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<td></td>
<td>Fruitless payments (including abandoned capital schemes – over to £250,000)</td>
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<tr>
<td></td>
<td>Bad debts, claims abandoned and writing off-non-NHS debtors</td>
<td>AC</td>
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</tbody>
</table>
### Ref

**Delegated Matter**

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<table>
<thead>
<tr>
<th>Crediting of debtors (eg invoice raised in error, or CCG has no legal right to income)</th>
<th>Council of Members</th>
<th>Committee</th>
<th>Chief Finance Officer</th>
<th>Director</th>
<th>Head of Finance</th>
<th>Designated Budget Holder (Head of Service)</th>
<th>Approved Other Mngs/Lin Mngr (for HR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>£1,000,000 or below</td>
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<td></td>
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<tr>
<td>Over £1,000,000</td>
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</tr>
</tbody>
</table>

### Compensation and ex-gratia payments

<table>
<thead>
<tr>
<th>Compensation payments made under legal obligation</th>
<th>Council of Members</th>
<th>Committee</th>
<th>Chief Finance Officer</th>
<th>Director</th>
<th>Head of Finance</th>
<th>Designated Budget Holder (Head of Service)</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Patients and staff for loss of personal effects (ex-gratia)</td>
<td>Council of Members</td>
<td>Committee</td>
<td>Chief Finance Officer</td>
<td>Director</td>
<td>Head of Finance</td>
<td>Designated Budget Holder (Head of Service)</td>
<td>Approved Other Mngs/Lin Mngr (for HR)</td>
</tr>
<tr>
<td>Up to £10,000</td>
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<td>£10,001 to £20,000</td>
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<td>Over £20,000</td>
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</tbody>
</table>

### For clinical negligence

<table>
<thead>
<tr>
<th>For clinical negligence</th>
<th>Council of Members</th>
<th>Committee</th>
<th>Chief Finance Officer</th>
<th>Director</th>
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</thead>
<tbody>
<tr>
<td>Up to and including £250,000 (negotiated settlements including claimant's costs)</td>
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<td></td>
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<tr>
<td>Over £250,000</td>
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</tbody>
</table>

### For personal injury claims involving negligence where legal advice obtained and guidance applied

<table>
<thead>
<tr>
<th>For personal injury claims involving negligence where legal advice obtained and guidance applied</th>
<th>Council of Members</th>
<th>Committee</th>
<th>Chief Finance Officer</th>
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<tbody>
<tr>
<td>Up to and including £250,000 (including plaintiff’s costs)</td>
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<td>Over £250,000</td>
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</table>

### Other, where no financial loss by claimant

<table>
<thead>
<tr>
<th>Other, where no financial loss by claimant</th>
<th>Council of Members</th>
<th>Committee</th>
<th>Chief Finance Officer</th>
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</thead>
</table>

### Damage to buildings, fittings, furniture and equipment, and loss of equipment and property in storage and in use due to culpable causes (eg wilful damage, neglect etc)

<table>
<thead>
<tr>
<th>Damage to buildings, fittings, furniture and equipment, and loss of equipment and property in storage and in use due to culpable causes (eg wilful damage, neglect etc)</th>
<th>Council of Members</th>
<th>Committee</th>
<th>Chief Finance Officer</th>
<th>Director</th>
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</tr>
</thead>
</table>

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**Receiving Gifts & Hospitality (applies to both individual and collective hospitality receipt items)**

**Detailed Scheme of Delegation v. 1.1**

**Date approved:** 11 May 2017

**Review date:** May 2018

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<tr>
<th></th>
<th>Council of Members</th>
<th>Chief Officer</th>
<th>Chief Finance Officer</th>
<th>Director</th>
<th>Head of Finance</th>
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</thead>
<tbody>
<tr>
<td>Hospitality in excess of £25 per item received</td>
<td>●</td>
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<td>Gifts below £10 in accordance with relevant policy</td>
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<td>●</td>
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<tr>
<td>Maintaining register of gifts, hospitality and sponsorship</td>
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<table>
<thead>
<tr>
<th>Register of sealings</th>
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<tbody>
<tr>
<td>Attestation of sealings in accordance with Standing Orders</td>
</tr>
<tr>
<td>Maintain a register of sealings</td>
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</table>

<table>
<thead>
<tr>
<th>Declaration of Interests register</th>
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<tbody>
<tr>
<td>Maintain a register of declarations of interest</td>
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<table>
<thead>
<tr>
<th>Monitoring and reporting of new drugs</th>
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<tbody>
<tr>
<td>Estimated total yearly cost up to £75,000</td>
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<tr>
<td>Estimated total yearly cost of £75,000 or above</td>
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</tbody>
</table>

* Director of Quality & Chief Nurse

<table>
<thead>
<tr>
<th>Patients' &amp; relatives' complaints</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall responsibility for ensuring that all complaints are dealt with effectively</td>
</tr>
<tr>
<td>Responsibility for ensuring complaints relating to a directorate are investigated thoroughly</td>
</tr>
<tr>
<td>Co-ordination of management of medico-legal complaints</td>
</tr>
</tbody>
</table>

* Director of Quality & Chief Nurse

<table>
<thead>
<tr>
<th>Relationships with press</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dealing with enquiries within hours</td>
</tr>
</tbody>
</table>

* Principal Associate, Communications and Engagement

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Detailed Scheme of Delegation v. 1.1
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</tbody>
</table>

## Dealing with enquiries outside hours

- Council of Members
- Committee
- Chief Officer
- Director
- Head of Finance
- Designated Budget Holder (Head of Service)
- Approved Other Mngs/Line Mngrs/L (for HR)

## Reporting incidents to the police

### Where a criminal offence suspected:
- Violent
- Other
- Where fraud suspected

* through the Local Counter Fraud Specialist

## Other

### Condemning and disposal of equipment including IT

- Council of Members
- Committee
- Chief Officer
- Director
- Head of Finance
- Designated Budget Holder (Head of Service)
- Approved Other Mngs/Line Mngrs/L (for HR)

### Maintenance of financial procedures

- Council of Members
- Committee
- Chief Officer
- Director
- Head of Finance
- Designated Budget Holder (Head of Service)
- Approved Other Mngs/Line Mngrs/L (for HR)

### Insurance policies and risk management

- Council of Members
- Committee
- Chief Officer
- Director
- Head of Finance
- Designated Budget Holder (Head of Service)
- Approved Other Mngs/Line Mngrs/L (for HR)

### Implementation of internal and external audit recommendations

* Relevant to the report in question

### Management of infectious diseases and notifiable outbreaks

- Council of Members
- Committee
- Chief Officer
- Director
- Head of Finance
- Designated Budget Holder (Head of Service)
- Approved Other Mngs/Line Mngrs/L (for HR)
Purpose

This paper updates the Governing Body on the outcome of the public consultation on the proposed changes to NHS prescriptions in Southwark. The paper also sets out the recommendations made to the Governing Body by the Commissioning Strategy Committee on 7 September 2017.

Background

The following proposals were presented to the Commissioning Strategy Committee in June 2017:

- revision of local prescribing guidelines for general practice to cease to provide malaria prophylaxis on an NHS prescription
- to review current arrangements for the provision of some over the counter (OTC) medications for acute, self-limiting conditions by GPs on NHS prescriptions
- to encourage adherence to the implementation of national policy which does not support the provision of selected vaccines for travel purposes on an NHS prescription:
  - Meningitis vaccine (ACWY)
  - Yellow Fever
  - Japanese B encephalitis
  - Tick-borne encephalitis
  - Rabies vaccine
  - Hepatitis B (single agent vaccine)

These proposals form part of the Medicines Optimisation Quality, Innovation, Productivity and Prevention (QIPP) plans for 2017/18 and anticipated savings from this element of the QIPP are approximated at £375k if implemented from October 2017.

A recommendation was made at the June 2017 meeting that the Commissioning Strategy Committee formally endorse support for these initiatives and give approval.
for a consultation and engagement phase to commence with patients and the public. The recommendation was agreed.

Consultation

A consultation on the proposed changes to prescribing guidelines for OTC, malaria prophylaxis and travel vaccines was held over an 8-week period, from 26 June to 20 August 2017.

The Consultation Report was presented to the Commissioning Strategy Committee on 7 September 2017. The objectives of the consultation were to seek people’s views on:

- The principles of restricting routine NHS prescribing of over the counter medicines for self-limiting conditions
- How far they agree or disagree with the individual proposals
- Any specific concerns about the proposals
- Suggested mitigating actions for concerns expressed
- Optimum channels for communication with Southwark people on the proposed and final decision

Summary of results

The response to the proposals set out has been positive. At the close of the consultation period most respondents (78%) indicated that they understand the rationale for the proposals and broadly support them.

NHS professionals have welcomed the attempt to provide clarity and promote greater consistency in prescribing practice between clinicians, across Southwark GP practices and NHS organisations and in relation to neighbouring boroughs and national prescribing. They are joined by patients and residents in voicing support for principles of self-care and the intention to reduce unnecessary demand on GP time through these proposals.

Patient groups and clinicians appear to support the proposals for malaria prevention medicines and travel vaccines more cautiously than the proposals for over the counter medicines.

➢ Over the counter medicines

There was widespread support for principles of self-care and reducing demand on GP time, as illustrated by the level of agreement with the following statement:

<table>
<thead>
<tr>
<th>GPs should spend less time treating people who</th>
<th>Agree/</th>
<th>Disagree/</th>
</tr>
</thead>
</table>
could obtain self-care medication and health supplements from a pharmacy without a prescription

<table>
<thead>
<tr>
<th></th>
<th>strongly agree</th>
<th>strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>76%</td>
<td>15%</td>
<td></td>
</tr>
</tbody>
</table>

➢ Malaria prevention medicines

There was a majority support for the proposal to remove the provision of malaria prevention medicines from NHS prescription:

<table>
<thead>
<tr>
<th>The local NHS should stop offering NHS prescriptions for malaria prevention medicines for travel</th>
<th>Agree / strongly agree</th>
<th>Disagree / strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>55%</td>
<td>32%</td>
<td></td>
</tr>
</tbody>
</table>

➢ Selected travel vaccines

The principle that people travelling should be expected to factor the cost of vaccination and preventive medicines into their travel budget received a majority support among survey respondents:

<table>
<thead>
<tr>
<th>The local NHS should stop offering the selected vaccines for travel on the NHS</th>
<th>Agree / strongly agree</th>
<th>Disagree / strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>55%</td>
<td>36%</td>
<td></td>
</tr>
</tbody>
</table>

The full Report on the Consultation is attached with this briefing. The consultation report includes all the issues raised during the consultation period and sets out actions and mitigations in response to these issues.

Recommendations

The following recommendations were made to the Commissioning Strategy Committee on 7 September 2017:

1. To note the outcome of the consultation which indicates overall support for the proposed changes to the prescribing of some OTC medications, malaria prophylaxis and selected travel vaccines
2. To make a recommendation to the NHS Southwark CCG Governing Body that the proposals outlined in this paper are implemented.
The Commissioning Strategy Committee discussed the paper and the consultation report in full.

The Commissioning Strategy Committee recommended to the Governing Body the proposal for changes to prescription for OTC, malaria and travel vaccines should be approved for implementation. The Commissioning Strategy Committee recommends that Governing Body also notes the following:

- the need for on-going evaluation, with the outcome of this to be reviewed by CSC in 18 months to 2 years to monitor any impact of the changes to the prescription of malaria and travel vaccines.
- recommended that as part of implementation, the public campaign is utilised fully in particular as a means to address health inequalities
- endorsed, in particular, the effective communication out to practices which supports them with consistent messaging to patients as part of a coordinated approach with other parties including schools.
Report of findings from the consultation on proposed changes to NHS prescriptions in Southwark

1. Introduction

This report describes the engagement and consultation that took place regarding NHS Southwark Clinical Commissioning Group’s proposals to make some changes to prescribing guidance for over-the-counter medicines, malaria prevention medicines and selected travel vaccines.

The objectives of the consultation were to seek people’s views on:

- the principle of restricting routine NHS prescribing of over-the-counter medicines for self-limiting conditions
- how far they agree or disagree with the three specific proposals
- any specific concerns about the proposals
- suggested mitigating actions for concerns expressed
- optimum channels for communication with Southwark people on the proposed and final decision

The report outlines the findings from pre-consultation engagement with clinicians in May and patients in June before outlining the findings from the consultation which took place between 26 June 2017 and 20 August 2017. The report also highlights the main issues expressed by respondents and highlights some of the suggestions made by respondents to address these as well as actions identified by the CCG to address them.

1.1. Proposals for change and rationale

The CCG carried out a public consultation from 26 June 2017 until 20 August 2017 on proposals to make changes to prescribing guidance in three areas. The consultation took place later than originally planned due to purdah after the announcement of the general election which took place on 8 June 2017. The CCG proposed to no longer support the routine prescribing of the following products on the NHS:

1. Self-care medications for short term minor illnesses and injuries and health supplements
2. NHS prescriptions for malaria prevention medicines for travel
3. NHS prescriptions for selected travel vaccinations:
   - Hepatitis B – (single agent vaccine)
   - Meningitis vaccine
   - Japanese B encephalitis
   - Rabies vaccine
   - Tick-borne encephalitis
   - Yellow Fever
These proposals are part of Southwark plans within the community-based care workstream of the south east London Sustainability and Transformation Plan (STP). Similar discussions are taking place or are planned in each area within the south east London STP area, as well as in many other areas of the country.

The rationale for making these changes is to:

- promote self-care
- align NHS Southwark CCG guidance with national guidance
- provide clarity of guidance and policy and reduce unwarranted variation in practice across the health economy
- to free up doctor and nurse time for those most in need
- to bring Southwark into line with national guidance
- to get the best value from funding that we have available

Taken together, these proposals support the CCG’s work to contain the costs of medicines on the local NHS budget, and if taken forward will contribute to the commissioner cost saving and quality improvement programme (QIPP). We estimate cost savings of £375,000 for current year (from October 2017).

2. Pre-consultation – engagement with clinical colleagues and other stakeholders

In developing the proposals the CCG held discussions at the Area Prescribing Committee (March 2017), the Southwark Medicines Management Committee (September 2016, January 2017, April 2017), with public health specialists, the Local Medical Committee (LMC), and with the Local Pharmaceutical Committee. Comments and questions from clinical colleagues helped to shape the focus of the consultation and to highlight key areas that would need to be addressed if the proposals were taken forward.

Discussions were had at the Practice Managers’ Forum on 4 May 2017 as part of a broader agenda item on the Prescribing Incentive Scheme. The proposed changes to NHS prescriptions was also a main agenda item at the GP locality meetings on 25 May 2017 which were attended by 23 GPs and ten practice managers representing 27 practices.

A briefing was prepared and shared with the Local Authority Healthy Communities Overview and Scrutiny Chair and Vice-Chair with the offer of attending a meeting to clarify and outline proposals and answer any questions, to outline plans for consultation and to seek support in reaching Southwark patients and public. The CCG was informed on 13 June that they did not require a presentation and there was no further request for information.
Discussions on the consultation approach also took place at the CCG’s Engagement Advisory Group on 1 May 2017 and this includes representatives from Healthwatch and the Council’s Community Participation team.

Issues highlighted as part of the above discussions included:

- Majority support from the Medicines Management Committee to revert to national policy regarding the availability of malaria chemoprophylaxis on private prescription only
- The need to be explicit that the proposals would not challenge the primacy of clinical judgement – the CCG clarified that clinicians would be expected to use their judgement when considering whether it is acceptable to recommend that patients should purchase their medication
- The need for clarity of whether a clinician can legally make a clinical recommendation for a patient to purchase over the counter treatments or remedies, instead of providing the treatment on an NHS prescription - Guidance from the General Medical Council (GMC) on the GP contract does support GPs to be able to do this (Good practice in prescribing and managing medicines and devices, General Medical Council, 2013). In addition, legal advice was obtained by Bromley CCG on behalf of all six south east London CCGs
- The desirability of public health advice on stopping the provision of malaria prevention medicines – the CCG sought advice from public health experts in formulating and risk-assessing the proposals around malaria prevention medicines
- The helpfulness of the proposals to bring alignment with national guidance in prescribing practice and hence, removing potential confusion for local patients
- Questions of potential adverse impact on people on low incomes who are eligible for free NHS prescriptions
- Concern about clinicians having to explain to patients the need to buy items they have previously received on prescription, if the proposals go through and the need for centrally produced communication aids to support them in this
- The possibility of increased attendance at A&E by patients for minor illnesses and ailments in order to get medicines on prescription rather than buy them and patients feeling upset rather than empowered and the need for consistent messages across all health service providers
- The need for effective patient communications following a decision on proposals
- The need for communication material if the proposals go ahead to support clinicians communicating with patients and to consider communication campaigns around malaria prevention
- Clarifying the parameters of the consultation in light of the NHS England consultation around gluten free products and clarifying that baby milk is not part of the proposals
- The importance of the Pharmacy First scheme and the need to not destabilise this service, given the number of local people on low incomes and entitled to free prescriptions
Need for clarity about the overlap between the proposed list of over-the-counter medicines being taken off NHS prescriptions and those included in the Pharmacy First scheme

The potential risk of destabilising the healthy child programme

Pharmacists may be put under great pressure from patients insisting on a supply of over-the-counter products from the Pharmacy First scheme

Concerns that there may be an increase in inequalities for patients who can’t afford these medications, and therefore an increased risk of their condition worsening

May mean that patients opt to buying medication in supermarkets instead of pharmacies, meaning pharmacists may not be able to make interventions and signpost patients as appropriate

Need for clarity of the definition of ‘short term’ minor illnesses and conditions and at what point does it become ‘long term’

The importance of pharmacists within hospitals, urgent care centres and the 111 service being aware of any changes that might be implemented so that they are not directing patients to GPs for prescriptions for items that would no longer be available on prescription if the propels go ahead.

Discussions took place at the CCG’s Commissioning Strategy Committee on 1 June 2017. Membership includes GP and nurse clinical leads, lay members, CCG directors, a hospital doctor and nurse, a LMC representative and Healthwatch. Issues raised included:

- Giving travel vaccines to people who do not normally attend general practice provides an opportunity to give further travel advice around safe sex and sun protection etc
- Available data does not support whether the current local arrangements for antimalarial prophylaxis on the NHS have had a positive impact on malaria case numbers, especially compared to other similar areas where such arrangements are not in place. It was also noted that stopping this provision could be seen as being counterintuitive.
- Whether the data can show who is receiving malaria prevention medicines on NHS prescriptions in Southwark.
- Concerns about the impact on proposals on people with low incomes and people from minority ethnic communities.
- The need to monitor the effects of the proposals, if they are implemented, closely over the next 18 months.
- The importance of education for people travelling to countries with malaria.

A patient workshop to test the proposals was held on 16 June 2017. The purpose of the workshop was to test the draft consultation document and leaflet, to test the proposals, positive and negative impacts of the proposals and any concerns people had and how these could be addressed.
12 local people attended the workshop; of which seven were women and four were men. Six people identified as White British, four as Black or Black British – African and one as Black or Black British – Caribbean. Six people were aged 45 – 59, five were aged 65 – 74 and two were aged 75 – 84. Five people have long term conditions, two have physical disabilities, two are deaf or hard of hearing and one has mental health needs.

After presenting the proposals and outlining the plans for the consultation, we answered any questions before dividing up into two groups to go through the draft consultation document page by page. Participants made a number of suggestions regarding phrasing, terminology and lay out of the document to make it easier to understand for the general public and, where there was a consensus of opinion, these were incorporated into the published version.

The two groups were then invited to discuss the proposals. Some of the participants expressed concern about people getting malaria if they cannot afford anti-malaria medicines. They suggested that the CCG needs to promote how to protect against malaria, its importance and the need to budget for this as well as the importance of talking to a health professional if the proposals are accepted. There was some concern expressed about people who may buy cheap and ‘poor’ drugs from abroad. Participants felt that background information on the CCG website and information about the importance of taking malaria prophylaxis before travel would be important if the proposals were accepted. There was also some concern noted about the future potential cost to the NHS if there are more malaria cases. Participants welcomed the fact that this would be monitored closely if the proposals are agreed.

Participants also raised concerns about people who cannot afford medicines and people who are not linked into services such as homeless people. To address this, they felt that the Pharmacy First scheme should be advertised as well as promoting the role of pharmacists.

Participants felt that the positive benefits of the proposals would be that people would have to take more responsibility for their own health and lives and not use GP/nurse time for minor ailments. In terms of promoting the consultation, people suggested churches, mosques and faith groups as places to reach people from black and minority ethnic communities as well as use of twitter, websites, libraries and community council meetings.

3. Target groups

- Patients registered at Southwark GP practices, particularly those which are high prescribers of anti-malarials (the majority of the mefloquine prescribing takes place in practices in Peckham, Borough & Walworth areas)
- The CCG engagement mailing list
• Groups representing Southwark patients (e.g. Healthwatch Southwark, practice and locality patient participation groups (PPGs)
• Southwark residents who may be likely to travel to countries needing the selected vaccinations or malarial prevention medicines
• Voluntary and community sector (VCS) organisations as representatives of particular groups who may be affected, including people on very low incomes and those who are entitled to free NHS prescriptions
• Elected representatives (local councillors) of Southwark residents
• Groups of people likely to be impacted by the proposals as identified in the equality analysis including but not limited to those from West Africa, Latin America, South Asia and those who are economically deprived.

4. Consultation approach

Methods to reach and engage with patients and members of the public were varied and included:

• Using the CCG website to inform and invite comment – a prominent banner on the home page, together with news articles, and links to the consultation document, summary, link to survey and full details on the NHS prescriptions page under the Get Involved section. During the consultation period there were a number of spikes in website activity corresponding directly with social media posts about the consultation and directing people to the consultation page, culminating in 569 page views, of which 368 were unique page views.
• Using the CCG Twitter presence to alert followers to the consultation and pull them to the CCG website content – during the consultation period the CCG posted 22 tweets about the consultation encouraging people to respond; these 22 tweets reached 8,230 twitter feeds.
• Informing and inviting comment using the consultation document, summary documents and paper surveys distributed through all GPs, pharmacies, King’s College Hospital NHS Foundation Trust, the Urgent Care Centre at Guy’s Hospital, libraries, Citizens Advice local offices, Southwark Pensioner’s Centre, the Southwark Wellbeing Hub.
• Sending out a summary email of proposals with links to all documents and the survey to the CCG’s engagement database of just over 700 local people and just under 60 local organisations and groups on 27 June and 24 July.
• Inclusion of article and links in the fortnightly CCG staff bulletin twice during the consultation period on 26 June and 10 July
• Email outlining consultation, links to the consultation document, summary and consultation page for the survey on the CCG website and an FAQs was sent to Southwark councillors, council directors, three Southwark MPs and Healthwatch on 29 June 2017
• An email to GPs as above was sent on 29 June and links to the consultation were included in the CCG’s weekly GP bulletin throughout the consultation
period to engage with our GP membership. Practice staffs were also encouraged to discuss the proposals with patients at their practice patient participation groups (PPGs) and asking them to invite the CCG to a PPG if they wanted someone to talk through proposals.

- Email outlining proposals with links and FAQs was sent to the communications leads on 29 June at King’s College Hospital NHS Foundation Trust, Guy’s and St Thomas’ NHS Foundation Trust and the South London and Maudsley NHS Foundation Trust. Leads were asked to share the information with their relevant staff and patients.

- Email to community pharmacists outlining consultation, links to the consultation document, summary and consultation page for the survey on the CCG website and a FAQs was sent on 30 June and followed up by an email highlighting that the consultation documentation had been sent to them for display on 11 July 2017.

- Written briefings including the proposals about NHS prescriptions was written for the meeting with Helen Hayes, MP, on 11 July 2017.

- Email highlighting consultation and links with FAQs was sent to the chief pharmacists at Guy’s and St Thomas’ NHS Foundation Trust and King’s College Hospital NHS Foundation Trust as well as the consultant pharmacist for the Older People’s Team and the community health services pharmacists at GSTT, the Southwark Local Pharmaceutical Committee representative who is also the Chair of the Community Pharmacy Forum; and the Chair of the Local Medical Committee on 4 July 2017.

- Information stall at the Our Healthier Southwark STP engagement event 11 July 2017.

- Article as part of the CCG advertorial in Southwark News on 29 June and 27 July 2017.

- An article was in the Healthwatch July e-bulletin and on their website during the consultation period.

- An article in the CCG’s stakeholder bulletin on 16 August.

- Attendance at community and PPG meetings.

- Attendance at the Practice Nurse Forum, the Local Pharmaceutical Committee meeting and the north and south GP locality meetings.

- Direct emailing to the following groups outlining the consultation proposals, links to the documents and the survey and offering a CCG member of staff to discuss with any group meetings:
  - Somali Integration Project
  - Sierra Leone Hajj Pilgrimage UK
  - Friends of Diabetes Sierra Leone
  - Astley Coopers TRA
  - Sierra Leone Friendship Association
  - The Kris Dot company
  - The Dulwich Milan Association
  - The Dulwich Punjabi Community Centre
  - The Pioneer African Caribbean Group
People were encouraged to give their views by:

- Completing an online or paper survey
- Emailing or writing questions or comments to the CCG (a freepost address was included in the consultation document)
- Attending Our Healthier Southwark STP event on 11 July 2017
- Attending their PPG meeting – we provided GP practices in Southwark with consultation documents, summary leaflets and paper questionnaires and offered CCG staff to attend PPG meetings to present and lead discussions if they required
5. Who we heard from

During the consultation period we received 302 completed surveys; of which 105 were paper surveys and 197 were electronic surveys. 166 of all respondents identified as Southwark residents or patients or voluntary and community sector community organisations representing them, and 74 identified as a NHS professional in Southwark. Twenty two people identified as being residents or patients in another borough and three respondents identified as other; no respondents identified as being a Southwark ward councillor. Thirty seven people did not respond to this question.

In addition the CCG attended the following meetings to present the proposals, listen to views and encourage people to participate in the consultation:

- Patient Participation Group (PPG) at Dr Aru’s, 26 June 2017
- Borough, Walworth and Bankside Community Council meeting, 26 June 2017
- Peckham and Nunhead Community Council meeting, 27 June 2017
- Southwark and Lambeth Diabetes Forum, 28 June 2017
- South Southwark Locality PPG, 4 July 2017
- Our Healthier Southwark STP event, 11 July 2017
- Somali Women’s Group, 12 July 2017
- Advising London Latin American Women’s Group at Pembroke House, 18 July 2017
- Southwark Legal Advice Network, 19 July 2017
- FULA Latin American Elders Group, 21 July 2017
- PPG at New Mill Street Surgery, 9 August 2017
- Latin American Disabled People’s Project, 10 August 2017

Through our attendance and discussions with the above groups we reached approximately 250 people, including men and women and people from black and minority ethnic communities. Key themes that arose include:

- Cost for families travelling and the need to also purchase malaria medicines and travel vaccines and impact this could have on the local diverse community
- Concern that, if approved, the proposals would stop people from seeing their GPs
- Queries about the professional knowledge of pharmacists
- Lack of knowledge of the Pharmacy First scheme and how you demonstrate eligibility for free medicines
- Queries about varying costs of the different malaria medicine available and travel vaccines
- Queries about monitoring cases of malaria post any implementation
• Some local councillors noted the lack of available data on the detail of who is accessing malaria medication on NHS prescriptions
• Some local councillors had some concern about the consultation taking place during the holiday period when people affected might be away
• Some lack of awareness of how malaria is transmitted
• Positive feedback about role of pharmacists in terms of patients receiving advice and being able to buy over-the-counter medicines
• Some positive feedback about all proposals and providing same offer as elsewhere and we should follow national guidelines
• The need for the NHS to tackle medicines wastage
• Concern and confusion about people with long term conditions and being able to access over-the-counter medicines for their treatment
• Clarification that GPs will still be able to take a clinical view, using their clinical judgment
• The need for communication with an education element to it about travel health advice particularly around malaria prevention
• Some people have previously bought malaria medicines and travel vaccines as were not aware that they were available on NHS prescriptions

The CCG also attended the following meeting with people providing NHS services:
  o Practice Nurse Forum, 28 June 2017
  o Local Pharmaceutical Committee, 6 July 2017
  o North and South Locality Commissioning Groups, 27 July 2017

At the above meetings, the CCG spoke to 35 practice nurses, 13 pharmacists and 23 GPs, and nine practice managers. There were also five CCG clinical leads present at the locality meetings. Key themes that arose include:

• Questions about prevalence rates
• Clarity about whether the proposal included hepatitis B vaccines for occupational health reasons
• Need for a clear communications campaign to help health professional with giving the message to local patients
• Clarity about prescribing paracetamol and ibuprofen to babies under three months as this is not available on Pharmacy First scheme
• Whether GP federations could provide travel clinics
• The desirability to signpost patients to community pharmacy rather than supermarkets to purchase medicines, so that advice from pharmacists is available
• The issue of how to manage schools and nurseries that have a policy in place of not administering medication to children if it does not have a label provided by the dispensing pharmacist
• GP role is not to means test patient’s ability to pay for medicines
• Whether the proposals take away a GP’s ability to use clinical judgment
• Impact on children of families not being able to afford to buy anti malaria medicine

The CCG also received written submissions from the LMC, a pharmacist and two members of the public, which are attached in Appendix 1. The key themes of these responses are:
• Availability of busy pharmacists to provide medical advice / consultation
• Lack of transparent information in the consultation documentation about the cost of malaria medicines and the impact of paying for this on the diverse communities of Southwark
• Cost of over-the-counter medicines being transferred to the individual
• Impact of malaria medicines cost to families travelling to high risk malaria zones
• Cost to NHS of treating more malaria cases as people will inevitably not take malaria medicines and there will be more cases
• Removing over-the-counter medicines from NHS prescriptions could be confusing for patients in terms of understanding what a short term condition is and when it becomes long term. This will be particularly confusing for older people needing vitamin D and those with dementia
• The schemes should not inconvenience patients with long-term-conditions such as managing chronic pain by asking them to buy small packs of medicines on several occasions
• Concern that if the proposal is implemented, some patients would still be able to obtain medication free of charge under the Pharmacy First Scheme but if they go to their GP they will have to pay for such medication
• The need for a publicity and posters and leaflets to be made available for GP practices to display and this would help avoid practice staff having to spend time having difficult conversations with patients during consultations
• The need for clear and concise guidance to be made available to practices setting out when it would be appropriate to prescribe for example, for chronic pain.
• Query about the timing of the consultation as a national consultation has just begun and would be better to wait for the outcome of this

In response to the issue about not having information available about the cost of malaria medicines, the CCG updated its Frequently Asked Question to include this information, published it on the consultation page of the website and sent a copy to the individual.

6. Respondent profile

The demographics of the respondents who gave them (256 people) show that we have received responses from 67% people who identified as being from a White background and 33% from people who identified as being from a Black, Asian or Minority Ethnic background. According to the Southwark Council’s Demographic
Factsheet published in May 2015, 52% of the Southwark population belong to a White group and 42% belong to a Black, Asian and Minority Ethnic group. This demonstrates that we made some progress in reaching people identified in the equalities analysis and the consultation plan. The full breakdown is below:

White background:
- 59% identified as White British
- 4% identified as White – Irish
- 3.5% identified as White – European

Black, Asian or Minority Ethnic background:
- 8% identified as Latin American
- 6% identified as Black or Black British African
- 5% identified as other ethnic background
- 3% identified as Black or Black British Caribbean
- 3% identified as Black British
- 3.5% identified as Asian
- 2.5% identified as Mixed - White and Black African or Mixed- White and Black Caribbean
- 1% identified as Chinese
- 0.5% identified as Arab

In terms of gender (261 responses):
- 71% identified as female
- 28% identified as male
- 1% identified as other

In terms of age (262 responses):
- 2% were aged 21 – 24
- 5% were 25 – 29
- 24% were 30 – 44
- 34% were 45 – 59
- 15% were 60 – 64
- 16% were 65 – 74
- 4% were 75 – 84
- 0.38% were 85 – 89

In terms of disability (233 responses):
- 45% identified as having no disabilities
- 26% identified as having a long-term illness
- 8% identified as having other long term health problems
- 6% identified as having a physical disability
- 5% identified as having mental ill health
5% as being deaf or hearing impaired
3% as having other disabilities
2% as being blind or partially sighted
1% as having a learning disability or developmental disorder

7. Findings from engagement and consultation

7.1 Self-care medicines and treatments

The rationale for these proposals was clearly understood. The following box shows the strength of agreement with the following statement:

<table>
<thead>
<tr>
<th>I understand why NHS Southwark CCG is proposing to change guidelines for prescribing health supplements and self-care medication for short-term minor ailments?</th>
<th>Agree/strongly agree</th>
<th>Disagree/strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>78%</td>
<td>14%</td>
<td></td>
</tr>
</tbody>
</table>

Survey response (all stakeholders)

There was widespread support for principles of self-care and reducing demand on GP time, as illustrated by the level of agreement with the following statement:

<table>
<thead>
<tr>
<th>GPs should spend less time treating people who could obtain self-care medication and health supplements from a pharmacy without a prescription</th>
<th>Agree/strongly agree</th>
<th>Disagree/strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>76%</td>
<td>15%</td>
<td></td>
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</tbody>
</table>

Survey response (all stakeholders)

There was substantial agreement with the following statement:

<table>
<thead>
<tr>
<th>The NHS should not routinely prescribe health supplements and self-care medication for short-term minor ailments and conditions that usually get better with time</th>
<th>Agree/strongly agree</th>
<th>Disagree/strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>73%</td>
<td>16%</td>
<td></td>
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</tbody>
</table>

Survey response (all stakeholders)

7.1.1 Issues raised and actions identified

A number of issues relating to the proposals about over-the-counter medicines were received, including those highlighted overleaf:

<table>
<thead>
<tr>
<th>Number of comments</th>
<th>Issue raised</th>
<th>Actions</th>
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<tbody>
<tr>
<td>20</td>
<td>Cost of over-the-counter medicines</td>
<td>Retain Pharmacy First scheme to provide access to free over the counter medicines for those entitled to free prescriptions Promote self-care through</td>
</tr>
</tbody>
</table>
| 17 | Concern about minor ailments becoming more serious if not treated appropriately | The annual NHS Stay Well campaign reinforces messages about seeing a pharmacist before a minor illness becomes more serious.

The CCG would continue to support campaigns promoting the community pharmacy role such as “Ask your pharmacist” week and national self-care awareness campaigns and consider whether the promotion of these could be strengthened.

Provision of educational material supporting patients with how to manage common minor ailments and when to seek further advice from a health care professional to continue to be made available in community pharmacies and GP |
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<td></td>
<td></td>
<td>practices. We will review what NHS self-care information is available for local use. To consider promoting the Pharmacy First scheme again.</td>
</tr>
<tr>
<td>10</td>
<td>Access to over-the-counter medicines for people with long term conditions</td>
<td>The proposals exclusions include OTC treatments being used for a long term condition for example, treatment of chronic eczema with emollients. We will review what NHS self-care information is available for local use. Should the proposals be agreed, the CCG will write to stakeholders to clarify what has been agreed and who would be affected.</td>
</tr>
<tr>
<td></td>
<td>Access to emollients (2)</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Access to free over-the-counter medicines for marginalised groups such as refugees and asylum seekers, homeless people etc</td>
<td>The CCG will explore allowing hostel/day centre address to be used as proof of living in Southwark for Pharmacy First scheme. Clinical judgement should always be used when considering whether it is acceptable to ask a patient to purchase their medication. This may include OTC licence restrictions, long-term (chronic) treatment, where there are possible safeguarding concerns, including, but not limited to, children where there might be concerns that treatment might otherwise not be provided. This may also be the case where there is a significant clinical risk to the patient if they did not purchase the product and there is a diagnosis requiring treatment for example, thiamine in patients with alcohol use disorders.</td>
</tr>
</tbody>
</table>
The CCG received 214 comments (some people raised multiple issues) to the question about the kinds of support people might need to manage minor illnesses themselves:

<table>
<thead>
<tr>
<th>Number of comments</th>
<th>Issue raised</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>80</td>
<td>Use pharmacy and pharmacists</td>
<td>The ideas provided by respondents will be considered by the CCG should the proposals be agreed. The CCG will aim to address the issues raised through coordinated communications that build on existing national and London-wide campaigns designed to empower patients and public by giving them tools to understand how to manage their health.</td>
</tr>
<tr>
<td>39</td>
<td>Print posters and leaflets</td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>On-line including promoting NHS Choices, CCG website and practice websites</td>
<td></td>
</tr>
<tr>
<td>28</td>
<td>Support and information at GP practices including leaflets, posters, face to face from GP and nurse, films on screens</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Phone lines including 111 (some people still referenced NHS Direct)</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Advice and education</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Outreach including libraries, supermarkets, community centres, community councils</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Use of media including TV and soap operas</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Communication through schools and colleges as we need to change behaviour and need to work with young people</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>People referenced need to need to be able to access GPs and nurses for minor ailments</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Highlighted language issues and difficulties in diverse community</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Use of smart phone apps and social media</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Need to work through voluntary and community sector</td>
<td></td>
</tr>
</tbody>
</table>
7.2 Malaria prevention medicines

There was majority support for the proposal to remove provision of malaria prevention medicines from NHS prescription:

<table>
<thead>
<tr>
<th>The local NHS should stop offering NHS prescriptions for malaria prevention medicines for travel</th>
<th>Agree / strongly agree</th>
<th>Disagree / strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>55%</td>
<td>32%</td>
</tr>
</tbody>
</table>

7.2.1 Issues raised and actions identified

A number of issues relating to the proposal about malaria prevention medicines were received, including those highlighted below:

<table>
<thead>
<tr>
<th>Number of comments</th>
<th>Issue raised</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>36</td>
<td>Concern about spread of infection and possible death from people who do not buy anti malaria medicines or travel vaccines</td>
<td>To address the importance of malaria prevention measures and adequate travel vaccination prevention prior to travel, the CCG will work with and promote the bi-annual malaria awareness public health campaign developed by South London Health Protection team and the Local Authority to run at peak travel times. The purpose of the campaign is to remind anyone travelling to countries where malaria is endemic of the risks of malaria, how malaria is transmitted, raise awareness of all protection methods and the importance of taking their medications as well as reminding health care workers on how to identify potential cases of malaria. Patients will be encouraged to obtain advice from health care workers when travelling abroad, and informed to factor in the cost of preventive medicines into their budget for travel. The campaign</td>
</tr>
<tr>
<td>19</td>
<td>Concern about costs of malaria prevention medicine and cost to NHS of treating people with malaria One person asked whether a cost benefit analysis has been carried out</td>
<td></td>
</tr>
</tbody>
</table>
material will include posters and malaria factsheets.

The CCG will use its usual communication channels in GP practices, community pharmacies, CCG website and will explore other suggestions from the survey on how to communicate with Southwark patients.

Practical advice will be in line with current advice from Public Health England.

Public Health Southwark has estimated an additional 10-12 imported cases of malaria. The additional cost of treating these cases on the NHS, is £52,000 against a saving of £125,000 in malaria prevention prescription costs.

<table>
<thead>
<tr>
<th>8</th>
<th>Concern about impact of proposals on Southwark black and minority ethnic community</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>To address the importance of malaria prevention measures prior to travel the CCG will work with South London Health Protection team and the Local Authority public health team so above campaign reflects diversity of Southwark and is targeted at organisations and groups working with the black and minority ethnic community, including providing directly the campaign materials to the BME organisations and groups outlined in Section 4 of this document. Information on how to access medications via the GP or private travel clinic will be made available to patients.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2</th>
<th>Need to monitor impact of proposals if implemented of numbers of malaria cases in Southwark</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Public Health will work with the South London Health Protection Unit to monitor the rate of reported and imported malaria cases over the next 18 months.</td>
</tr>
</tbody>
</table>
7.3 Travel vaccines

The principle that people travelling should be expected to factor the cost of vaccination and preventive medicines into their travel budget received majority support among survey respondents.

<table>
<thead>
<tr>
<th>The local NHS should stop offering the selected vaccines for travel on the NHS</th>
<th>Agree / strongly agree</th>
<th>Disagree / strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>55%</td>
<td>36%</td>
<td></td>
</tr>
</tbody>
</table>

7.3.1 Issues raised and actions identified

A number of issues relating to the proposal about travel vaccines were received, including those highlighted below:

<table>
<thead>
<tr>
<th>Number of comments</th>
<th>Issue raised</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>36</td>
<td>Concern about spread of infection and possible death from people who do not buy anti malaria medicines or travel vaccines and cost to NHS of people having malaria (as above)</td>
<td>See above response in section 7.2.1</td>
</tr>
</tbody>
</table>
| 26 | Concerns about cost of travel vaccines  
- Could cost NHS more if people do not take and return with disease  
- One person asked whether a risk analysis had been carried out | See above response in section 7.2.1  
Many travel vaccines are administered as single doses or as part of a course of 2-3 injections. Many travel vaccines provide immunity for long periods of time (3-10 years). |
| 5 | Particular mention of hepatitis B and the concern that all hepatitis B vaccines will be coming off NHS prescriptions | Hepatitis B vaccine is available free on the NHS as part of the NHS vaccination schedule and to those at high risk of the infection and its complications for example, people who inject drugs or have a partner who injects drugs, people who change their sexual partners frequently, men who have sex with men.  
For voluntary travel, the vaccine is available privately either via a GP or |
private travel clinic. Hepatitis B vaccine is not provided on the NHS as part of occupational health services for patients. The responsibility rests with the employer.

7.4 Suggestions on best way to communicate with Southwark patients

Respondents were asked to indicate from a drop down list the best way to communicate the decision about these proposals. 272 people answered:

<table>
<thead>
<tr>
<th>ANSWER CHOICES</th>
<th>RESPONSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information in GP practices</td>
<td>91.18% 248</td>
</tr>
<tr>
<td>Information in community pharmacies</td>
<td>85.29% 232</td>
</tr>
<tr>
<td>Information on NHS Southwark CCG website and GP practice websites</td>
<td>65.07% 177</td>
</tr>
<tr>
<td>Information and discussion at GP patient participation groups</td>
<td>51.47% 140</td>
</tr>
<tr>
<td>Using social media (eg Twitter)</td>
<td>61.03% 166</td>
</tr>
<tr>
<td>Using local press and magazines (please say which)</td>
<td>54.04% 147</td>
</tr>
<tr>
<td>Articles in Southwark community newsletters and bulletins (please say which)</td>
<td>48.16% 131</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>39.34% 107</td>
</tr>
<tr>
<td>Total Respondents: 272</td>
<td></td>
</tr>
</tbody>
</table>

In addition we received 75 free text comments on further suggestions on communicating with Southwark patients, including the key themes highlighted below

<table>
<thead>
<tr>
<th>Number of comments</th>
<th>Issue raised</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>14</td>
<td>Outreach, drop-ins and suggestions included supermarkets, places of worship, libraries, post office, gyms, tenants and residents associations and community councils.</td>
<td>We value insight and ideas from respondents and will consider these in relation to whatever communications are needed should the proposals be agreed. The CCG would aim to address the issues raised through coordinated communications that build on existing national and London-wide campaigns designed to empower patients and public by giving them tools to understand how to manage their health. We seek to use channels that effectively reach target groups and are best value for the reach they provide.</td>
</tr>
<tr>
<td>8</td>
<td>Press and suggestions included: Southwark Life (6) Southwark News (3) Local press such as South London Press, SE21 / 22 Local radio National</td>
<td></td>
</tr>
<tr>
<td>Number of comments</td>
<td>Issue raised</td>
<td>Actions</td>
</tr>
<tr>
<td>--------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>21</td>
<td>Concerns about costs</td>
<td>To explore promoting Pharmacy First scheme to provide access to free over the counter medicines for those entitled to free prescriptions and the Public Health twice yearly campaign about malaria prevention and importance of travel vaccines</td>
</tr>
<tr>
<td>12</td>
<td>Supportive of proposals</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Access to malaria medicines and medicines for children</td>
<td>Information on how to access medications via the GP or private travel clinic will be made available to patients at the GP practices</td>
</tr>
</tbody>
</table>

**7.5 General issues raised**

A number of general issues relating to the proposals were received which could not be attributed to a specific proposal:
Concerns about post-code lottery and/or NHS privatisation

The proposals to review the prescribing arrangements for General Practice in the provision of malaria chemoprophylaxis and for travel vaccines align with current national guidance. NHSE is currently running a consultation on items which should not be routinely prescribed in primary care and is planning on developing proposals to potentially restrict items that are available over the counter.

Concern that the CCG is limiting access to GPs

The proposals do not limit access to GP practices. Patients will still be able to make appointments and speak with a GP, Nurse or Practice Pharmacist, but may be asked to either buy their medicines over the counter or by using a private prescription for malaria prevention medicines and some travel vaccines.

The need for guidance/information for clinicians

The medicines optimisation team will communicate with primary care clinicians and partner prescribing colleagues prior to implementation to raise awareness of any new changes.

7.6 Other considerations

Respondents were asked as part of the consultation whether there was anything else they think the CCG should consider. 127 comments were received:

<table>
<thead>
<tr>
<th>Number of comments</th>
<th>Issue raised</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>16</td>
<td>The need for communication and education programme to inform people of any changes</td>
<td>The CCG would consider how much and what communication and education is required specifically on any changes agreed and what campaigns and tools already exist that support patients around self-care.</td>
</tr>
<tr>
<td>12</td>
<td>Clarity about over-the-counter medications for people with long term conditions</td>
<td>The proposals exclusions include OTC treatments being used for a long term condition e.g. treatment of</td>
</tr>
<tr>
<td></td>
<td>The need for access to advice and medication for vulnerable people such as refugees and asylum seekers, disabled people etc</td>
<td>chronic eczema with emollients. We will review what NHS self-care information is available for local use. Should the proposals be agreed, the CCG will write to stakeholders to clarify what has been agreed and who would be affected.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>11</td>
<td>The proposals do not limit access to GP practices. Patients will still be able to make appointments and speak with a GP, nurse or practice pharmacist, but may be asked to either buy their medicines over the counter or by using a private prescription for malaria prevention medicines and some travel vaccines. Local community pharmacists can give professional advice on how to self-care. Clinical judgement should always be used when considering whether it is acceptable to ask a patient to purchase their medication. This may include OTC licence restrictions, long-term (chronic) treatment, where there are possible safeguarding concerns, including, but not limited to, children where there might be concerns that treatment might otherwise not be provided. This may also be the case where there is a significant clinical risk to the patient if they did not purchase the product and there is a diagnosis requiring treatment for example, thiamine in patients with alcohol use disorders.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Retain Pharmacy First scheme to provide access to free over the counter medicines for those entitled to free prescriptions</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Concern about costs of over-the-counter medication</td>
<td></td>
</tr>
</tbody>
</table>
| 8 | Issues about pharmacy. Some comments mentioned privacy, access and quality | It is a legal obligation for all pharmacies to have a private consultation room so that patients
can have a private consultation should they chose to do so. The CCG will work with the LPC to promote awareness to patients of this facility.

| 8 | Concern about spread of disease and infection | To address the importance of malaria prevention measures and adequate travel vaccination prevention prior to travel, the CCG will work with and promote the biannual malaria awareness public health campaign developed by South London Health Protection team and the Local Authority to run at peak travel times |
| 5 | Concern that the CCG is limiting access to GPs | The proposals do not limit access to GP practices. Patients will still be able to make appointments and speak with a GP, nurse or practice pharmacist, but may be asked to either buy their medicines over the counter or by using a private prescription for malaria prevention medicines and some travel vaccines |
| 4 | Specific support for the proposal about over-the-counter medicines | |
| 4 | Importance of role of receptionist and nurses in being clear about messages to patients. | The medicines optimisation team will produce a briefing document for primary care clinicians and staff so that clear messages are given to patients |
| 4 | Need to address medicines wastage | The medicines optimisation team will work with GP practices, the Local Pharmaceutical Committee and other medicines optimisation teams across south east London to develop a model for managing repeat prescriptions. Encourage patients to order their own medicines online. The CCG will consider running a medicines waste campaign, working |
The need to review the numbers of malaria cases

Public Health will work with the South London Health Protection Unit to monitor the rate of reported and imported malaria cases over the next 18 months.

Concerns about post-code lottery and / or NHS privatisation

The proposals to review the prescribing arrangements for General Practice in the provision of malaria chemoprophylaxis and for travel vaccines align with current national guidance.

NHS England is currently running a consultation on items which should not be routinely prescribed in primary care and is planning on developing proposals to potentially restrict items that are available over the counter.

7.7 Reducing negative impacts

Respondents were asked as part of the consultation how we can remove or reduce any drawbacks or negative impacts. 159 comments were received:

<table>
<thead>
<tr>
<th>Number of comments</th>
<th>Issue raised</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>50</td>
<td>Provide communication / education</td>
<td>The CCG would consider how much and what communication and education is required specifically on any changes agreed and what campaigns and tools already exist that support patients around self-care.</td>
</tr>
<tr>
<td>10</td>
<td>The CCG should not implement the proposals</td>
<td>The overall consultation supports the proposals</td>
</tr>
<tr>
<td>10</td>
<td>To consider exemptions to taking off over-the-counter medicines from NHS prescriptions, of which:</td>
<td>Those on benefit who are entitled to free prescriptions can access OTCs without payment as part of the Pharmacy First scheme.</td>
</tr>
<tr>
<td></td>
<td>• Those on benefit (3)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Those with long term conditions (3)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Provide discount vouchers</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>7</td>
<td>The CCG should carry out a cost benefit analysis or audit and review of proposals</td>
<td>Public Health will work with the South London Health Protection Unit to monitor the rate of reported and imported malaria cases over the next 18 months</td>
</tr>
<tr>
<td>5</td>
<td>Promote Pharmacy First</td>
<td>We are exploring further promotion</td>
</tr>
<tr>
<td>5</td>
<td>Provide travel vaccines and malaria medicine to children for free</td>
<td>This is against national guidance</td>
</tr>
<tr>
<td>5</td>
<td>Keep malaria medicines on NHS prescriptions</td>
<td>The overall consultation supports the proposals. Keeping malaria medicines on NHS prescriptions is against national guidance.</td>
</tr>
<tr>
<td>5</td>
<td>Ensure access to vulnerable groups (homeless people, refugees): - Address free policy for Pharmacy First (1) - Ensure acceptance of HC2 (low income forms) at Pharmacy First</td>
<td>The CCG will explore allowing hostel/day centre address to be used as proof of living in Southwark for Pharmacy First scheme.</td>
</tr>
<tr>
<td>5</td>
<td>Agreement that people should pay for travel vaccinations</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>GPs to have discretion to prescribe over-the-counter medicines for people on benefits / using food banks</td>
<td>Clinical judgement should always be used when considering whether it is acceptable to ask a patient to purchase their medication. This may include OTC licence restrictions, long-term (chronic) treatment, where there are possible safeguarding concerns, including, but not limited to, children where there might be concerns that treatment might otherwise not be provided. This may also be the case where there is a significant clinical risk to the patient if they did not purchase the product and there is a diagnosis requiring treatment for example, thiamine in patients with alcohol use disorders</td>
</tr>
<tr>
<td>4</td>
<td>CCG to ensure access to GPs</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>To ensure travel vaccines are provided at reduced or cost price</td>
<td>The overall consultation does not support this and it is against national guidance</td>
</tr>
<tr>
<td></td>
<td>Proposals should be nationally funded or should be national policy, including one comment about the CCG lobbying for more money.</td>
<td>The proposals to review the prescribing arrangements for General Practice in the provision of malaria chemoprophylaxis and for travel vaccines align with current national guidance. NHS England is currently running a consultation on items which should not be routinely prescribed in primary care and is planning on developing proposals to potentially restrict items that are available over the counter.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
</tbody>
</table>
| 4 | Travel clinics, of which:  
  - Nurse led travel clinics (2)  
  - Private travel clinic for which the CCG should charge | Where specific travel clinics are provided in general practice these are nurse led. |
| 3 | No drawbacks |
Appendix one: Narrative consultation responses received

From:  
Sent: 29 June 2017 16:08  
To: southwark-ccg (NHS SOUTHWARK CCG)  
Subject: Consultation

As to the consultation on proposed changes to NHS prescriptions, I am sure that my local community pharmacist can give me professional advice. But surely this depends on his/her availability. Are they not commonly remote from customers, frantically busy preparing prescriptions, with contact delegated to receptionists? My own experience at Morrisons Supermarket in Peckham, hopefully not typical, is not encouraging. Some months ago, having a very sore eye I asked if a pharmacist could have a look at it. The receptionist spoke 'behind the scenes', but I was then fobbed off by the receptionist with an Optrex product. The condition quickly deteriorated and I went to my GP, who prescribed an ointment, and told me that if the condition persisted I should urgently go straight to Moorfield A&E department. It did persist and I decided to follow my doctor's advice. At Moorfields the triage nurse prioritised an examination, having discovered that I could see nothing through the sore eye. This revealed a severely scratched cornea. Fortunately the GP's medication was appropriate, and in time my eye healed with no long-term damage.

I complained twice, in writing, to Morrison's manager but received no reply. I gave up, and right now I don't want to pursue a complaint: but it is relevant to this consultation.

From:  
Sent: 13 July 2017 18:07  
To: southwark-ccg (NHS SOUTHWARK CCG)  
Cc: WATTS, Rosemary (NHS SOUTHWARK CCG); michael.situ@southwark.gov.uk; gavin.edwards@southwark.gov.uk; scrutiny@southwark.gov.uk; richard.livingstone@southwark.gov.uk; evelyn.akoto@southwark.gov.uk  
Subject: Re: Consultation on proposed changes to NHS prescriptions in Southwark

Dear Southwark CCG,

I would like to bring to your attention of lack of transparent information relating to the proposed prescribe of selected medicines and treatments in Southwark. I noticed that you mentioned the cost saving on your consultation paper but you did not mentioned how much it will cost patients to purchase these selected medicines especially the malaria medicines which could cost up to £48.00.
Furthermore, we should also know that not everyone travelling to these regions are going for holidays. Some could be going to these regions due to family member's bereavements or family members very sick. There are many factors that could warrant people travelling to these regions and we cannot base our thinking or judgement on holidays only.

The national guidance is an advice which tells what to do to improve health and social care but not a mandatory policy. So we have a choice to look deeply into our population in Southwark, the effect and cost it will have on NHS if patients travel to these regions without any early prevention and how diverse the Borough is. This is a Borough with high deprivation and diverse communities. We have to strike balance on what we intend to achieve and the effect on patients concern.

In addition, the proposed prescribe of selected medicines and treatments in Southwark especially malaria medicines is discriminating against certain ethnicities in the Borough who had already paid through their National Insurance contributions into NHS and could not have full access use of the service provision. This is not accepted in today's world.

The Southwark CCG should rethink of this proposal and the future it could have on the NHS and other services provision especially the malaria medicines. We also need to see the statistics of how you came up with this proposal. I understand that we have to do things in different ways but not when it discriminate others from full use of the service provided in our Borough.

However, I am very concern that the consultation would not get to the right patients affected most and the outcome of the survey will not reflect on the service users and the lack of information on the cost of medicines not included in the consultation paper. Although, you can argue that there are many manufacturer providers but at least give the estimate cost, e.g., the cost of malaria medicines is £4.85 - £48.00 will be helpful for patients who are completing the survey.

I look forward to your reply.

Kind Regards,

From:
Sent: 20 August 2017 19:40
To: southwark-ccg (NHS SOUTHWARK CCG)
Subject: Consultation on proposed changes to NHS prescriptions in Southwark

To NHS Southwark CCG

Re: Consultation on proposed changes to NHS prescriptions in Southwark.

General Points

1. UK taxpayers and persons making N.I. contributions pay towards a NHS that is Free at the point of delivery. Persons who are exempted from paying prescription charges do not pay for their prescriptions and the others pay £8.60 per prescription item. Persons who have contributed their tax will be required to pay for medicines which were free before.
2. On initial consideration the above proposal appears reasonable and agreeable. However when considered in depth, it is a formula for chaos, has unintended consequences and is likely to be costly.

3. It is generally accepted that clinicians respond to patient need. This proposal will remove low cost prescription items and valuable disease prevention malaria treatments and vaccines from CCG budget and transfer to the service user ie a PRIVATE budget. Malaria prophylaxis on NHS prescriptions is charged at cost price or trade price to the NHS, however when ordered on a private prescription, there is an additional profit margin on the cost thereby working out quite expensive for a family travelling to a high risk malaria zone.

As Southwark has residents from many countries, who visit high risk Malaria zones, it is inevitable that people will travel and contract Malaria, which will be more expensive to treat.

4. It must be recognised that GP workload will increase and will be confusing for many patients. There will be a need to decide when a short term medication changes to medium term and long term. How do we deal with patients with dementia, patients who get easily confused, elderly patients needing vitamin D supplements, etc

Specific Points

5. Prescription medicines are costed at trade price/ Drug tariff price. However when patients buy an item over-the-counter, it will have 2 extra elements added to the cost price namely the profit margin and 20% VAT. It is quite possible consequently for a £5 medicine at trade price to be charged at £10 to the consumer.

6. Some medicines which are widely prescribed and used for pain relief, are likely to cause considerable inconvenience to consumers.

eg a patient has back pain and is prescribed 100 Paracetamol tablets by their GP. At pharmacies, the maximum pack size for sale is 32 tablets, which the patient will need to buy on 3 separate occasions to minimise overdose risks.

7. The current UK economy on the way to Brexit has resulted in a weaker Pound against the Euro. There are huge fluctuations in price of medicines due to numerous factors.

There is a likelihood that many of the OTC low cost medicines in this proposal will shoot up in price, for the consumer, as the demand for a given product will increase and the stock levels will be inadequate in the country. We must be aware that medicines on prescriptions and medicines OTC for sale have different rules and regulations and packages.

In conclusion, there are considerable risks in this proposal, for consumers ie the members of the public who will be required to pay a much higher cost for the estimated £750,000 saving to our CCG. For patients who have complex needs this proposal will enhance barriers to their care.
By email

Ms Sadhna Murpy
Chief Pharmacist
NHS Southwark CCG
1st Floor, Hub 5
PO Box 64529
London SE1 P 5LX

25 August 2017

Dear Ms Murphy

I am writing on behalf of Southwark LMC to provide a response to the consultation for the proposal for changes to NHS prescription in Southwark CCG. It is appreciated that the period of consultation closed on 20 August but I hope that the LMC’s comments can be considered.

The proposal is to no longer support the routine prescribing on the NHS for self-care/over the counter medication for short-term minor illnesses and conditions and health supplements, stop prescribing malaria prevention medicines and selected vaccines on the NHS for travel.

The LMC understands that the Pharmacy First Scheme will continue in Southwark, whereby some patients can attend pharmacies and obtain the types of medication above free of charge. If the above proposal goes ahead it would mean that some patients would still be able to obtain medication free of charge under the Pharmacy First Scheme but if they go to their GP they will have to pay for such medication. Has this been taken into account?

If the proposal is to work there needs to be a publicity campaign locally to raise public awareness and material such as posters and leaflets should be provided for GPs to display in their surgery to avoid practices having to spend time having difficult conversations with patients during consultations.

Clear and consistent guidance will need to be made available to practices setting out when it would be considered appropriate for practices to prescribe og for chronic pain etc.

Finally, the LMC queries why this consultation is being undertaken locally in Southwark now. Would it not be better to await the outcome of the national consultation rather than implement something locally?

Yours sincerely

Nicola Rice
Assistant Director of Primary Care Strategy
# Equality Analysis Template

This document should be completed in conjunction with the Equality Analysis Guidance produced by the Equality, Diversity and Inclusion Team. Should you have any queries, please contact the Equality, Diversity and Inclusion Team at NELCSU.Equality@nhs.net who will be pleased to help.

## Section 1: Policy, Function or Service Development Details and Authorisation

<table>
<thead>
<tr>
<th>Name of Organisation:</th>
<th>Southwark CCG</th>
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<tbody>
<tr>
<td>Name of the policy, function or service development being assessed:</td>
<td>Changes to prescribing guidance for self-care medications for acute, self-limiting conditions and minor illnesses for which over the counter medicines can be purchased and advice sought from the community pharmacy</td>
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<tr>
<td>Is this a new/existing/revised policy, function or service development?</td>
<td>New</td>
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| Briefly describe its aims and objectives | • To promote self-care and self management of minor and short term illnesses inline with the NHS Five Year Forward View strategy  
• To reduce unnecessary demand on GP time and free up doctor and nurse time for people who have more complex healthcare needs and require more active support in managing their health.  
• To bring Southwark in alignment with current national guidance  
• To get the best value from the medicines budget available for Southwark patients |
| Analysis Start Date: | 26.7.17 |
| Lead Author of Equality Analysis: | Ann-dora Kwame |
Completed Equality Analysis Templates must be reviewed by the ED&I Team. Following any suggested amendments/additions, the final version must then be submitted to the Equality & Diversity (E&D) Service Lead for final approval
Name of Initial Reviewer:

Date of approval by Wasia Shahain, EDI Service Lead:

Have any financial or resource implications been identified? None

Date of Executive Management Team/Governing Body Meeting where the Equality Assessment was ratified: 7.9.17

### Section 2: Equality Analysis Checklist

For each of the nine protected characteristics and other groups in the table below, consider whether the policy/function/service development could have a positive or negative outcome on each of these groups. Involve service users where possible to obtain their opinion, use demographic/census data (available from public health and other sources), surveys (previous surveys or perhaps conduct one), ask PALS and Complaints for reports/data, obtain subject specific reports from providers and other published data. Ensure any remedial actions are Specific, Measureable, Achievable, Realistic, and Timely (SMART)

<table>
<thead>
<tr>
<th>Equality Group</th>
<th>What evidence has been used for this analysis?</th>
<th>What engagement and consultation has been used?</th>
<th>Identify positive / negative / no outcomes</th>
<th>How are you going to address issues identified?</th>
<th>Specify the Named Lead and Timeframe</th>
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<tbody>
<tr>
<td>Age</td>
<td></td>
<td>Formal consultation period with Southwark residents, patients, carers and clinical staff</td>
<td><strong>Potential Negative impact</strong> for those exempt for age-related reasons from prescription charges i.e. people aged over 60 and</td>
<td>Clear communication strategy to ensure local prescribers are briefed on the applicability of the guidance for short-term/acute illnesses and not applicable for the management of long term conditions Promote Pharmacy First Minor Ailment Scheme. Promote preventative measures to avoid ill-</td>
<td>To be identified as part of implementation strategy</td>
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Think about different age groups and the policy/function/service development and the way the user would access it, is it user friendly for that age group?
What is the age breakdown in the community/workforce? Will the change/decision have significant impact on
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<td>certain age groups?</td>
<td>working in Southwark over an 8week period (26th June – 20th August 2017) Target groups included people of all ages</td>
<td>under 16 and those aged 16, 17 or 18 in full-time education. Patients in these age categories requiring treatment for minor acute illnesses in the therapeutic areas listed would incur charges for treatment with medication readily available over the counter. Older people in care homes would not be able to access over the counter medicines. People of working age who are exempt from prescription charges will need to pay for treatments no longer routinely prescribed for acute minor</td>
<td>health and promote healthy lifestyle living For this cohort of patients, the option to utilise the local Community Pharmacy minor ailment scheme to receive selected over the counter treatments free (without the need for a GP consultation or green prescription form) will remain available in this current financial year (2017/18). This service will be monitored and reviewed in the next financial year. This service is currently running in Southwark for all patients exempt from paying prescription charges. Homely remedies will be encouraged in care homes (via our care home pharmacist) i.e. care homes to keep stock of simple treatments for common illnesses e.g. aches and pains, cough and cold etc. We will work closely with the GSTT community health services pharmacy team as well.</td>
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<td>Formal consultation period with Southwark residents, patients, carers and clinical staff working in Southwark over an 8 week period (26th June – 20th August 2017)</td>
<td>ailments and conditions.</td>
<td>Community pharmacies already have to comply with the disability element of the Equality Act and will therefore have considered how people with disability will access their service and advice.</td>
<td>Neutral</td>
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<tr>
<td>Disability</td>
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<td>Neutral</td>
<td>Many community pharmacies also provide a delivery service including for OTC medicines. They are conveniently located and open longer hours including weekends.</td>
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<td>Gender Reassignment</td>
<td></td>
<td>Formal consultation period with Southwark residents, patients, carers and clinical staff working in Southwark over an 8 week period (26th June – 20th August 2017)</td>
<td>Neutral</td>
<td>The proposals apply to people with different sexual orientations equally and will not either increase or decrease inequalities between people with different sexual orientations, or promote better relations between people who have different sexual orientations.</td>
<td>Neutral</td>
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<td>The therapeutic areas in which it is proposed to limit prescribing affect people of different sexual orientations equally and so no person will be either disadvantaged or advantaged by these proposals on</td>
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<td>Target groups was all inclusive</td>
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<td>People of all sexual orientations who are exempt from prescription charges will need to pay for treatments no longer routinely prescribed for acute minor ailments and conditions. For this cohort of patients, the option to utilise the local Community Pharmacy minor ailment scheme to receive selected treatments free (without the need for a GP consultation or green prescription form) will remain available in this current financial year (2017/18). This service will be monitored and reviewed in the next financial year. See section on socio-economic groups below.</td>
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<tr>
<td>Marriage and Civil Partnership</td>
<td>Think about access and confidentiality, the partner may not be aware of involvement or access to the service</td>
<td>Formal consultation period with Southwark residents, patients, carers and clinical staff working in Southwark over an 8week period (26th June – 20th August 2017) Target groups was all inclusive</td>
<td>Neutral</td>
<td>The proposals apply to people who are married, single, divorced or separated equally and will not either increase or decrease inequalities between different people with different marital status, or promote better relations between people who have different marital status in relation to access or treatment. The therapeutic areas in which it is proposed to limit prescribing affect people who are married, single, divorced or separated equally and so no person will be either disadvantaged or advantaged by these proposals on the grounds of their marital status. People of all marital statuses who are exempt from prescription charges will need to pay for treatments no longer routinely prescribed for acute minor ailments and conditions. For this cohort of patients, the option to utilise the local Community Pharmacy minor ailment scheme to receive selected treatments free (without the need for a GP consultation or green prescription form) will remain available in this current financial year (2017/18). This service will be monitored and reviewed in the next financial year. See section on socio-economic groups below.</td>
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<td>minor ailment scheme to receive selected treatments free (without the need for a GP consultation or green prescription form) will remain available in this current financial year (2017/18). This service will be monitored and reviewed in the next financial year. See section on socio-economic groups below.</td>
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<tr>
<td>Pregnancy &amp; Maternity</td>
<td>The policy/function/service development must be accessible for all e.g. opening hours</td>
<td>Formal consultation period with Southwark residents, patients, carers and clinical staff working in Southwark over an 8week period (26th June – 20th August 2017) Target groups was all inclusive</td>
<td>Potential negative impacts as pregnant women and women who have had a baby in the previous 12 months are are exempt from prescription charges if they have an exemption certificate.</td>
<td>A clear Communication strategy to ensure healthcare professionals working closely with this group of patients (e.g. community midwives, health visitors, district nurses) are aware of services available for this cohort and have support material such as information leaflets available to direct patients to appropriate services Promote awareness of Pharmacy First Scheme for eligible people Promote Community Pharmacy Services for the provision of appropriate health advice and support to promote good childhood development. Promote Healthy Living lifestyle through community pharmacy usage and access to healthy living champions Local commissioned services fir this cohort e.g. Vitamin D scheme, Healthy Start scheme</td>
<td>Communication team</td>
</tr>
<tr>
<td>Race</td>
<td>You need to think carefully about the local demographics of the population who will be accessing the policy/function/service development. Talk to public health. Consider for example: Cultural issues (gender, clothing etc.) Languages</td>
<td>Formal consultation period with Southwark residents, patients, carers and clinical staff working in Southwark over</td>
<td>Neutral</td>
<td>The proposals apply to people of different ethnic groups equally and will not either increase or decrease inequalities between different ethnic groups or promote better relations between different ethnic groups in relation to access or treatment. The therapeutic areas in which it is proposed to limit prescribing affect people from different ethnic groups equally and so no person will be either disadvantaged or advantaged by these proposals on</td>
<td>Neutral</td>
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### Equality Group

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<tr>
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<td>Support to access</td>
<td>an 8 week period (26th June – 20th August 2017)</td>
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<td>account of their ethnicity.</td>
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<td>Staff training on cultural awareness, interpreting etc.</td>
<td>Target groups was all inclusive</td>
<td></td>
<td>People from all ethnic groups who are exempt from prescription charges will need to pay for treatments no longer routinely prescribed for acute minor ailments and conditions. For this cohort of patients, the option to utilise the local Community Pharmacy minor ailment scheme to receive selected treatments free (without the need for a GP consultation or green prescription form) will remain available in this current financial year (2017/18). This service will be monitored and reviewed in the next financial year.</td>
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### Religion or Belief

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<td>Formal consultation period with Southwark residents, patients, carers and clinical staff working in Southwark over an 8 week period (26th June – 20th August 2017)</td>
<td>Neutral</td>
<td>The proposals apply to people of different religious beliefs equally and will not either increase or decrease inequalities between different religious beliefs or promote better relations between different religious groups in relation to access or treatment.</td>
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<tr>
<td>Religions or Beliefs</td>
<td>Target groups was all inclusive</td>
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<td>The therapeutic areas in which it is proposed to limit prescribing affect people from different religions and beliefs equally and so no person will be either disadvantaged or advantaged by these proposals on the grounds of their religion.</td>
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<td>Again, think about the local population and what religion or beliefs they may have. Consider for example:</td>
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<td>People from all religious beliefs who are exempt from prescription charges will need to pay for treatments no longer routinely prescribed for acute minor ailments and conditions. For this cohort of patients, the option to utilise the local Community Pharmacy minor ailment scheme to receive selected treatments free (without the need for a GP consultation or green prescription form) will remain available in this current financial year (2017/18). This service will be monitored and reviewed in the next financial year.</td>
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<td>Staff training on respecting differences and religious beliefs</td>
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<td>Are you trying to implement a change/activity at an inconvenient time e.g. during a time of religious holiday such as Ramadan?</td>
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<td>Is there an area for prayer times, religious rituals e.g. washing area?</td>
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<td>Equality Group</td>
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<tr>
<td><strong>Sex</strong></td>
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<td>See section on socio-economic groups below.</td>
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This is the impact on males and females. For example same sex accommodation - are there areas for privacy? Is it accessible for both taking into account working service users? Would it be a venue they would go to?

What does research show regarding the incidence of for example, mental health, cancers, early or late diagnoses for males or females?

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<td><strong>Neutral</strong></td>
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<td>The proposals apply to males and females (across all ages) equally and will not either increase or decrease inequalities between males and females or promote better relations between males and females in relation to access or treatment.</td>
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<td>The therapeutic areas in which it is proposed to limit prescribing affect males and females equally and so individual will be either disadvantaged or advantaged by these proposals on account of their gender.</td>
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<td>Both males and females who are exempt from prescription charges will need to pay for treatments no longer routinely prescribed for acute minor ailments and conditions.</td>
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<td>For this cohort of patients, the option to utilise the local Community Pharmacy minor ailment scheme to receive selected treatments free (without the need for a GP consultation or green prescription form) will remain available in this current financial year (2017/18). This service will be monitored and reviewed in the next financial year.</td>
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<td>See section on socio-economic factors below.</td>
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<td><strong>Sexual Orientation</strong></td>
<td>Don’t make assumptions as this protected characteristic may not be visibly obvious. Providing an environment that is welcoming - for example visual aids, posters, leaflets. Using language that respects LGB&amp;T people. Staff training on how to ask LGB&amp;T people to disclose their sexual orientation without fear or prejudice.</td>
<td>Formal consultation period with Southwark residents, patients, carers and clinical staff working in Southwark over an 8week period (26th June – 20th August 2017) Target groups was all inclusive</td>
<td>Neutral</td>
<td>The proposals apply to people with different sexual orientations equally and will not either increase or decrease inequalities between people with different sexual orientations, or promote better relations between people who have different sexual orientations. The therapeutic areas in which it is proposed to limit prescribing affect people of different sexual orientations equally and so no person will be either disadvantaged or advantaged by these proposals on the grounds of their sexual orientation. People of all sexual orientations who are exempt from prescription charges will need to pay for treatments no longer routinely prescribed for acute minor ailments and conditions. For this cohort of patients, the option to utilise the local Community Pharmacy minor ailment scheme to receive selected treatments free (without the need for a GP consultation or green prescription form) will remain available in this current financial year (2017/18). This service will be monitored and reviewed in the next financial year. See section on socio-economic groups below.</td>
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<tr>
<td><strong>Carers</strong></td>
<td>Does your policy/function/service development impact on carers? Ask them. Do you need to think about venue, timing? What support will you be offering?</td>
<td>Formal consultation period with Southwark residents, patients, carers and clinical staff working in Southwark over an 8week period</td>
<td>Neutral</td>
<td>Many carers in Southwark are not in paid employment. Carers who are exempt from prescription charges will need to pay for treatments no longer routinely prescribed for acute minor ailments and conditions. They would be eligible to access the Pharmacy First Scheme. Mitigation Encourage flu vaccination for carers to support prevention and keep carers well through GP</td>
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<td>(26th June – 20th August 2017) Target groups was all inclusive</td>
<td>practices and Community Pharmacies</td>
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<tr>
<td>Other</td>
<td>Does your policy/function/service development impact on for example, those on low incomes, those who are homeless etc.?</td>
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<td>People who do not speak English as a first language</td>
<td>Formal consultation period with Southwark residents, patients, carers and clinical staff working in Southwark over an 8week period (26th June – 20th August 2017) Target groups was all inclusive</td>
<td>Potentially negative impact.</td>
<td>The local community pharmacies often have pharmacists/staff from a BME background and a wide range of languages are spoken. For this cohort of patients, the option to utilise the local Community Pharmacy minor ailment scheme to receive selected treatments free (Without the need for a GP consultation or green prescription form) will remain available in this current financial year (2017/18). This service will be monitored and reviewed in the next financial year.</td>
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<td>economic groups below.</td>
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<td>Asylum seekers and refugees</td>
<td>Formal consultation period with Southwark residents, patients, carers and clinical staff working in Southwark over an 8 week period (26th June – 20th August 2017) Target groups was all inclusive</td>
<td></td>
<td>Negative impact</td>
<td>Promote Community Pharmacy Services Promote preventative measures to avoid ill-health and promote healthy lifestyle living</td>
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<td>People living in deprived areas and people from different socio-economic groups</td>
<td>Formal consultation period with Southwark residents, patients, carers and clinical staff working in Southwark over an 8 week period (26th June – 20th August 2017)</td>
<td></td>
<td>Potentially negative impact.</td>
<td>Enhanced promotion of preventive and self-care activity Promotion of generic medicines and treatments that are generally cheaper than branded options, and reassurance regarding effectiveness of unbranded or ‘own brand’ treatments compared with brands</td>
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<td>Those who have very low incomes would potentially be at a disadvantage if they felt they could not afford the recommended medicines.</td>
<td>Continued access to the local Community Pharmacy minor ailment scheme to receive selected treatments free (without the need for a GP consultation or green prescription form) will remain available in this current financial year (2017/18). This service will be monitored and reviewed in the next financial year.</td>
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<td>Target groups was all inclusive</td>
<td>A relatively high proportion of Southwark’s registered patient population is eligible for free NHS prescriptions and so likely negative impacts will require mitigation.</td>
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<tr>
<td>People who have a mental illness or disability</td>
<td>Formal consultation period with Southwark residents, patients, carers and clinical staff working in Southwark over an 8 week period (26th June – 20th August 2017) Target groups was all inclusive</td>
<td>Potential negative impact for those whose mental health condition or lifestyle might be resistant to purchasing over the counter remedies, or whose income is limited by their condition. See below re: socio-economic groups Potential negative impact for people whose cognitive ability may indicate they would be unlikely to act on advice to purchase over the counter treatment.</td>
<td>GP clinical judgment should be used when considering whether it is acceptable or appropriate to ask a patient to purchase their medication.</td>
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</table>
Section 3: Action Plan

For any negative outcomes identified in Section 2, it is important to identify the steps you will take to mitigate consequences on the nine protected characteristics and other groups. Complete the Action Plan below to identify and record how you will address these.

<table>
<thead>
<tr>
<th>Equality Group</th>
<th>Negative Outcome</th>
<th>Mitigating Action (Identify any resource/other implications)</th>
<th>Named Lead and Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Potential –see above</td>
<td>See above</td>
<td>To worked up as part of implementation strategy</td>
</tr>
<tr>
<td>Disability</td>
<td>no</td>
<td></td>
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</tr>
<tr>
<td>Gender Reassignment</td>
<td>no</td>
<td></td>
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</tr>
<tr>
<td>Marriage &amp; Civil Partnership</td>
<td>no</td>
<td></td>
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<tr>
<td>Pregnancy &amp; Maternity</td>
<td>Potential – see above</td>
<td>See above</td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td>no</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religion or Belief</td>
<td>no</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td>no</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual Orientation</td>
<td>no</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carers</td>
<td>no</td>
<td></td>
<td></td>
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<tr>
<td>Other</td>
<td>Potential – see above</td>
<td>See above</td>
<td></td>
</tr>
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</table>
Section 4 : Submission

On completion of all sections of the Equality Analysis Form, submit your draft along with the policy, function, or service document to the Equality, Diversity and Inclusion Team for an initial review. Once reviewed, the team will provide feedback and any recommended amendments/additions. Having made any necessary changes, the final version should then be submitted to the next Executive Management Team/Governing Body Meeting for ratification and subsequent publication on the CCG website/intranet. The ratified EA Template should be appended to the policy, function or service development documentation.
### Section 1: Policy, Function or Service Development Details and Authorisation

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<tr>
<th>Name of Organisation:</th>
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<tr>
<td>Name of the policy, function or service development being assessed:</td>
<td>The revision of guidance to Southwark prescribers to no longer offer malaria chemoprophylaxis for travel purposes in line with national NHS guidance</td>
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<td>Is this a new/existing/revised policy, function or service development?</td>
<td>New</td>
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</table>
| Briefly describe its aims and objectives | (1) Align Southwark CCG with national prescribing policy relating to malaria chemoprophylaxis provision  
(2) Empower people to self-manage malaria chemoprophylaxis requirements for travel purposes  
(3) Release NHS resource for funding other areas  
(4) Provide clarity of guidance and reduce unwarranted variation in prescribing practice across the health economy |
| Analysis Start Date: | 26.7.17 |
| Lead Author of Equality Analysis: | Ann-dora Kwame |
Completed Equality Analysis Templates must be reviewed by the ED&I Team. Following any suggested amendments/additions, the final version must then be submitted to the Equality & Diversity (E&D) Service Lead for final approval
Name of Initial Reviewer:

Date of approval by Wasia Shahain, EDI Service Lead:

Data and research used to assist the analysis and assessment (e.g. public health data, national reports)

- NHS Executive circular FHSL (95)7 14 February 1995 - Malaria Prophylaxis: regulation permitting GPs to charge for prescribing or providing anti-malarial drugs

Summary of data findings in relation to protected characteristics

- Reported rate of imported malaria has decreased in the past 4 years across the UK including in London Southwark, Lambeth and Lewisham. However, it remains a significant public health concern in Southwark, especially Plasmodium falciparum malaria. In 2015, 305 South London residents were notified as having been infected with malaria, including 65 Southwark residents. The risk of imported malaria, especially Plasmodium Falciparum malaria, is greater for residents from Black African background who go and visit friends and relatives in their home countries. The black African population of Southwark is estimated at 16%, of whom approximately 7054 are thought to travel to malarious zones annually and who should take malaria chemoprophylaxis. For a two week stay there is approximately a 2.4% probability of contracting malaria.

- Decrease in reported malaria cases may be associated with:
  - Under reporting of malaria cases
  - Increased use of chemoprophylaxis or other prevention method.

- However no information is available about trend of malaria chemoprophylaxis in travellers from the UK. Decreasing risk of being infected by the parasite when visiting endemic countries. While incidence has decreased in Africa, number of travels from the UK to West Africa has increased, and the number of residents from
Black African origin has increased in Southwark.

The impact of antimalarial prophylaxis prescribing policy is difficult to assess for a number of reasons e.g. patterns of travel for comparator areas not available, known under-reporting, small numbers of reported cases by borough. There was no significant difference in reported malaria cases between Southwark, Lambeth and Lewisham (the 3 borough with access to chemoprophylaxis on NHS prescription) and Hackney (a borough with similar population composition and no chemoprophylaxis on NHS prescription).

A model of impact of the change in access to chemoprophylaxis provided an estimate of the additional cases of malaria per year in Southwark. It focused on the impact for residents from African origin and from low social class. Not providing access through NHS could result in additional 12 cases of imported malaria annually.

The assumption is that in absence of access to malaria chemoprophylaxis on the NHS, 100% of black African residents of working class visiting friends or relatives in Africa will not pay for the chemoprophylaxis. Also assuming that all additional cases will be among black residents from working class who did not take chemoprophylaxis.

| Analyse and assess the likely impact on equality or potential discrimination with each of the following groups. | Is the impact likely to be positive, negative, neutral or unknown for people within any of the following categories? Please say which. Give further details where possible, including any evidence you have |
| Have any financial or resource implications been identified? | |
| Date of Executive Management Team/Governing Body Meeting where the Equality Assessment was ratified: | 7.9.17 |
| How and when will you monitor and review your equality analysis? | 24 months following implementation as a Public Health review and impact analysis will be completed 18-24 months following implementation. |
### Section 2: Equality Analysis Checklist

For each of the nine protected characteristics and other groups in the table below, consider whether the policy/function/service development could have a positive or negative outcome on each of these groups. Involve service users where possible to obtain their opinion, use demographic/census data (available from public health and other sources), surveys (previous surveys or perhaps conduct one), ask PALS and Complaints for reports/data, obtain subject specific reports from providers and other published data. Ensure any remedial actions are Specific, Measureable, Achievable, Realistic, and Timely (SMART)

<table>
<thead>
<tr>
<th>Equality Group</th>
<th>What evidence has been used for this analysis?</th>
<th>What engagement and consultation has been used?</th>
<th>Identify positive / negative / no outcomes</th>
<th>How are you going to address issues identified?</th>
<th>Specify the Named Lead and Timeframe</th>
</tr>
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<tbody>
<tr>
<td><strong>Age</strong></td>
<td>Public Health data</td>
<td>Formal consultation period with Southwark residents, patients, carers and clinical staff working in Southwark over an 8week period (26th June – 20th August 2017) Target groups included people of all ages</td>
<td><strong>Potential Negative impact</strong> For those exempt from prescription charges e.g. elderly, children. Children are at particular risk of severe and fatal malaria; therefore Public Health England advises parents/carers/guardians against taking infants and young children to malarious areas without adequate precautions.</td>
<td>Public Health campaign to raise awareness and educate the public regarding the importance of prevention against mosquito bites and encouraging public to factor in the cost of anti-malarials when considering booking a holiday or travel plans. Awareness-raising activity to target Black West African populations in particular Provide easily accessible information on where private travel clinic services can be accessed.</td>
<td></td>
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<td>Equality Group</td>
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<td>Disability</td>
<td>Think outside the box – you may not be able to see the disability. It could be physical (for instance hearing or visual impairment), unseen (for instance mental health) or a learning disability (for instance Autism). Consider for example: Accessibility – venue, location, signage, furniture and getting around Disability awareness training for staff Actively involve the service user and talk it through with them</td>
<td>Formal consultation period with Southwark residents, patients, carers and clinical staff working in Southwark over an 8week period (26th June – 20th August 2017)</td>
<td>Potential negative impact for those who are more vulnerable and who may find it difficult to access services.</td>
<td>Organisations that provide travel clinic services (General Practice, private travel clinic services and Community pharmacies) already have to comply with the disability element of the Equalities Act and will therefore have considered how people with disability will access their service and advice. Many private travel clinics are conveniently located near public transport hubs and are open longer hours including weekends. Many community pharmacies are also located near General Practices and/or public transport hubs and are usually open longer hours including weekends. Many Community Pharmacies also provide a delivery service for medicines. Public Health campaigns to raise awareness and educate the public regarding the importance of prevention against mosquito bites</td>
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<tr>
<td>Mental Health</td>
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<td>does this affect significant communities in the local population?</td>
<td></td>
<td></td>
<td>and encouraging public to factor in the cost of anti-malarials when considering booking a holiday or travel plans. Provide easily accessible information on where private travel clinic services can be accessed.</td>
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<tr>
<td>Gender Reassignment</td>
<td>Neutral</td>
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<tr>
<td>Marriage and Civil Partnership</td>
<td>Neutral</td>
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<tr>
<td>Pregnancy &amp; Maternity</td>
<td>The policy/function/service development must be accessible for all e.g. opening hours</td>
<td>Potential negative impact, as these people are exempt from prescription charges during pregnancy and for the first year following pregnancy/birth. Public Health England advises that pregnant women avoid travel to malarious areas.</td>
<td>Public Health campaign to raise awareness and educate women who are pregnant or are on maternity leave regarding the importance of prevention against mosquito bites, assessing the necessity for travel to a malaria endemic country and encouraging public to factor in the cost of anti-malarials when considering booking a holiday or travel plans. Provide easily accessible information on where private travel clinic services can be accessed for advice.</td>
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<tr>
<td>Race</td>
<td>Negative impact for those of black West African origin. It is estimated that these</td>
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<td>Public Health campaigns to raise awareness and educate the public regarding the importance of</td>
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<td>You need to think carefully about the local demographics of the population who will be accessing the policy/function/service development. Talk to public health. Consider for example:</td>
<td>proposals may affect around 7054 Southwark residents of Black African origin annually who travel to malaria-affected countries.</td>
<td></td>
<td>prevention against mosquito bites and encouraging public to factor in the cost of anti-malarials when considering booking a holiday or travel plans. Providing information to the black African population most at risk of contracting malaria about obtaining the medication required for their chemoprophylaxis from a reputable source in the UK before they travel. Provide easily accessible information on where private travel clinic services can be accessed.</td>
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<tr>
<td>Cultural issues (gender, clothing etc.)</td>
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<td>Languages</td>
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<td>Support to access</td>
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<td>Staff training on cultural awareness, interpreting etc.</td>
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<tr>
<td><strong>Religion or Belief</strong></td>
<td></td>
<td></td>
<td>Neutral</td>
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<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
<td>Neutral</td>
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<td></td>
<td></td>
<td></td>
<td>The proposals apply to males and females (across all ages) equally and will not either increase or decrease inequalities between males and females or promote better relations between males and females in relation to access</td>
<td></td>
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<td>Sexual Orientation</td>
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<td></td>
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<td>The proposals apply to males and females (across all ages) equally and will not either increase or decrease inequalities between males and females or promote better relations between males and females in relation to access or treatment.</td>
<td></td>
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<tr>
<td>Carers</td>
<td></td>
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<td>Neutral</td>
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<tr>
<td>Other People who do not speak English as a first language</td>
<td></td>
<td></td>
<td>Potentially negative impact</td>
<td>Patients and public may take along a friend or relative to translate at any appointment with a private travel clinic service. Local community pharmacies often have pharmacists/staff from a BAME background and a wide range of languages may be spoken. NHS choices provides a translation service on the website so people may be directed here to raise awareness and educate the public regarding the importance of prevention against mosquito bites</td>
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<tr>
<td>People living in deprived areas and people from different socio-economic groups</td>
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<td></td>
<td>Potentially negative impact. Those who have very low incomes or who are homeless would potentially be at a disadvantage if they felt they could not afford to purchase anti-malarial chemoprophylaxis.</td>
<td>Public Health campaigns to raise awareness and educate the public regarding the importance of prevention against mosquito bites and encouraging public to factor in the cost of anti-malarials when considering booking a holiday or travel plans. Provide easily accessible information on where private travel clinic services can be accessed.</td>
<td></td>
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<tr>
<td>Asylum seekers and refugees</td>
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<td></td>
<td>As Above</td>
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<tr>
<td>People who have a mental illness or disability</td>
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<td></td>
<td>Potential negative impact for those who are most vulnerable.</td>
<td>Public Health campaigns to raise awareness and educate the public regarding the importance of prevention against mosquito bites and encouraging public to factor in the cost of anti-malarials when considering booking a holiday or travel plans. Provide easily accessible information on where private travel clinic services can be accessed.</td>
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Section 3: Action Plan

For any negative outcomes identified in Section 2, it is important to identify the steps you will take to mitigate consequences on the nine protected characteristics and other groups. Complete the Action Plan below to identify and record how you will address these.

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<tr>
<td>Age</td>
<td>potential</td>
<td>See above</td>
<td>TBC</td>
</tr>
<tr>
<td>Disability</td>
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This document should be completed in conjunction with the Equality Analysis Guidance produced by the Equality, Diversity and Inclusion Team. Should you have any queries, please contact the Equality, Diversity and Inclusion Team at NELCSU.Equality@nhs.net who will be pleased to help.

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</tr>
<tr>
<td></td>
<td>□ Hepatitis B (single vaccine)</td>
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<td></td>
<td>□ Rabies vaccine</td>
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<td></td>
<td>□ Tick-borne encephalitis vaccine</td>
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<td></td>
<td>□ Meningitis ACWY vaccine</td>
</tr>
<tr>
<td></td>
<td>□ Japanese encephalitis vaccine</td>
</tr>
<tr>
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<td>□ Yellow fever</td>
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<td>Is this a new/existing/revised policy, function or service development?</td>
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<tr>
<td>Briefly describe its aims and objectives</td>
<td>(1) Empower people to self-manage vaccination requirements for travel purposes</td>
</tr>
<tr>
<td></td>
<td>(2) Align NHS Southwark with national guidance in this area</td>
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Completed Equality Analysis Templates must be reviewed by the ED&I Team. Following any suggested amendments/additions, the final version must then be submitted to the Equality & Diversity (E&D) Service Lead for final approval
Name of Initial Reviewer:

Date of approval by Wasia Shahain, EDI Service Lead:

| Data and research used to assist the analysis and assessment (e.g. public health data, national reports) | • Lambeth and Southwark Public Health and Public Health South London data and impact analyses.  
• British Medical Association Guidance:  
  ➢ Focus on travel immunisations Guidance for GPs  
  Focus on hepatitis B immunisations guidance for GPs |
| Summary of data findings in relation to protected characteristics | Rabies, Tick-borne encephalitis, Japanese encephalitis and Yellow fever vaccines are not included in the GMS and PMS Additional Services contract and so cannot be given as an NHS Service. The impact of promoting self-management of vaccination requirements for travel is expected to be limited and mitigated by the existing national immunisation programme in the case of most infectious vaccine preventable diseases. |
| Analyse and assess the likely impact on equality or potential discrimination with each of the following groups. | Is the impact likely to be positive, negative, neutral or unknown for people within any of the following categories? Please say which. Give further details where possible, including any evidence you have |
| Have any financial or resource implications been identified? | |
| Date of Executive Management Team/Governing Body Meeting where the Equality Assessment was ratified: | 7.9.17 |
| How and when will you monitor and review your equality analysis? | 24 months following implementation as a Public Health review and impact analysis will be completed 18-24 months following implementation. |
Section 2: Equality Analysis Checklist

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<tr>
<td>Age</td>
<td>Think about different age groups and the policy/function/service development and the way the user would access it, is it user friendly for that age group? What is the age breakdown in the community/workforce? Will the change/decision have significant impact on certain age groups?</td>
<td>Formal consultation period with Southwark residents, patients, carers and clinical staff working in Southwark over an 8 week period (26th June – 20th August 2017)</td>
<td><strong>Negative impact</strong> for those exempt from prescription charges e.g. elderly, children</td>
<td>Public Health campaign to raise awareness and educate the public regarding the importance of vaccination against some of the serious diseases found in other parts of the world and encouraging public to factor in the cost of travel vaccinations when considering booking a holiday or travel plans. Provide easily accessible information on where private travel clinic services can be accessed.</td>
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<td>Think outside the box – you may not be able to see the disability. It could be physical (for instance hearing or visual impairment), unseen (for instance mental health) or a learning disability (for instance Autism). Consider for example:</td>
<td>Formal consultation period with Southwark residents, patients, carers and clinical staff working in Southwark over an 8week period (26th June – 20th August 2017)</td>
<td><strong>Potential negative impact</strong> for those who are more vulnerable and who may find it difficult to access services.</td>
<td>Organisations that provide travel clinic services (General Practice, private travel clinic services and Community pharmacies) already have to comply with the disability element of the Equalities Act and will therefore have considered how people with disability will access their service and advice. Many private travel clinics are conveniently located near public transport hubs and are open longer hours including weekends. Many community pharmacies are also located near General Practices and/or public transport hubs and are usually open longer hours including weekends. Many Community Pharmacies also provide a delivery service for medicines; online advice is available from NHS sites including NHS Choices, which conforms to web standards for accessibility. Public Health campaign to raise awareness and educate the public regarding the importance of vaccination against some of the serious diseases found in other parts of the world and encouraging public to factor in the cost of travel vaccinations when considering booking a holiday or travel plans. Provide easily accessible information on where private travel clinic services can be accessed.</td>
<td></td>
</tr>
<tr>
<td>Equality Group</td>
<td>What evidence has been used for this analysis?</td>
<td>What engagement and consultation has been used?</td>
<td>Identify positive / negative / no outcomes</td>
<td>How are you going to address issues identified?</td>
<td>Specify the Named Lead and Timeframe</td>
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<td>Gender Reassignment</td>
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<td>Neutral</td>
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<td>Marriage and Civil Partnership</td>
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<td>Neutral</td>
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<tr>
<td>Pregnancy &amp; Maternity</td>
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<td></td>
<td>Potential negative impacts as these people are exempt from prescription charges.</td>
<td>Public Health campaign to raise awareness and educate women who are pregnant or are on maternity leave regarding the importance of vaccination against some of the serious diseases found in other parts of the world and encouraging public to factor in the cost of travel vaccinations when considering booking a holiday or travel plans. Provide easily accessible information on where private travel clinic services can be accessed.</td>
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<tr>
<td>Race</td>
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<td>Neutral</td>
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<tr>
<td>Religion or Belief</td>
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<td></td>
<td>Negative impact for people following Islam. All pilgrims travelling to the Kingdom of Saudi Arabia for the Hajj or Umrah are required to show proof of vaccination with quadrivalent (ACWY) meningococcal vaccine in order to obtain a visa.</td>
<td>Public Health campaign to raise awareness and educate the public regarding the importance of vaccination against some of the serious diseases found in other parts of the world and encouraging public to factor in the cost of travel vaccinations when considering booking a holiday or travel plans. Provide easily accessible information on where private travel clinic services can be accessed.</td>
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<td>Sex</td>
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<td>Sexual Orientation</td>
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<td>Carers</td>
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<tr>
<td>Other</td>
<td></td>
<td></td>
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<tr>
<td>People who do not speak English as a first language</td>
<td>Potentially negative impact. Interpreting services available to patients in GP practices may not available in community pharmacy. Local community pharmacies often have pharmacists/staff from a BAME background and a wide range of languages may be spoken. NHS choices provides a translation service on the website so people may be directed here to raise awareness and educate the public regarding the importance of vaccination against some of the serious diseases found in other parts of the world and encouraging public to factor in the cost of travel vaccinations when considering booking a holiday or travel plans.</td>
<td>Patients and public may take along a friend or relative to translate at any appointment with a private travel clinic service.</td>
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<tr>
<td>People living in deprived areas and people from different socio-economic groups</td>
<td>Potentially negative impact. Those who have very low incomes would potentially be at a disadvantage if they felt they could not afford the recommended medicines.</td>
<td>Public Health campaign to raise awareness and educate the public regarding the importance of vaccination against some of the serious diseases found in other parts of the world and encouraging public to factor in the cost of travel vaccinations when considering booking a holiday or travel plans. Provide easily accessible information on where private travel clinic services can be accessed.</td>
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<tr>
<td>Asylum seekers and refugees</td>
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<td>As above</td>
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<tr>
<td>People who have a mental illness or disability</td>
<td>Potential negative impact for those who are most vulnerable associated with navigating / accessing private travel clinics which may be in unfamiliar locations</td>
<td>Public Health campaign to raise awareness and educate the public regarding the importance of vaccination against some of the serious diseases found in other parts of the world and encouraging public to factor in the cost of travel vaccinations when considering booking a holiday or travel plans. Provide easily accessible information on where private travel clinic services can be accessed including community pharmacy which will be familiar to most people</td>
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</tbody>
</table>
Section 3: Action Plan

For any negative outcomes identified in Section 2, it is important to identify the steps you will take to mitigate consequences on the nine protected characteristics and other groups. Complete the Action Plan below to identify and record how you will address these.

<table>
<thead>
<tr>
<th>Equality Group</th>
<th>Negative Outcome</th>
<th>Mitigating Action (Identify any resource/other implications)</th>
<th>Named Lead and Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>potential</td>
<td>See above</td>
<td></td>
</tr>
<tr>
<td>Disability</td>
<td>potential</td>
<td>See above</td>
<td></td>
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<tr>
<td>Gender Reassignment</td>
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<td>Pregnancy &amp; Maternity</td>
<td>potential</td>
<td>See above</td>
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<tr>
<td>Race</td>
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</tr>
<tr>
<td>Religion or Belief</td>
<td>potential</td>
<td>See above</td>
<td></td>
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<tr>
<td>Sex</td>
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<tr>
<td>Sexual Orientation</td>
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<tr>
<td>Carers</td>
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<td></td>
</tr>
<tr>
<td>Other</td>
<td>potential</td>
<td>See above</td>
<td></td>
</tr>
</tbody>
</table>
### Section 4: Submission

On completion of all sections of the Equality Analysis Form, submit your draft along with the policy, function, or service document to the Equality, Diversity and Inclusion Team for an initial review. Once reviewed, the team will provide feedback and any recommended amendments/additions. Having made any necessary changes, the final version should then be submitted to the next Executive Management Team/Governing Body Meeting for ratification and subsequent publication on the CCG website/intranet. The ratified EA Template should be appended to the policy, function or service development documentation.
**Issue:**

Southwark and Lambeth CCGs are considering ending the provision of malaria chemoprophylaxis. Public health have been requested to input into the likely impact of this proposed change.

**Epidemiology of Imported Malaria:**

- In 2015, there were 1400 cases of confirmed malaria in the UK, with 49% of these in London.
- Last year, 305 South London residents were notified as having been infected with malaria on return from overseas, the majority of which were diagnosed in Southwark, Lewisham, Greenwich, Lambeth and Croydon.
- Each year approximately 5% (range 20-30 cases) of national notifications are amongst Southwark residents. This has been falling since 2013.
- Of all cases of imported malaria in South London, 93% were in patients of Black African ethnicity.
- The pattern of imported malaria cases are generally linked to travel in peak holiday seasons, particularly December and January, and July and September.
- The majority of imported malaria infections in South London (89%) were P. falciparum.

**Graph 1: Age Distribution of Reported Malaria Cases in Southwark in 2015**

The impact of malaria chemoprophylaxis in Southwark is difficult to assess for a number of reasons:

1. Patterns of travel for comparator areas are not available.
2. There is known under-reporting of malaria.
3. There is known but unassessed non-compliance with antimalarial medicines.
4. There is no evidence that free malaria chemoprophylaxis has resulted in fewer imported cases in Southwark. Comparison of rates of imported malaria (unadjusted) between borough which have had free prescribing and those which have not do not show any significant differences.
5. Information on travel patterns and adherence to chemoprophylaxis at borough level is not available and is thus not comparable.
6. There is no history of malaria chemoprophylaxis prescribing and adherence amongst cases.

**Summary and analysis of factors**

<table>
<thead>
<tr>
<th>Factor</th>
<th>Trend</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of travels to Africa</td>
<td>Increasing</td>
<td>Around 5% increase compared to 2011 (UK and any travel)</td>
</tr>
<tr>
<td>Registered population from African countries in Southwark</td>
<td>Increasing</td>
<td>Small increasing trend</td>
</tr>
<tr>
<td>Number of residents travelling to western Africa to visit friend or relatives (VFR)</td>
<td>Uncertain trend – possibly reducing</td>
<td>Reduction in 2013 and 2014 then small increase compared to baseline (2011) in 2015</td>
</tr>
<tr>
<td>Average length of stay</td>
<td>Constant</td>
<td>Remains constant around 11 bed days</td>
</tr>
<tr>
<td>Malaria endemicity trend</td>
<td>Reducing</td>
<td>Reducing malaria incidence and reducing imported incidence</td>
</tr>
<tr>
<td>Malaria resistance</td>
<td>Reducing</td>
<td>Less than 10% for most common used treatment</td>
</tr>
<tr>
<td>Uptake malaria chemoprophylaxis</td>
<td>Varies across population</td>
<td>Chemoprophylaxis use in Nigerians (50%) was substantially lower than in passengers departing to Kenya (78%) and Ghana (82%)</td>
</tr>
<tr>
<td>Cost of malaria chemoprophylaxis</td>
<td>Atovaquone plus proguanil £15.40 (travel pack) Doxycycline 100mg/d</td>
<td>Costs vary between pharmacy</td>
</tr>
</tbody>
</table>
Options:

Option 1 - Continue with current arrangements:
Malaria chemoprophylaxis is prescribed on an NHS prescription for any patient registered with a GP practice in Lambeth, Southwark or Lewisham. Patients usually pay a prescription charge of £8.60 or may be exempt from paying a prescription charge if they fall into one of the following categories:
In 2011 practices were advised to prescribe the first line recommended anti-malarial for the country the patient is visiting, which in most cases was either mefloquine (Larium) or doxycycline. Prescribers were advised to not prescribe Malarone first line unless all other antimalarials recommended for the endemic area being visited, are contra-indicated.

Option 2 – Revert to National Policy malaria chemoprophylaxis not available on NHS:
This would involve withdrawing the local arrangement that supports prescribing of malaria chemoprophylaxis on a NHS prescription for any patient registered with a GP practice in Lambeth, Southwark or Lewisham to bring the three boroughs in line with a) the amendments to the NHS (General Medical Services) 1992 outlined in NHS Executive circular FHSL (95)7 14 February 1995 - Malaria Prophylaxis: regulation permitting GPs to charge for prescribing or providing anti-malarial drugs; and b) prescribing practice across England and Wales since 1995.

Summary of Impacts:

<table>
<thead>
<tr>
<th>Required resources &amp; capacity</th>
<th>Option 1</th>
<th>Option 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost over £125,000 a year.</td>
<td>Saving £125,000 a year in prescription costs.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Proportion needs which would be addressed</th>
<th>Option 1</th>
<th>Option 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%</td>
<td>Not all. An unknown number of residents may not choose to purchase anti-malarials or could not afford to.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cost effectiveness implications</th>
<th>Option 1</th>
<th>Option 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malaria chemoprophylaxis is cost effective compared to treating improved malaria cases; This scheme is likely to be most cost effective as people more likely to travel to endemic countries are also to most benefit from free chemoprophylaxis, although there is no evidence that prescription costs would be prohibitive.</td>
<td>Increased risk of imported malaria cases. Risk of additional cost associated with additional malaria cases: £52,000 in Southwark.</td>
<td></td>
</tr>
<tr>
<td><strong>Readiness of the option</strong></td>
<td>Currently in place</td>
<td>Will need to be approved by CCG board and information communicated with primary care.</td>
</tr>
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<td>-----------------------------</td>
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</tr>
<tr>
<td><strong>Impact on other part of the care pathway</strong></td>
<td>Saving required across NHS. However likely to prevent further imported malaria cases and additional bed pressure on acute trusts.</td>
<td>Modelled 10-12 potential additional malaria cases. Increased demand on pharmacies.</td>
</tr>
<tr>
<td><strong>Implications for patients</strong></td>
<td>No change.</td>
<td>Need to be communicated with patients.</td>
</tr>
<tr>
<td><strong>Plus value as measured by cost per expected outcome (imported malaria cases prevented)</strong></td>
<td>Estimated the number of cases prevented is complex. Not available at that stage.</td>
<td>Estimated the number of additional cases prevented is complex. Not available at that stage.</td>
</tr>
<tr>
<td><strong>Risks</strong></td>
<td>£125,000 for maintaining access to malaria.</td>
<td>Potential increase in imported malaria cases.</td>
</tr>
<tr>
<td><strong>Mitigation</strong></td>
<td>Better control on prescribing Malarone; Monitor lab reports of imported malaria cases.</td>
<td>Close monitoring of lab report and assessing the completeness of lab reporting. Disseminate information about access to quality prophylaxis. Work to raise awareness of all prevention methods.</td>
</tr>
</tbody>
</table>

**Conclusions:**

1. The impact of Southwark’s policy of prescribing malaria chemoprophylaxis on imported malaria incidence is difficult to assess.
2. Analysis of crude rates of malaria notifications in Lambeth and Southwark compared to statistical neighbour boroughs which do not have a free prescribing policy do not show any significant differences.
3. The age distributed shows the majority of cases were in the 45-54 age group and there is a clear targeted group for health promotion and advice.
4. Withdrawing malaria chemoprophylaxis would bring Southwark in line with the rest of country and enable significant savings.
5. If a decision is taken by the Southwark Medicine’s Management Committee to no longer provide malaria chemoprophylaxis on prescriptions then Public Health will work with the South London Health Protection Unit to monitor trends in notifications over the 12 months post implementation.
6. Public health will support health promotion advice around malaria prevention (using ABCD model).
Southwark CCG Committee Report

ITEM FOR DECISION

<table>
<thead>
<tr>
<th>CCG Committee</th>
<th>Governing Body</th>
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<tr>
<td>Month</td>
<td>September</td>
</tr>
<tr>
<td>Year</td>
<td>2017</td>
</tr>
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</table>

Item title: South East London CCG review

Enclosure number: E

Any known conflict of interest: Yes

<table>
<thead>
<tr>
<th>Report Author</th>
<th>Responsible Director</th>
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<tr>
<td>Name</td>
<td>Name</td>
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<tr>
<td>Andrew Bland</td>
<td>Andrew Bland</td>
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<tr>
<td>Job title</td>
<td>Job title</td>
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<tr>
<td>Chief Officer, Southwark CCG</td>
<td>Chief Officer, Southwark CCG</td>
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<td>Email</td>
<td>Email</td>
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<tr>
<td><a href="mailto:andrewbland@nhs.net">andrewbland@nhs.net</a></td>
<td><a href="mailto:andrewbland@nhs.net">andrewbland@nhs.net</a></td>
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</tbody>
</table>

Process followed for development of this paper:
<table>
<thead>
<tr>
<th>Followed agreed CCG process in full</th>
<th>✓</th>
<th>Urgent paper</th>
<th>□</th>
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</table>

For urgent papers only: explain the reason for urgency

Click here to enter text.

<table>
<thead>
<tr>
<th>Have you described the below impacts as part of this proposal?</th>
<th>Have you considered either of the below to be relevant to this proposal?</th>
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<tbody>
<tr>
<td>Impact on patients / service users</td>
<td>Financial impact</td>
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<tr>
<td>Yes</td>
<td>✓</td>
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<td>N/A</td>
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Does the recommendation align with the CCG’s objectives and responsibilities?

<table>
<thead>
<tr>
<th>Deliver IAF improvement</th>
<th>Improve patient outcomes</th>
<th>Improve quality / safety</th>
<th>Secure financial sustainability</th>
<th>Support integration</th>
<th>Address health inequalities / parity of esteem</th>
<th>Enable the delivery of care coordination</th>
<th>Promote early action</th>
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<tr>
<td>□</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<td>✓</td>
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1. **Purpose of the paper**

To update the Governing Body on the progress made under the current review of collaborative commissioning arrangements across south east London’s CCGs (Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark); and to seek governing body approval for the initial recommendations of the Review’s Sponsor board to:

- Make changes to the executive leadership structure for south east London’s CCGs, following any required consultation with relevant staff (see Section Five (page 8) for these recommendations)
- Progress with further phases of engagement and design in relation to the organisation of the wider functions under review, developing proposals for change and improvement before the end of this financial year

2. **Describe the issue being presented to the committee**

The SEL CCGs have a long history of collaboration however, in order to more effectively address the current and continued requirements of CCGs (individually and collectively) a new leadership structure is proposed, alongside a review of wider arrangements over a longer period. The intention of these proposals is therefore both to better support the requirements of these organisations in the short and medium term, and also to enable the capacity and local focus required to deliver the longer term objectives (e.g. Accountable Care type systems).

The Governing Body are asked to note the context, case for change and progress of the overarching review and approve these initial recommendations of the Review’s Sponsor Board as detailed in section three below in order to allow implementation to commence, whilst the remainder of the review is progressed.

3. **What is your recommendation to the committee (i.e. what course of action do you suggest is taken?)**

The Governing Body is asked to:

- Note the context, case for change and progress of the overarching review and endorse the approach to the future phases of work for the remainder of the financial year.
- Approve the proposals for changes to the executive leadership structure for CCGs put forward by the Sponsor Board from the first phase of the review.
- Approve delegated authority for the CCG Chair, as a member of the review Sponsor Board and on behalf of the CCG’s Governing Body, to act upon the outcome of any staff consultation and the management response, to implement the new leadership structure.
- Commit to considering and taking forward any required constitutional changes required of the CCG to enable the final implementation of this structure.

In considering these recommendation, the Governing Body is also asked to note the specific areas of ongoing work (in addition to the future option appraisal of the optimal scale and organisation of functions) that the paper outlines for the review process, namely:

- The development of a robust Organisational Development programme to support the implementation of this proposed leadership structure if approved, recognising that the successful operation of these arrangements will require clear and agreed operating models and ways of working.
• The development of enhanced governance arrangements that will facilitate the effective operation of future arrangements. This will give specific focus to the appropriate alignment of CCG Constitutions, arrangements for the accountability of shared posts to each Governing Body (including a Memorandum of Understanding to codify this) and opportunities for shared decision making where appropriate and paying due regard to local sovereignty.
• In the context of established clinical leadership within each borough, the opportunity for enhanced clinical leadership of commissioning across the six CCGs in south east London.

4. What is the rationale for your recommendation?

These recommendations for changes to the executive leadership of south east London’s CCGs and for the further phases of work under the review seek to address the case for change outlined in section four of the paper.

• The review approach and proposals have been deliberately phased and prioritised. The proposals included here focus on executive leadership, aiming to ensure this supports the successful operation of CCGs - both individually and collectively, addresses changes and gaps in the current leadership structure, and aims to secure best value leadership for functions already provided at scale. Importantly they aim to support clinical leadership of each CCG and across south east London and ensure CCGs are able to effectively operate at borough, south east London and Pan-London levels simultaneously, as the current operating environment requires.

• The proposals provide an initial response to a case for change related to the CCGs objectives for population based commissioning and accountable care systems, delivery of the operational and (STP) programme requirements of the SEL system and opportunities and challenges related to capacity and capability. Noting that there is further work (described as two further phases) required to complete the review and therefore this response.

5. What stakeholder engagement has taken place?

The Sponsor board has undertaken regular engagement and communications and has ensured regular updates have been provided to Governing Body members, member practices, staff and other stakeholders over the last six months, including two six-way Governing Body workshops over the summer months. In turn, each Chair and Chief Officer has held undertaken more local engagement upon the review in their boroughs.

The proposals themselves have been generated through the engagement and contribution of more than 50 CCG subject matter experts and executive directors.

Finally, the review has been regularly discussed and presented to NHS England (London Region) at executive level.
6. Do stakeholders support the recommendation being made?

Yes, the proposals are made by the CCG Chairs and Chief Officers, following the process of engagement outlined above.

NHS England (London) also support the proposals and process described in this document.

7. What other options were considered?

Preceding this proposed structure was a process which identified (through workshops with CCG subject matter experts and endorsed through the review governance) a number of options for what level functions might be led and deployed.

Two to three options were identified for each of the 50+ functions and those options will be subject to ongoing work in the further phases of the review, noting that proposals for the Executive leadership outlined in these proposals are agreed to support and not prohibit those future considerations.

From this process, and wider stakeholder feedback the leadership structure relating to the preferred options were identified and the executive structure was developed based on this. Through its development it has also been tested through discussion against the current state e.g. ‘do nothing’ option.

8. What are the risks in proceeding with the recommendation?

There is an inherent risk associated with the change management process that will effect these changes, which will require the robust programme management approach established by the sponsor board. It is also important to note that the proposals are being considered during a period of significant operational challenge and system leaders will need to ensure the appropriate management focus is directed to this.

9. What are the risks in not proceeding with the recommendation?

There is a general risk that the CCGs in south east London will be unable to populate a management structure that is able to response to their local and south east London commissioning objectives as discussed in section four of the paper.

More immediately, there is a risk that CCG will be unable to realise best value from their investment in management resources, given the immediate opportunity to review contracts for external support, and the longer term opportunities to derive greater value from the commissioning architecture that supports CCGs.

Finally CCGs will not have the capacity and capabilities to address current operational pressures that require enhanced local and collective action.
### Supporting information / documents

Please append any relevant documents including detailed reports; options appraisals; background documents; national guidance etc.

<table>
<thead>
<tr>
<th>Appendix #</th>
<th>Name of document</th>
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<tbody>
<tr>
<td>i</td>
<td>South east London CCG review</td>
</tr>
</tbody>
</table>

| Date paper completed | Friday, 08 September 2017 |
South east London CCG review

September 2017

1. Purpose

1.1. To update the Governing Body on the progress made under the current review of collaborative commissioning arrangements across south east London's CCGs (Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark); and to seek governing body approval for the initial recommendations1 of the Review's Sponsor board to:

- Make changes to the executive leadership structure for south east London's CCGs, following any required consultation with relevant staff (see Section Five (page 8) for these recommendations)
- Progress with further phases of engagement and design in relation to the organisation of the wider functions under review, developing proposals for change and improvement before the end of this financial year

1.2. The Sponsor Board recommendations are being made to all six CCG Governing Bodies during September 2017. The Sponsor Board is comprised of the six CCG Chairs and Chief (Accountable) Officers and they have worked closely with, and through their teams upon the review since April 2017. The Sponsor Board has provided regular updates to NHS England (London Region) who have confirmed their support for the review and its initial recommendations, as the body that assures CCGs.

1.3. These recommendations will require the support of all six Governing Bodies in order to move forward with this work and to begin implementation of the proposed leadership structure changes from October 2017.

2. Context

2.1. In order to ensure that their CCGs continue to have the leadership, capacity and capabilities to fulfil their statutory duties and strategic objectives, the CCGs in south east London decided to review their individual and collaborative commissioning arrangements in March 2017. The review seeks to ensure these remain fit for purpose in a changing policy context and operating environment, whilst ensuring they always provide effective support to CCG Governing Bodies in exercising their commissioning responsibilities for local populations as sovereign bodies.

2.2. Since their inception in 2013, the CCGs have, individually and through collaborative arrangements, successfully commissioned for improved quality and outcomes for their residents. They have also developed and are implementing a series of ambitious borough and south east London wide health improvement strategies for their residents.

2.3. However, over the last two years CCGs in south east London have seen a significant number of changes, both in their own approaches and in the wider operating environment:

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1 The full recommendations of the paper are provided in section 7.1
Crucially, each CCG is developing proposals for new population based approaches to commissioning (often referred to as accountable care systems);

They are also part of a south east London Sustainability and Transformation Partnership (STP) along with providers, local authorities and residents – the STP seeks to deliver system improvement and sustainability within the context of the south east London strategic plan - Our Healthier South East London

They continue to face significant quality, performance and financial challenges - many of which will require greater collective action if they are to be addressed sustainably.

2.4. Over the same period the NHS in England published the Five Year Forward View (2014) and more recently the Five Year Forward View - Next Steps (2017) that set out new and different approaches to the commissioning and delivery of health and care services.

2.5. When taken together these changes and plans are placing new and different challenges upon commissioners and in response, like many places in the country, all London’s CCGs have begun to review and change their collaborative arrangements across their respective STP footprints.

Review governance

2.6. The south east London CCG review has been overseen by a Sponsor board (see 1.2) that is co-chaired by the Chairs of NHS Bromley CCG and NHS Lambeth CCG. That board has been supported by a steering group drawn from CCG executive directors and subject matter experts, sub-groups (focused on Communications, Human Resources and Governance), review focused workshops and a small programme management office.

2.7. The Sponsor board has undertaken regular engagement and communications and has ensured regular updates have been provided to Governing Body members, member practices, staff and other stakeholders over the last six months, including two six-way Governing Body workshops over the summer months. In turn, each Chair and Chief Officer has held undertaken more local engagement upon the review in their boroughs.

Review principles

2.8. Importantly the review was instigated using a set of agreed principles that can be found in Appendix A. They make a commitment to developing and pursuing proposals that enhance and optimise current and future commissioning arrangements that will improve the health and care outcomes that residents receive. They set a requirement to secure best value from the money they spend on their functions.

2.9. Critically the principles also established clear fixed points for the review:

- That CCGs (as clinically led, membership based, locally focused and sovereign bodies) will remain in all six boroughs, each with a Governing Body and a Clinical Chair
- That arrangements will pay due regard to commissioning across health and social care locally, recognising the importance of the relationship and joint working with local authorities at borough level.

There are five STP areas in London – North West, North Central, North East, South East and South West.
• Clear consideration must be given to those functions that might optimally be organised and delivered at scale, across the six CCGs

2.10. The Sponsor board also made a clear commitment to reinvestment of any funds freed up by proposals, in to local borough based capacity for transformation. The primary focus of the review was not to secure the delivery of management cost reductions. Whilst this remains true, the Five Year Forward View – Next Steps, equally sets a clear expectation that CCGs will take action to reduce management costs in the same period. The Sponsor board and CCGs will need to take account of that requirement as it relates to south east London.

**Sustainability and Transformation Partnership**

2.11. A clear context for the review is the establishment and operation of STPs, of which all CCGs are a part. Now and in the future, CCGs must give focus to their capacity and capability to participate in those arrangements. As such the review is also considering the interface and resourcing of collaborative work that spans the entirety of that partnership and beyond the six CCG commissioning organisations. The STP has already established leadership arrangements (both clinical and executive) and programme support to this system-wide programme, and ensuring these arrangements are both joined up with and aligned to CCG resources is a critical success factor for the review.

**NHS Lambeth CCG**

2.12. In addition to the changing policy and operating environment that pertains to all CCGs, there have also been particular changes to the leadership arrangements of NHS Lambeth CCG and NHS Croydon CCG. Since the start of this financial year, the Governing Bodies of those CCGs have agreed to share one Chief Officer, this role is being performed by Lambeth’s current Chief Officer under a secondment arrangement.

2.13. It is important to note that this arrangement will not change under the proposals outlined below. This has implications specifically for the CCG review proposals in relation to Accountable Officer and Chief Financial Officer roles. However, NHS Lambeth CCG remains a member of the south east London STP and are part of the collaborative arrangements for the six CCGs. NHS Lambeth CCG will remain fully involved in the development of further proposals for change to the collaborative arrangements for south east London.

3. **Process of review**

3.1. As the appended principles of the review confirm, the intention has been to review all functions undertaken by/ required of CCGs both now and in the future. More than 50 CCG functions were identified, and the scope of the review was to assess how CCGs might enhance and optimise the scale at which they are undertaken in the future.

3.2. As outlined below, the approach to functional review firstly sought to segment and target commissioning functions where greatest opportunity was felt to reside – as a result, some were determined to be ‘out of scope’, others were regarded as in need of very rapid or light touch review, and the remainder represented a targeted set of functions requiring more detailed considerations. The review has not sought to change the arrangements for clinical leadership to date, given that CCGs remain as

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3 Please see figure one (section 5.3) for the executive structure and roles relation some or all CCGs
clinically led organisations, however the sponsor board will seek to ensure that clinical leadership is, where necessary, enhanced to support collaborative arrangements as they change.

3.3. Post segmentation, the activity of the review has been ordered in to three phases (leadership of the system, functions with ‘at scale’ opportunities identified, and those regarded as potentially more local in scale)

Targeted review of functions

3.4. To date the review has undertaken work with more than 50 CCG Subject Matter Experts (SMEs) representing all disciplines and CCGs to develop draft proposals for change and improvement. This work has been undertaken alongside a clear commitment to:

- Engage thoroughly on draft or outline proposals with staff and stakeholders, working to a principle that some early thinking on these areas would best inform that engagement
- Assess or appraise options for change against agreed criteria

3.5. The Sponsor board has, however, agreed to take a differential approach to sub-sets of those functions. Full details are provided as Appendix B. As part of this approach a number of functions were determined to be ‘out of scope’ either because they are subject to an alternative and parallel process of review (e.g. Business Intelligence), or because they were not felt to represent any significant opportunity for change within this review process (e.g. management of Freedom of Information requests), or finally because, in the case of the primary care contracting team, they have been recently established following a separate review (on 1 April 2017).

3.6. A further set of functions were identified for ‘quick review’ where the nature of the commissioning function did warrant some review but was unlikely to lend itself to a change in delivery approach or scale, usually because of external arrangements (e.g. London-wide commissioning of the London Ambulance Service). This then left a significant number of functions for more dedicated review, upon which proposals will be made.

Phasing of functional review

3.7. Targeted functions have been organised in to three phases of work as described in 3.3. Phase one proposals are included in this document, and proposals related to phases two and three will be brought to Governing Bodies by March 2018.

3.8. The Sponsor board has agreed to prioritise recommendations for changes to the executive leadership of CCGs within the review, and these form the recommendations in this paper (e.g. Phase One). Importantly these changes seek to enable the organisations to:

- Successfully operate against current CCG and STP requirements at the earliest opportunity
- Address current changes and gaps in the leadership of both the CCGs and the STP (where key vacancies will exist from quarter three, 2017/18)
- To secure best value leadership of functions already delivered at scale but with reliance upon external (interim and consultancy) support.
- Continue to support the clinical leadership of CCGs and the STP
3.9. Under the second phase, the Sponsor board will receive proposals to address a number of prioritised ‘in scope’ functions for accelerated review, either because they are already undertaken at scale but potentially sub-optimally, or because they are required to support the executive leadership changes proposed in phase one.

3.10. The third and final phase relates to the wider (majority) of ‘in scope’ functions. The timing of proposals relating to phase two and three will be determined by a balance of allowing time for detailed consideration and engagement against the opportunity cost of not making changes for improvement as early as possible. It is anticipated that all proposals will be made within this (2017/18) financial year, with opportunities for earlier consideration, by agreement of the Sponsor Board, being afforded by the Governing Body meetings held in public in November and January of this financial year. By considering all phases of work, the Sponsor board has assured itself that these changes support and do not prohibit or restrict options for change in other areas.

4. Case for change

4.1. The review has been conducted against an emerging case for change that pertains to the on-going ability of commissioners to deliver their strategic objectives, the current challenges to their operational capacity and capabilities, and the inherent challenge of securing appropriately balanced investment of limited resource to both its local and at scale delivery approaches.

Strategic

4.2. In general terms, the review is seeking to ensure that the CCGs are able to successfully achieve their stated strategic objectives that are increasingly organised at borough, multi-borough, pan south east London, and in some instances London level. The organisation of CCG resources must successfully operate at these levels simultaneously.

Population based commissioning and arrangements for accountable care

4.3. The primary driver of the review has been to ensure that CCGs have the capacity and capability to realise their ambitions to move to accountable care systems delivering best value outcomes for their local populations. This work is focused upon addressing segments of the population that have similar needs, and in a system as complex as south east London’s, this requires the design of solutions that are both relatively small in scale for some populations and much wider spread for others. CCG’s require the capacity and skills to design and implement this system, whilst having the right combination of scaled arrangements to serve it in future.

4.4. It is recognised that there will be a number of local Accountable Care systems within south east London (e.g. a series of ‘systems within a system’). Whilst thinking on future accountable care arrangements is emergent (and at different stages in each borough) this review has made a clear assumption there will be a number of arrangements within this geography. Accountable care is likely to have significant elements that are organised very locally at borough or sub-borough level, particularly for generally healthy populations, and the model will look different in parts of south east London. Equally, there will be segments of the population (such as some acute and specialised services) for which services are commissioned for a wider geography. Where functions are proposed to have some ‘at scale’ element, consideration has been made as to the likely scale required to support Accountable Care Systems. At the
same time the delivery of many pathways of care and the standards associated with them will span the entirety of the sub-region and will require accountable care arrangements that see systems work together to achieve them.

4.5. As a result, the proposals both at this, and in future, phases seek to secure the right combination of local and STP wide resource to allow the significant work required on delivery and transformation locally, whilst ensuring there is an ability to provide oversight, coordination and system delivery at south east London level in future.

4.6. In this same context, the review has recognised that many of the skills and models of operation found today would need to change quite radically to support accountable care systems as they evolve. The commissioning architecture that is likely to support accountable care is not routinely found in current CCG arrangements. A step change in the availability of data, use of business intelligence systems and actuarial skills, as examples, will be required.

4.7. When taken together, the current arrangement of CCG management resource does not currently optimise our ability to support and realise this ambition, or indeed to manage it when it emerges. Critically, this work must be ‘owned’, as mainstream activity by CCG teams and cannot be contracted out to third party expertise if it is to be prioritised. It must also be resourced alongside a recognition that immediate system pressures and challenges will remain and organisations must make arrangements that seek to address immediate and future facing work.

Sustainability and Transformation Plan - Our Healthier South East London

4.8. The strategic plan agreed by governing bodies in October 2016 describes a series of strategic priorities that cannot be achieved by any one organisation (commissioner or provider) alone. Whilst collaboration of CCGs has been effective in developing system wide plans, it currently lacks the capacity to operationalise or implement many of those strategic plans as leadership, resource and decision-making is dispersed across the six organisations.

4.9. The current approach is too often reliant upon senior responsible officers, drawn from the current leadership of CCGs, in addition to their substantive roles without dedicated resources to support them. Whilst CCGs have made huge gains and delivered in many respects, in overall terms the approach has been sub-optimal to support delivery at the same time as draining capacity away from locally focused leadership and resource. This situation has led to a reliance upon externally procured capacity that is not affordable and can lead to a loss of ownership of plans and their delivery.

4.10. Going forward the CCG’s limited management resource must mainstream activities that span more than one borough without denuding local initiatives of resource. The STP itself is very clear that delivery is required at both borough and south east London levels.

Operational capability

4.11. Following the establishment of STPs in England there is now a dual requirement for system management to occur and be assured at both CCG and STP level. Whilst CCGs are seeking to address this, their present management arrangements give predominant focus to the former. All CCGs will require the ability to plan, monitor and take action to improve commissioning outcomes at both levels and this will require a more formalised and appropriately resourced ability to do this. This goes beyond
piecemeal or one off collaboration as has been the case, replaced by a systematic approach to system as well as CCG oversight.

4.12. At the same time NHS regulators are increasingly seeking to assure the performance of systems rather than individual organisations. This has been most apparent in emergency care and cancer to date; and the Five Year Forward View – Next Steps expands this to financial management and system delivery plans for Primary Care, Cancer, Mental Health and Urgent and Emergency Care specifically.

4.13. At the same time, these developments are set in a context of significant and immediate performance challenges across a range of quality, performance and financial areas—many of which will require formalised action across the system to address them. Although CCGs have made progress in recovery plans across the full range of indicators, the scale of the challenges requires more rigorous action to be undertaken at pace. Current arrangements do not currently optimise our collective ability to respond to these challenges.

**Investment in capacity and capability**

4.14. The work undertaken by the review to date has recognised a likely reduction in management resource for commissioning activity over time; an under resourcing of local commissioning activities, particularly focused upon transformation; and a series of potentially sub-optimal and poor value arrangements for functions currently delivered at scale.

4.15. Collaborative responses to recovery of performance across the system or collaborative commissioning activities often represent duplicated effort across a range of teams that leads to sub-optimal co-ordination of our collective resource and inefficiencies. This review is seeking to identify those areas that might best be delivered or coordinated once across south east London with the dual benefit of more effective response whilst allowing local leaders and teams for focus on those things that should be undertaken locally.

4.16. Many of the CCG’s functions (and certainly those that will be considered under phase two of the review) are currently delivered at scale but this has been dependent on externally procured and more expensive executive capacity and leadership solutions, or those centralised functions have not been utilised effectively as they have several ‘masters’ with different requirements. The review must achieve arrangements that derive best value responses from organisations that are external to us (e.g. Commissioning Support Services) or mainstream activities that are unnecessarily procured from third parties (e.g. consultancy resource).

4.17. Finally, it is clear that recruitment to specific roles and areas of expertise has been challenging with a scarcity of high quality supply from the market. Since their inception a number of CCGs have failed to consistently recruit to key positions and this may be addressed by a more coordinated or consolidated response across south east London.

**Summary**

4.18. Section Four sets out a clear case for change in relation to strategic, delivery, capacity and capability considerations and challenges. In developing the Sponsor Board proposals for change and improvement the expectation is that planned changes will support south east London in meeting these challenges.
4.19. As we progress though the different stages of the CCG review, the sponsor board is committed to ensuring options and proposals are tested in detail against agreed criteria, noting that the proposals put forward in the first phase of the review reflect a consensus view of the optimal executive leadership required.

5. **Phase one proposals**

5.1. Phase one proposals have been agreed by the sponsor board for recommendation to Governing Bodies. Importantly they relate to the executive leadership team across the six CCGs that will serve our clinically led and sovereign Governing Bodies for each borough and across the STP.

5.2. The proposals relate to a core set of south east London executive leadership roles focused upon system wide and local delivery. They assume that local managerial leadership teams will be retained in each borough, working to these arrangements, and whilst these proposals are to be applied consistently across the CCGs it is anticipated that local CCGs will design the local management teams that best serve their populations needs and support the clinical leadership of commissioning. This is with the exception of any ‘at scale’ teams or resources agreed - either existing or that will be required. The Sponsor board will ensure the appropriate involvement of clinical and managerial input any such review, ahead of receiving recommendations.

5.3. **Figure one** provides a proposed organisational chart for the leadership arrangements and proposed changes are outlined below:

*Figure one: Proposed Leadership structure – please note where roles relate to some or all CCGs, or the STP footprint as a whole*  

5.4. The structure seeks to address those elements of the case for change that are amenable to change through different executive leadership arrangements, recognising this will be one part of the solution. The team of local and south east London roles proposed seeks to address the need to lead a response that is both local and south east London wide at the same time. The autonomy invested in locally facing teams is significant and together with a more coherent response to system wide issues it is our expectation that this will accelerate transformational work whilst operating within the management cost envelope available to us.
5.5. The sections that follow are supported by a brief description of each role’s responsibility as set out in Appendix C:

**Accountable Officers and Managing Directors**

**Accountable Officers**

5.6. Proposals describe the establishment of a single accountable officer for five of the six CCGs and the retention of the current Accountable Officer role for NHS Lambeth CCG and NHS Croydon CCG. This five borough post will be accountable to, and be a member of, each of the five Governing Bodies and will be lead an executive team that seeks to secure optimal leadership of local and pan south east London commissioning activities. They will work with and allow local leadership teams to focus upon the needs of their borough whilst working through a small team of south east London Directors to ensure the effective management of activities at that scale (across all six CCGs). The single Accountable Officer will also be the STP Leader for south east London.

**Managing Directors**

5.7. A Managing Director role will be established for each of the five CCGs. They will report to the Accountable Officer and will be responsible for all aspects of local commissioning activities of their CCG working to the Governing Body and through a local CCG senior management team. They will form part of the south east London executive team but their predominant focus, enacted with considerable autonomy, will be on borough based local delivery, and importantly the transformation that will support the achievement of accountable care. The Managing Director would be a voting member of the Governing Body to which they relate and will work closely with the Chair and local clinical leadership to secure local delivery of CCG plans.

**CCG Financial leadership and accountability**

5.8. The financial leadership arrangements described in 5.9 and 5.10 relate to financial activity of the five CCGs (note the STP based finance role described in 5.19). These proposals seek to provide a combination of co-ordinated focus to local financial leadership whilst enhancing strategic capacity and opportunities. Whilst local Directors of Finance will be shared across either two or three boroughs, they will retain local finance teams and their scope of focus will not mirror current arrangements for Chief Financial Officers that span a variety of other, non-finance responsibility unless a local CCG arrangement is made for this.

**Chief Financial Officers**

5.9. Mirroring the Accountable Officer arrangement, the proposal is to establish a single Chief Financial Officer (CFO) for the five of the six CCGs and the retention of the current Chief Financial Officer for NHS Lambeth CCG. This leadership position will report to the Accountable Officer and will be a member of the Governing Bodies to ensure they can provide visible and effective financial leadership both across south east London and for individual CCGs. Again, they will ensure the coordinated leadership of both system wide financial activities and support local teams in support of borough based strategies. Importantly the single CFO will develop and lead a coherent financial strategy for the benefit of all CCGs in south east London and they

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4 Although they will also have oversight responsibility for the Director of Strategic Finance which is an STP based role (e.g. covers the entire south east London footprint)
will manage a team of Finance Directors (see 5.10 and 5.19) focused and dedicated to local or system wide activities.

**Directors of Finance**

5.10. Under these proposals there will be two locally focused Directors of Finance – one for NHS Lewisham CCG and NHS Greenwich CCG, and one for NHS Bexley CCG, NHS Bromley CCG and NHS Southwark CCG. These Director posts will work with absolute local focus whilst being part of the overall south east London executive teams. They will report to the single Chief Financial Officer but work with and for the local Governing Bodies, their Managing Director and leadership teams. They will also manage local finance teams for their respective boroughs. Importantly they will give focus to local CCG financial performance and support local transformation activities.

**South east London CCG leadership roles**

**Director of Commissioning Operations**

5.11. This new post will lead a series of functions on behalf of all CCGs in south east London with the dual advantage of ensuring a coordinated and comprehensive leadership response to those areas, whilst ensuring that local leadership teams are supported to meet their responsibilities and have, as a result, dedicated time for locally focused delivery and transformation activities.

5.12. The responsibilities will include leading the response to system wide assurance, a single coordinated programme management office response to all CCG collaborative activity and for the wider STP, coordination of pan south east London governance requirements and a lead responsibility for pan south east London commissioning requirements - including Integrated Urgent Care (111) and commissioning and management of commissioning support services contracts. They will be supported by an Operations team that will work with other Directors and CCG management teams (the composition of which will be determined in later phases of the review to ensure appropriate alignment to local teams).

**Director of the Integrated Contracts Delivery Team (ICDT)**

5.13. From September 2017 onwards acute, contracting for the six CCGs will be undertaken by a single team and this proposed post, already established in existing collaborative arrangements, will be a confirmed member of the south east London executive team. The post holds responsibility for all elements of acute (and where integrated contracts exist – community services) contracting as well as playing a vital role in co-producing, with CCGs, acute commissioning intentions and QIPP plans, and developing new approaches contracting approaches to reflect and support accountable care arrangements. The team is multi-disciplinary, combining contracting, finance, quality and performance disciplines to give a coherent, comprehensive and expert response to this critical area of delivery.

5.14. They will ensure a coordinated approach to acute contract management alongside management of key constitutional target delivery including A&E, Referral to Treatment and Cancer performance. They will work closely with local CCG teams to ensure a cohesive approach to contracting, management of performance and delivery.

**Director of Quality**
5.15. This new role will work with and through existing quality teams, rightly established across the wider structure in both local CCG settings and provider facing teams. With a clinical background, they will champion the quality and safety agenda and lead the spread of best practice, the development of consistent quality standards and their delivery, whilst taking action to address quality issues that span more than one borough or provider. This aims to support and supplement continued local quality and safety activities.

5.16. Importantly, they will also take the lead for the delivery of the Transforming Care Programme across south east London and be responsible for developing (across commissioner and the STP system) approaches to workforce development, professional leadership and clinical networks.

**STP leadership roles**

5.17. The south east London executive leadership team will also host and provide leadership resources to the south east London STP, reporting to the STP Lead (agreed to be the single Accountable Officer for the five CCGs (once appointed), by the STP Leadership\(^5\)). Importantly the roles below are already established within the current leadership system for south east London but have, to date, been performed by long term interim appointments that have either ended or will end by January 2018.

**STP Programme Director**

5.18. The post will report to the STP lead and will lead the STP programme covering all members of the partnership. They will be responsible for the management of this complex programme spanning clinical service redesign (including specialised services), provider collaboration and wider system transformation. They will coordinate the delivery of the STP working through the STP’s governance structure and work streams and with clinical leaders. To do this they will be supported by the STP’s existing Programme Directors, Senior Responsible Officers and the established STP team (the composition of which will be re-visited as part of the later phases of the review).

**Director of Strategic Finance**

5.19. This Director position is proposed to report to the single Chief Financial Officer for the five CCGs and will work with the STP Programme Director and wider STP team to lead the financial planning to support the delivery of the STP and the financial aspects of the programmes of work it pursues. The post will also provide expertise and support to each boroughs transformation work as a member of the south east London Executive leadership team. They will be supported a small financial strategy team.

**Operating model for the leadership team**

5.20. Under the leadership of a single Accountable Officer for five of the six south east London CCGs, the proposed executive management team will be accountable to and deliver upon the priorities of those five CCG Governing Bodies. It is important to note that the pan south east London Director positions, reporting to that single Accountable Officer will also be responsible for functions that serve all six CCGs, including NHS Lambeth CCG.

\(^5\) The Job description for the Accountable Officer role will include the STP leadership responsibility
5.21. They will give priority to supporting the delivery of locally focused objectives either
through direct delivery or by taking responsibility ‘once’, for appropriate activities in
order to free local leadership and teams to focus on borough activities and working
with local authorities and other partners. Plans, either local or pan south east London,
will be developed by CCGs in discussion with and championed by their clinical
leadership, working with their members.

5.22. The Accountable Officers will be accountable to their respective CCG Governing
Bodies and NHS England (through their accountability to NHS England’s Chief
Executive). Day to day management of the new five borough Accountable Officer
arrangement will be need to be determined in agreement with CCG chairs.
Irrespective of the chosen practical arrangement, this principle of accountability to the
Chair(s) remains.

Organisational development and ways of working

5.23. These proposals do not address issues related to organisational development (OD). It
is however clear that CCGs will need to take forward a comprehensive OD programme
to ensure that ways of working and interfaces between and across teams are
understood, embedded and work optimally. Appropriate consideration will also need
to be given to key enablers, such as IT, information and workforce development, as
well as ensuring effective approaches and sufficient consistency in the interactions
between ‘at scale’ functions, CCG teams and Governing Bodies. The CCGs forward
OD programme will further need to give focus to ensuring the identification and spread
of learning and best practice across south east London, with the proactive adoption of
a 'best in class' philosophy and approach.

Clinical leadership

5.24. These proposals seek to provide an executive support to governing bodies. Clinical
leadership will continue to be provided by clinical chairs and governing body members,
both through their leadership of the local agenda and presence on local decision and
working groups and committees; and increasingly through their clinical leadership of
pan south east London clinical boards, many of which exist in the current structure.
The steering group for the review will give focus to the composition, number and focus
of those boards to ensure the commissioning system (and wider STP system) remains
clinically led and driven.

5.25. In addition to local clinical leadership, the Sponsor Board is giving active consideration
to the enhanced clinical leadership of south east London’s STP and commissioning
groups and boards.\(^6\)

Voting and CCG Constitutions

5.26. Should these proposed leadership arrangements be approved then they will
perpetuate the voting membership of an Accountable officer and chief financial officer
on each governing body. Some constitutions require a memorandum of understanding
to be established to support the sharing of such roles and it is proposed that this is
developed and agreed. Further work will be required, in advance of implementing this

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\(^6\) Current and planned groups and boards at a south east London level either include or are proposed to include the following
areas: Urgent and Emergency Care, Planned Care, Maternity and Young People, Mental Health, Cancer, Transforming Care
Programme, Community Based Care (STP Delivery Board), and the Area Prescribing Committee.
new model, to ensure the alignment of standing financial orders and instructions that currently afford different levels of delegation and powers to these positions.

5.27. In addition, it is proposed that the Managing Directors (MD) of each of the five CCGs have a vote on the Governing Body. In order to achieve that whilst meeting membership expectations of each CCG, will require some changes to wider Governing Body composition or voting rights in some CCGs. Any changes, including the voting rights of the MD would require changes to the constitution to be agreed ahead of operationalising these new leadership arrangements.

5.28. Each CCG has confirmed its ability to make such changes that allow this locally, although this requires different changes in different boroughs. These will be a local responsibility to enact and do not have to be uniform, provided all Managing Directors have a vote in each borough as a result. In this instance the membership decision on changes to the constitution would be to determine whether their local Managing Director would have a vote or not, in light of the new structure that will have been established. Proposals assume all Managing Directors will be afforded a vote by CCG memberships.

Costings and affordability

5.29. The total costs of the proposed leadership team equate to £2,350k per annum based on the assumptions outlined below, which would be appropriately apportioned to CCG’s. This is expected to be cost neutral based on the assumptions below.

5.30. Key assumptions include:

- Costs are inclusive of employer’s superannuation and National Insurance contributions
- CCGs will receive 20% of the cost of the single Accountable Officer role as the STP lead from NHS England
- Actual costs of current staffing in post for the purpose of comparison
- Indicative grading of each new post and ‘Inner London’ weighting for all new posts
- The costs of the existing STP Director and Director of Financial Strategy are currently represented by the costs of their current recruitment methods (interim and consultancy)
- NHS Lambeth Accountable Officer costs are split between that CCG and NHS Croydon CCG

5.31. Whilst this cost is similar to current arrangements, it is important to note that the structure anticipates the removal of any requirement for interim recruitment going forward and provides additional whole time equivalent directors and the capacity they bring.

5.32. The structure also ensures the remainder of the review is well placed to derive best value from commissioning resource spend as it allows the cessation of wider consultancy contract support for the STP; facilitates a review of overall spend on current ‘at scale’ delivery resourcing relating to the STP team and the CSU contract delivery teams; and it allows for the potential for other ‘at scale’ consolidation relating to functions such as finance and assurance.

5.33. The introduction of this structure within the year 2017/18 will introduce a non-re-current cost pressure, potentially in the region of £300k to £500k but this will be mitigated in
full by underspends within the current CCG funded elements of the STP (OHSEL) budget and existing corporate budgets.

6. **Next steps**

   **Phase one proposals**

6.1. Following the approval of Governing Bodies, noting that meetings will conclude on 28 September 2017, implementation would commence immediately with three weeks formal consultation with staff using a consultation document, briefing and one-to-one meetings with staff affected. Each CCG’s management of change policies have been reviewed to ensure sufficient similarity to allow the same process to be used in all of the CCGs concerned. Pending the outcome of formal consultation and the management response, this proposal seeks delegated authority to the CCG Chair, as a member of the Sponsor Board, to act on the outcomes of those processes and commence the recruitment process on behalf of the governing body.

6.2. In parallel to governing body consideration of these proposals the steering group is overseeing the drafting of all Job Descriptions and the consultation document to ensure that appropriate preparation has been completed to enable this timescale. In addition, the governance group will take forward preparatory work upon the constitutional change requirements and any other governance issues for recommendation to the Sponsor Board to support implementation. It is envisaged that the establishment of new leadership arrangements will facilitate different and enhanced governance arrangements in some areas.

6.3. Finally, the Sponsor Board will receive and agree a proposal for the actual start date or full implementation date for this new structure based upon the progress and timing of the wider review phases and the outcome of recruitment processes for this leadership team.

   **Wider review**

6.4. The parallel phases of the review outlined by this document will be taken forward by the review programme team with next steps involving engagement in and upon the design of accelerated and wider functions with staff and stakeholders. This will inform further proposals for the consideration of the Sponsor Board in order that they can make recommendations to the CCG Governing Bodies over the remainder of 2017/18.

7. **Recommendations**

7.1. The Governing Body is asked to:

- Note the context, case for change and progress of the overarching review and endorse the approach to the future phases of work for the remainder of the financial year.
- Approve the proposals for changes to the executive leadership structure for CCGs put forward by the Sponsor Board from the first phase of the review.
- Approve delegated authority for the CCG Chair, as a member of the review Sponsor Board and on behalf of the CCG’s Governing Body, to act upon the outcome of any staff consultation and the management response, to implement the new leadership structure.
- Commit to considering and taking forward any required constitutional changes required of the CCG to enable the final implementation of this structure

Appendix list:

A – CCG review principles Page 16
B – Functions list Page 17 - 18
C – Leadership team role outlines Page 19 - 22
Appendix A – CCG review principles

The following principles and fixed points were agreed through the south east London Review governance in April:

Our design principles
We will review all the STP and CCG level functions to identify options for future commissioning arrangements and areas for collaboration, which align to principles that options should:

- Optimise the scale and pace of effective delivery
- Ensure capacity and capability at each scale
- Initially include all functions (some of which will be removed from scope during the review – subject to agreement from the Steering Group and Sponsor Group)
- Speak to immediate and future operating environments for commissioning
- Reduce our dependency on external support for the delivery of strategic programmes

Our fixed points
Our fixed points for the organisational structure to adhere to include:

- CCG Governing Bodies and Chairs will continue to exist in each six boroughs
- We will ensure our ability for effective health and social care commissioning across all boroughs
- There is no targeted management cost reduction as this is not the primary focus of the commissioning review
- We aim to reinvest any financial benefit released from the revised organisational form back into south east London CCGs*

* Please note: since agreeing to initiate the review, the Five Year Forward View refresh has been issued. It is noted this review will need to take into account any requirements associated with that document
### Appendix B – Functions under review

<table>
<thead>
<tr>
<th>Phase of review</th>
<th>Included Functions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Function currently determined as out of scope</td>
<td>Surge, Community Safety, Financial Accounts, Data Warehousing and BI, IFRs, Complaints, FOIs, Human Resources and Payroll, Workforce and Training, Estates*, IT – Network support and Primary Care*, Digital*</td>
</tr>
<tr>
<td>Function where a ‘quick review’ was conducted</td>
<td>Primary Care contracting, 111**, LAS, Procurement (clinical and non clinical), Safeguarding Adults and Safeguarding Children and LAC</td>
</tr>
<tr>
<td>Phase One: System leadership</td>
<td>See proposals contained in this document</td>
</tr>
<tr>
<td>Phase Two: functions with ‘at scale’ opportunities</td>
<td>Financial management and accounting, Strategic Finance, STP Programme &amp; Leadership, Assurance and System Performance, Acute, Quality</td>
</tr>
<tr>
<td>Phase Three: Functions expected to be local</td>
<td>Transformation &amp; Provider Development; including local Primary Care Commissioning, Transforming Care Programme (was clustered with Learning Disabilities), Governance (Corporate and IG), Organisational Development, Patient Engagement, Corporate Support, Membership Support, Urgent Care Commissioning, Planned Care Commissioning, Primary Care and Integrated Community Services, Maternity</td>
</tr>
</tbody>
</table>

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7 Please note this list where appropriate has combined names of functions. The groupings reflect potential levels of scale identified in initial phases of the review; but are working assumptions requiring further discussions
<table>
<thead>
<tr>
<th>Cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Contracting</td>
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<tr>
<td>Mental Health Commissioning</td>
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<tr>
<td>CYP Commissioning</td>
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<td>Adults/Physical Disability</td>
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<td>Learning Disability</td>
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<td>Equality and Diversity</td>
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</tr>
<tr>
<td>Internal Comms</td>
</tr>
<tr>
<td>CHC &amp; Brokerage</td>
</tr>
<tr>
<td>Medicine Optimisation</td>
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</table>

* These functions are being partially considered through discussions related to current CFO oversight responsibilities, and planned STP programme discussions
** Note that leadership of these functions is referenced in the Director of Commissioning Operations Job Description
Appendix C – Leadership team role outlines

The below details aim to highlight key information on the potential CCG and Finance lead roles.

The **Accountable Officer** role:

- Accountable for 5 south east London CCGs, responsible for the leadership of shared functions for 6 south east London CCGs
- Has line management responsibilities for the MDs, CFO and Directors of shared functions
- Is the STP Lead as part of the STP leadership quartet. On behalf of the six CCG’s, leads development, planning, and implementation of the STP, as part of the STP leadership team
- Ensures clear strategic direction and vision for health and social care services in South East London
- Ensures CCGs commission the highest quality services with a view to securing the best possible outcomes for patients and maintaining a consistent focus on quality, integration and innovation

The **Managing Director** roles:

- Dual responsibility - both for the day to day leadership of the CCG, responding to the current operating environment, and for leading the redesign of the CCG’s local governance
- Are expected to spend the majority of their time leading local functions and supporting development of ACS’ and the remainder supporting delivery of south east London activity
- Part of the Governing Body (voting members) and will support ensuring pan south east London activities are representative of the needs of their borough
- Provide leadership and direction to develop and implement local commissioning strategies and plans
- Together with the Accountable Officer and Chair, share responsibility for the continuous development of the CCG

The **Chief Financial Officer** role:
• Executive responsibility for the financial management, control and CCG financial strategy for 5 CCGs
• Leads development and implementation of the financial strategy of the 5 CCGs working with the CFO for Croydon and Lambeth to ensure alignment
• Provides oversight and leadership of the Strategic Finance function for all 6 south east London CCGs and the south east London providers
• Line management for the 2 X Directors of Finance and Director of Financial Strategy

The **Director of Financial Strategy** role:

• Supports the development and delivery of the financial strategy and respective programmes of work for the 11 STP organisations (e.g. working with providers as well)
• Works closely with provider equivalents
• Works with the Accountable Officer, CFO and local CCG Executive teams to plan and deliver against collaborative commissioning initiatives
• Provides leadership and strategic direction to a range of financial deliverables for STP work streams in line with the STP Programme and Finance work stream priorities
• Directs and delivers financial/activity models that inform the financial strategy and where relevant supports cost savings

The **Directors of Finance (for CCGs)** roles:

• Have financial responsibility for 2 or 3 CCGs
• Will lead the finance teams as they exist in each borough
• Will not have the portfolio role of the current CFOs (i.e. will have predominant focus on Finance)
• Responsible for developing and implementing the financial strategy of the CCGs, supporting the Governing Body and the Managing Director to commission high quality services
• Provide strategic financial advice and financial management leadership to the CCGs to exercise their commissioning functions and deliver their statutory responsibilities effectively
• Non-voting member of relevant Governing Bodies

The below diagram highlights potential pan south east London roles. These roles aim to support and release capacity for local CCGs. Their work ultimately reports into the GBs through the Accountable Officer:
The **Director of Quality** role:

- Leads the quality and safety agenda across south east London’s CCGs
- Leads on system wide issues; including managing system clinical and risk summits as well as inter-provider system failure/ clinical risk
- Develop and maintain an effective framework by which to consistently understand the quality of all commissioned services across the STP footprint and to assure Governing Bodies, the Accountable Officer and the south east London executive team(s) that the scale of response is both located and resourced at the right level
- Work with the leads of multi-disciplinary teams to identify and articulate quality in all functions and CCGs
- Develop south east London quality standards and lead the delivery of these and Regional and National standards
- Will provide director oversight to Transforming Care Programme

The **Director of Integrated Contracts Delivery Team (ICDT)** role:

- Lead the day to day strategic, operational and relationship management of the CCG’s key acute providers
- Given a mandate and parameters by CCG Governing Bodies to negotiate contracts
- Develops, negotiates and agrees these with south east London acute providers
- Monitors and manages contracts, working closely with CCGs
- Coordinates the ICDT’s contribution to CCG strategic and operating planning processes with a particular focus on ensuring acute requirements, priorities and expectations
- Manages on behalf of the CCG’s the interface with the commissioning support service (CSS) to ensure the optimal delivery of agreed support services

The **Director of Commissioning Operations** role:

- Coordinates assurance information for south east London CCGs, working with MDTs and boroughs – building a strong assurance reporting relationship with NHSE
- Supports consolidation of south east London PMO (and provide leadership for that function) to ensure appropriate governance for collaborative decision making and delivery oversight
- Leads and directs performance improvement initiatives and reporting across south east London CCGs
- Leads procurement, contract and performance management of the CSU and other suppliers (for pan south east London contracts)
• Senior Responsible Officer (SRO) for the monitoring, reporting and establishment of system wide recovery plans across the six CCGs
• Responsible for the leadership, direction and oversight of the Integrated Urgent Care service (111).

The **STP Programme Director** role:

• Director with responsibility for strategic development of the STP
• Drives delivery of clinical programmes, collaborative transformation and enabling work streams.
• Translates strategy into delivery on the ground, leading teams through significant change across multiple providers and commissioners, gaining buy in from multiple stakeholder groups
• Drives development and implementation of clinical, patient and public engagement
• Works closely with CCGs, providers and other health and care stakeholders as well as NHSE and NHSI
• Line manager to the Programme Director of Community Based Care, and other STP programme directors
• Responsible for a team of Programme Directors and wider management resource to support the key work programmes of the STP
• Leads the strategic engagement and communications required by the STP
Summary and Background

Summary:

- This report provides the latest performance data for the following:
  - Constitutional standards
  - Improvement and Assessment Framework
  - Quality Premium
  - Metrics agreed by IGP as requiring additional focus

- It was agreed at the January 2017 IGP that the format of the assurance agenda item would be amended to focus specifically on non-urgent/unplanned care and emergency/urgent care on alternate months. The January 2017 Governing Body also agreed an approach to providing regular ‘deep dives’ into key performance indicators.

- The format of the assurance report has been updated to support this focus while retaining all metrics across constitutions standards, the IAF, Quality Premium and additional metrics agreed as requiring additional assurance.

Background:

In addition to the main NHS constitution standards, the following data are included:

- The Improvement and Assessment Framework includes indicators across four domains (Better Health, Better Care, Sustainability, Leadership) and six clinical priorities (Mental Health, Dementia, Learning Disability, Cancer, Diabetes, Maternity). Separate assessments for each of the clinical areas have now been made by NHS England, with clear targets for individual measures.

- The Quality Premium incentive scheme is intended to reward CCGs for improvements in the quality of the services they commission; for associated improvements in health outcomes; and for reducing health inequalities within their population. Local indicators were agreed by IGP. The 2017/18 targets and baselines are included.

- Supplementary metrics are those indicators which have been identified previously by IGP as requiring additional scrutiny at the committee.
Approach

This report is structured to provide:

• An in depth review of a key performance target/area to provide a more focussed look at local services.

• A dashboard view of the main provider and CCG constitution standards position vs agreed plans.

• Narrative highlighting trends, issues, actions and forecast position for each constitution standard.

• Current performance against the IAF measures and Quality Premium indicators. This includes a baseline and the current performance. Trends relative to the baseline have been included to indicate relative improvement. RAG ratings for the IAF are based on criteria described in the IAF guidance or, where not available, relative to Southwark’s position nationally. RAG ratings for Quality Premium Indicators are an assessment of how likely targets will be achieved with additional actions between now and the end of the year.

• Areas of focus previously identified as priorities at IG&P are also included for review.

Contents

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<th>Focus pack:</th>
</tr>
</thead>
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<tr>
<td></td>
<td>ii. e-RS update</td>
</tr>
<tr>
<td>2</td>
<td>Constitutional standards</td>
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<td>Appendix 1: Supplementary Metrics</td>
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<td>Appendix 2: Full IAF and assigned leads</td>
</tr>
<tr>
<td>5</td>
<td>Appendix 3: 2017/18 QP targets and baseline</td>
</tr>
</tbody>
</table>
RTT performance – Comparative Overview

These two tables show GSTT and KCH ranked by RTT incomplete performance in relation to all London Trusts and Shelford Group Trusts.

Nationally KCH is ranked 3rd from bottom with the lowest performing Trust at 75.9%. GSTT are 35th from bottom out of 187 reporting Trusts. On total incomplete waiters, i.e. the size of the waiting list, KCH have the largest nationally at 84337 with GSTT the next closest on 65027. They are followed by Imperial on 63014. There are currently 5 Trusts not reporting RTT information.

Both GSTT and KCH have produced RTT performance trajectories for next year that show under performance for all of 2017/18. GSTT highlights a return to target from Q1 2018/19, KCH shows a slow improvement to 82% from March 2019.

Performance at both GSTT and KCH has shown a reduction over the last 12 months.
## RTT performance – Comparative Overview

### GSTT 2017/18 Trajectory

<table>
<thead>
<tr>
<th></th>
<th>Apr-17</th>
<th>May-17</th>
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<th>Oct-17</th>
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<th>Jan-18</th>
<th>Feb-18</th>
<th>Mar-18</th>
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<td>60855</td>
<td>60605</td>
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<td>59855</td>
<td>59605</td>
<td>59355</td>
<td>59105</td>
<td>58855</td>
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<td>88.4%</td>
<td>88.5%</td>
<td>88.7%</td>
<td>88.9%</td>
<td>89.0%</td>
<td>89.2%</td>
<td>89.3%</td>
<td>89.3%</td>
<td>89.6%</td>
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<td>89.23%</td>
<td>88.50%</td>
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### KCH 2017/18 Trajectory

<table>
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<tr>
<th></th>
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<th>May-17</th>
<th>Jun-17</th>
<th>Jul-17</th>
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<td>82.2%</td>
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<tr>
<td>Actual Performance</td>
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<td>76.42%</td>
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</tbody>
</table>
**Current Performance**: Southwark CCG’s June e-RS utilisation was at 28%. This ranks Southwark at 24 out of 32 in London and 170 out of 209 nationally. Southwark CCG has improved from 22% in December.

**GSTT**: Currently have 92% of services linked to e-RS. The Trust have been chosen as early adopters of paper switch off and will close to non e-RS referrals for all specialties by April 2018. Phase 1 of the paper switch off will begin on 1 September.

**KCH**: Not yet submitted a clear breakdown of services currently available. The Trust are working to a plan to have all services available on e-RS by April 2018 and to have paper switch off by October 2018.

**Primary Care**: A large number of services are currently available on e-RS however, utilisation has not improved dramatically. All Practices in Southwark have self certified that they will be able to use e-RS for referrals to the phase 1 GSTT specialties and this is expected to increase utilisation. The CCG has given regular communications to Primary Care on the developments in e-RS. An IT facilitator is offering training to any practices in need and group training sessions have been arranged.

The CCG has agreed to review and sign off the finalised Directory of Services proposed by both Trusts prior to any paper switch off to ensure the system is usable from a GP perspective.
### GSTT Implementation Plan

<table>
<thead>
<tr>
<th>GSTT Specialties</th>
<th>Phase 1 Service available on e-RS</th>
<th>GSTT Stops Accepting Paper or email referrals – ERS only referrals accepted</th>
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<tbody>
<tr>
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<td>Diabetic Medicine</td>
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<td>01/02/2017</td>
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</tbody>
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Constitution Standards

Page 10 – 11: Acute Constitutional actuals against trajectory
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Page 16: Diagnostics
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Page 18: LAS
Page 19: IAPT
Page 20: Dementia
# Acute constitution standards: latest position against plan

## KCH

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Note latest month may not be based on published data.

## GSTT

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Note latest month may not be based on published data.
## Southwark CCG constitution standards: latest position against plan

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Latest data reflects continued local pressure on the 4 hour target into 2017/18, in line with national pressures. Recovery plans had been agreed with both local acute providers, and are subject to constant review, noting that a number of key actions relating to estates at KCH and GSTT have been subject to delay which have negatively impacted on capacity and patient flow.
Performance against the 4 hour standard at both GSTT and KCH remains below the national 95% target.

**KCH:** Performance at both Trust and site level continues to track slightly below the planned trajectory with system wide commitment to trajectory being resumed by September 2017. Initial data for July indicates improvement however, with Denmark Hill performance increasing by c3% in July. Key to the ED recovery plan is the implementation of the Here and Now Programme, which focuses on the delivery of flow on all sites, review of the minors and emergency care pathways, shortening the wait time for speciality review in ED, and weekly ED performance meetings, all of which feed into the Emergency Pathway Transformation Board. The new Urgent Care Centre (UCC) and the Charles Polkey ward opened in June and July respectively on the DH site, which is expected to have a positive impact on performance once fully embedded.

**GSTT:** Performance continues to be variable, with a key driver being the continued impact of the ED rebuild and high volumes of attendances. Performance is also driven by challenges with medical staffing. However, a successful recruitment drive has resulted in multiple posts being appointed to, including six ENPs, five consultants, and four middle grade doctors, with the posts commencing between July and October of this year. The trust also ran a ‘One Team’ week event in June, where all speciality teams worked on improving patient flow through the emergency pathway. The event was successful, and aided the improvement of professional standards. It was acknowledged that specialty input in the daily huddles was vital, and learning from this event will be embedded. ECIST visited GSTT on a number of occasions this year, focusing on UCC, Ambulatory Care, and the admission pathway. GSTT have committed to enacting all of the ECIST recommendations, which include the implementation of a flow coordinator in UCC, and piloting direct admissions processes from ED to the Acute Admissions Ward. As well as committing to these recommendations, the trust A&E recovery plan focuses on high impact changes which include; redesign of the AAU pathway, trust wide response to surge including the introduction of more robust inter-professional standards, and nursing leadership. Actions plans are monitored and assessed weekly with the Chief Operating Officer and monthly through Star Chamber events.
Referral-to-treatment: 18 weeks

**Incomplete (target 92%):** The % waiting to start treatment who have been waiting less than 18 weeks

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</table>

Overall RTT performance for Southwark CCG did not meet the 84.2% trajectory for June 2017, reaching 82.8%.

**Guy’s and St Thomas**: RTT performance for Southwark CCG at GSTT was 88%. GSTT are continuing to work with local commissioners on demand management for growth, including working with GPs to develop a screening process at point of referral for ENT patients on the Balance pathway, which would enable these patients to be identified and be given access to physiotherapy earlier on in the pathway. Although previous plans to outsource Orthopaedic hip and knee patients to BMI are no longer going ahead, additional capacity will be provided with the appointment of two substantive Orthopaedic consultants to the Trust, one of which is a hip and knee surgeon who starts in August.

**King’s College Hospital**: RTT performance for Southwark CCG at KCH was 76.9%, where all specialties with the exceptions of Rheumatology, General, Geriatric, and Thoracic Medicines were non-compliant. In July, 18 Week Support were contracted to provide additional capacity for KCH via insourcing, and outpatient clinics began with the Ophthalmology service on 22nd July. Other services currently planned to be insourced are outpatient appointments and day cases for Dermatology and General Surgery. Although insourcing will provide additional capacity and improve RTT performance, KCH are not expecting to be compliant with the RTT standard until March 2019.
The number of patients waiting over 52 weeks for Southwark CCG in June 2017 was 41. Of these 41 breaches, 38 occurred at KCH (13 in General Surgery, 10 in Urology, 7 in ‘Other’, 6 in T&O, 1 in Gynaecology, and 1 in Neurosurgery). The remaining three breaches occurred at GSTT (1 in ENT and 1 in General Surgery), and Imperial College Healthcare NHS Trust (‘Other’). The 52 week trajectory for KCH is set to be zero by November 2017.

Formal feedback has been received by KCH following the NHSI investigation into RTT, and the outcome was there would be no enforcement action against the trust. A condition of this outcome was for the trust to have a fully integrated recovery plan for RTT. This was submitted to NHSI at the end of June 2017, and the plan is currently being revised to reflect feedback, but has not yet been formally signed off. Additional support from NHSI has also been given to the trust with the placement of an RTT Improvement Director working on site.

Both GSTT and KCH will be focussing on the following actions in 17/18:

- Internal demand and capacity exercises and action to improve internal productivity and efficiency, including additional clinics and theatre sessions.

- Working with the independent sector to outsource/insource work where possible.

- Both Trusts are working with Southwark, Lambeth and Bromley CCGs participating in Referral Management groups focussing on 5 key specialties areas. (Neurology, ENT, Gynaecology, Dermatology, Ophthalmology)
Diagnostics

**Diagnostic target:** A maximum of 1% of patients should wait 6 weeks or more for a diagnostic test

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<th>Jun</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southwark CCG</td>
<td>4.5</td>
<td>0.95</td>
<td>0.9</td>
<td>0.6</td>
<td>1.2</td>
<td>0.99</td>
<td>0.96</td>
<td>0.87</td>
<td>1.1</td>
<td>1.3</td>
<td>1.3</td>
<td>1.5</td>
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<tr>
<td>KCH</td>
<td>6.8</td>
<td>2.0</td>
<td>1.0</td>
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<td>0.9</td>
<td>0.98</td>
<td>1.2</td>
<td>0.9</td>
<td>2.1</td>
<td>4.6</td>
<td>1.7</td>
<td>1.4</td>
</tr>
<tr>
<td>GSTT</td>
<td>1.1</td>
<td>0.90</td>
<td>1.2</td>
<td>0.9</td>
<td>1.3</td>
<td>1.6</td>
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<td>0.9</td>
<td>1.4</td>
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<td>1.4</td>
</tr>
</tbody>
</table>

The 1% diagnostic waits standard was not met by Southwark CCG in June 2017, reaching 1.5%. This was also a slight deterioration from 1.3% in May 2017.

**KCH:** Underperformance for Southwark CCG was driven by their position at KCH, which was compliant for 98.4% of diagnostics. Southwark CCG’s underperformance at KCH was attributed to CT and MRI services being non-compliant as a result of capacity challenges. KCH are mitigating this by outsourcing to the independent sector where feasible, securing agency locums, and reviewing booking and waitlist processes to ensure capacity is optimised. KCH are projecting full compliance of Diagnostic Waits performance from June 2017.

**GSTT:** Diagnostic waits performance for Southwark CCG at GSTT also fell short of the national standard, achieving compliance for 1.1% of diagnostic waits. Southwark CCG’s underperformance at GSTT was attributed to non-compliance in the Echocardiography, Urodynamics, and Endoscopy services. The Trust Performance team are working with the management teams for all non-compliant services on a weekly basis, to gather feedback on potential breaches and encourage earlier escalation of any challenges that the services are facing.
# Cancer waits

2 weeks GP referral (target 93%): % patients seen within 2 weeks of an urgent GP referral for suspected cancer  

31 days treatment (target 96%): % patients receiving first definitive treatment within 31 days of a cancer diagnosis  

62 days treatment (target 85%): % patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer  

<table>
<thead>
<tr>
<th></th>
<th>SCCG</th>
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<tr>
<td></td>
<td>Jul</td>
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<td>May</td>
</tr>
<tr>
<td>2 weeks</td>
<td>94.4</td>
<td>93.1</td>
<td>92.1</td>
<td>92.9</td>
<td>91.5</td>
<td>92.3</td>
<td>90.0</td>
<td>92.6</td>
<td>92.9</td>
<td>90.8</td>
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</tr>
<tr>
<td>31 days</td>
<td>98.6</td>
<td>97.1</td>
<td>100</td>
<td>92.6</td>
<td>97.2</td>
<td>97.1</td>
<td>97.1</td>
<td>94.3</td>
<td>95.8</td>
<td>96.1</td>
<td>96.7</td>
</tr>
<tr>
<td>62 days</td>
<td>93.1</td>
<td>83.8</td>
<td>69.7</td>
<td>73.5</td>
<td>82.9</td>
<td>62.5</td>
<td>73.7</td>
<td>79.2</td>
<td>80.5</td>
<td>88.5</td>
<td>70.4</td>
</tr>
<tr>
<td>King’s: 62 day</td>
<td>77.3</td>
<td>91.1</td>
<td>84.6</td>
<td>90.6</td>
<td>83.7</td>
<td>86.8</td>
<td>85.8</td>
<td>80.1</td>
<td>81.7</td>
<td>85.8</td>
<td>75.1</td>
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<tr>
<td>GSTT: 62 day</td>
<td>65.3</td>
<td>75.1</td>
<td>62.4</td>
<td>68.3</td>
<td>68.4</td>
<td>65.6</td>
<td>66.7</td>
<td>63.9</td>
<td>69.8</td>
<td>71.1</td>
<td>62.3</td>
</tr>
</tbody>
</table>

Southwark CCG did not meet their trajectory of 85% for Cancer 62 Day performance in June 2017, attaining 72.2% (10 out of 36 patients breached).

A SEL cancer recovery plan has been developed to ensure that the SEL providers can improve performance and improve treatment times for tertiary referrals. KCH, GSTT, and LGT all submitted refreshed cancer performance trajectories to NHSE in June 2017 as part of the update to the SEL cancer delivery plan. The revised trajectories were formally signed off by regulators in August. As part of the SEL cancer delivery plan, bids to support short term cancer diagnostic performance improvement were also invited. As a result of this, KCH were allocated funding for additional Endoscopy capacity to support the Upper and Lower GI pathways, and LGT were allocated funding to support the implementation of straight to test for the Lung pathway. A bid was not submitted for GSTT as it was thought that improved diagnostic access in LGT and KCH would improve ITT times to GSTT.

Additional funding was made available to bid for by SEL STP from NHS England under STP Transformational Fund. Bids were submitted to NHSE in January 2017, focusing on key themes of early detection, stratified follow-up, and recovery packages. The Early Diagnosis Transformation bid has been approved, but confirmation of the value is awaited. The other two bids (Recovery Package and Stratified Follow up) which are London-wide are still waiting confirmation.

Southwark CCG met the 93% national 2WW standard for all cancers in June 2017, achieving 94.0%. As well as an improvement from 91.1% in May 2017, performance was also compliant with the 93.0% trajectory for June 2017.
Performance for LAS as a whole gradually improved throughout 16/17 and 17/18, though LAS has highlighted performance issues due to significant demand pressures, where call volumes are consistently high. The national standard is for Category A calls to be responded to within 8 minutes, 75% of the time. Whilst LAS as a whole performed at between 62% and 68% during 16/17 this has improved to around 73% in 17/18, and Southwark’s performance has consistently been above the 75% standard.

Handover delays have improved dramatically in the sector with 5 Trusts in the South East at their lowest average handover times ever recorded. Denmark Hill is the only Trust to show an increase in handover time. KCH have implemented a new RAT model to try and improve on this position.

Demand Management – SEL are taking forward demand management actions, looking at HCPs, Care homes and ACPs to try to reduce demand on the LAS in SEL over 2017/18. A quarterly SEL wide Demand Management group has been set up which has tasked local A&E delivery boards with progressing actions in these areas.

Pan London Category A&C activity up to month 2 was 5% above contract baseline. SEL was 3.3% above baseline. However, there was a large disparity between category C and A activity with a 3.7% reduction in category C and a 12% increase in category A.
## Improving Access to Psychological Therapies (IAPT)

### Monthly 1st contacts to equal 15% trajectory

<table>
<thead>
<tr>
<th>Month</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
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<th>Apr</th>
<th>May</th>
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<tbody>
<tr>
<td>1st contacts</td>
<td>524</td>
<td>524</td>
<td>524</td>
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<td>524</td>
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<td>524</td>
<td>524</td>
<td>524</td>
<td>587</td>
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</table>

### Number of first contacts*

<table>
<thead>
<tr>
<th>Month</th>
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<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
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<th>Apr</th>
<th>May</th>
<th>Jun</th>
</tr>
</thead>
<tbody>
<tr>
<td>First contacts</td>
<td>432</td>
<td>660</td>
<td>392</td>
<td>428</td>
<td>779</td>
<td>444</td>
<td>423</td>
<td>378</td>
<td>722</td>
<td>637</td>
<td>716</td>
<td>552</td>
<td>584</td>
<td>601</td>
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</table>

### Recovery rate (target 50%) – Local data (corrected)

<table>
<thead>
<tr>
<th>Month</th>
<th>May</th>
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<th>Jun</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recovery rate</td>
<td>38%</td>
<td>35%</td>
<td>39%</td>
<td>42%</td>
<td>41%</td>
<td>44%</td>
<td>45%</td>
<td>47%</td>
<td>43%</td>
<td>48%</td>
<td>51%</td>
<td>47%</td>
<td>42%</td>
<td>42%</td>
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</table>

### Published Recovery Rate

<table>
<thead>
<tr>
<th>Month</th>
<th>May</th>
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<th>Apr</th>
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<th>Jun</th>
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<tbody>
<tr>
<td>Published Recovery Rate</td>
<td>39%</td>
<td>34%</td>
<td>37%</td>
<td>39%</td>
<td>38%</td>
<td>38%</td>
<td>44%</td>
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<td>36%</td>
<td>45%</td>
<td>50%</td>
<td>46%</td>
<td>tbc</td>
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### DATA AND NHSI SUPPORT UPDATE:

The reasons for the discrepancy between national published data and locally reported data was found to be because some patients who were signposted to different services after assessment are being counted as ‘not recovered’ when closed on the system, despite not starting IAPT treatment. This error is rectified in local data, but had not been rectified in the national data set submission. The CCG requested the NHSI IAPT intensive support team look at the issue in detail during a site visit in May 2017 to provide assurance on this issue and to explore if backdated changes could be made to national data. The nature of the error was discussed and recommendations were for improving data quality, but NHSI advised that backdating of the data is not an option as this would require backdated adjustments to clinical records.

The NHSI support team will provide a wider diagnostic review of the service to provide assurance that the current service model will enable targets to be met in 2017/18 and beyond. This will take place on 17/18 August 2017, and NHSI will also offer support to implement any recommendations from the review. NHSI will consider the current service model and the balance between IAPT Steps 2/3 and 4. The service caters for more higher needs patients than a standard IAPT service model, where Step 4 patients are likely to be treated in more intensive therapy services. This issue and its impact on targets will be a focus of the review which will lead to a revised recovery plan for the service. The reasons for the current decrease in recovery rate will also be considered.
Dementia Diagnosis Rate

2016/17 estimated prevalence = 1,499 (65+)

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</thead>
<tbody>
<tr>
<td>Trajectory – diagnoses</td>
<td>1000</td>
<td>1000</td>
<td>1000</td>
<td>1000</td>
<td>1000</td>
<td>1000</td>
<td>1000</td>
<td>1000</td>
<td>1010</td>
<td>1010</td>
<td>1010</td>
<td>1010</td>
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</tr>
<tr>
<td>Actual number diagnosed</td>
<td>1,166</td>
<td>1,183</td>
<td>1,187</td>
<td>1,182</td>
<td>1,188</td>
<td>1,185</td>
<td>1,183</td>
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<td>1,156</td>
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<tr>
<td>Trajectory - % diagnosed</td>
<td>67.0</td>
<td>67.0</td>
<td>67.0</td>
<td>67.0</td>
<td>67.0</td>
<td>67.0</td>
<td>67.0</td>
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<td>67.0</td>
<td>67.0</td>
<td>67.0</td>
</tr>
<tr>
<td>Actual % diagnosed</td>
<td>77.8</td>
<td>78.9</td>
<td>79.2</td>
<td>78.8</td>
<td>79.2</td>
<td>79.0</td>
<td>78.9</td>
<td>78.0</td>
<td>77.9</td>
<td>76.9</td>
<td>76.7</td>
<td>76.2</td>
<td>75.7</td>
</tr>
</tbody>
</table>

Data extracted from HSCIC monthly dementia registers publication. Green = above target; Amber = <1% below target; Red = >1% below target.

Reported Performance Position

In July 2017, there were 1,149 patients (65+) on dementia practice registers which means the CCG is exceeding the national two thirds diagnosis target and is performing at a rate of 75.7% with a gap of an additional 368 people who could benefit from diagnosis.
Supplementary metrics

Page 22: Mental Health CPA 7 day follow up on discharge
Page 23: Serious Incidents and Never Events
Page 24: MRSA and C Difficile
Page 25 - 26: Friends and Family Test
Page 27 - 28: Better care Fund Targets
## Mental health: Patients on CPA followed up within 7 days of discharge from psychiatric inpatient care 2015/16 – target 95%

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Number of patients on CPA who were followed up within 7 days after discharge from psychiatric inpatient care</th>
<th>Total number of patients on CPA discharged from psychiatric inpatient care</th>
<th>Proportion of patients on CPA who were followed up within 7 days after discharge from psychiatric inpatient care (Southwark)</th>
<th>London benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>15/16 Q1</td>
<td>75</td>
<td>77</td>
<td>97.4%</td>
<td>96.9%</td>
</tr>
<tr>
<td>15/16 Q2</td>
<td>80</td>
<td>80</td>
<td>100.0%</td>
<td>97.4%</td>
</tr>
<tr>
<td>15/16 Q3</td>
<td>104</td>
<td>106</td>
<td>98.1%</td>
<td>97.8%</td>
</tr>
<tr>
<td>15/16 Q4</td>
<td>82</td>
<td>88</td>
<td>93.2%</td>
<td>97.1%</td>
</tr>
<tr>
<td>16/17 Q1</td>
<td>86</td>
<td>89</td>
<td>96.6%</td>
<td>97.0%</td>
</tr>
<tr>
<td>16/17 Q2</td>
<td>97</td>
<td>101</td>
<td>96.0%</td>
<td>97.0%</td>
</tr>
<tr>
<td>16/17 Q3</td>
<td>97</td>
<td>101</td>
<td>96.0%</td>
<td>96.7%</td>
</tr>
<tr>
<td>16/17 Q4</td>
<td>88</td>
<td>92</td>
<td>95.7%</td>
<td>97.0%</td>
</tr>
<tr>
<td>17/18 Q1</td>
<td>81</td>
<td>83</td>
<td>97.6%</td>
<td>96.6%</td>
</tr>
</tbody>
</table>
The data represents when serious incidents (SIs) were reported to commissioners, not when they actually occurred. There were no Never Events reported in July.

London Ambulance Service (LAS) monthly SI figures will be provided during 2017/18. Due to reporting timeframes, these are sometimes in arrears of two months. The reports do not always say which borough the SIs refer to.

KCH reported six SIs at Denmark Hill in July 2017, one involved a Southwark resident. 15 SIs were notified at the PRUH. SIs logged at the PRUH are reviewed and assured by NHS Bromley CCG. The Southwark CCG Quality Team actively manage the assurance process to ensure robustness of investigations, action plans and implementation of lessons learnt.

GSTT reported seven SIs in July, none of which involved a Southwark resident. Southwark CCG support the lead commissioner, Lambeth CCG, in management of SIs at GSTT.

SLaM reported a total of 14 in July, one of which affected Southwark residents. All incidents are assessed case by case on level of significant harm outcome and significance for learning.
### Healthcare Acquired Infections – MRSA / c.difficile

<table>
<thead>
<tr>
<th>C Diff</th>
<th>April</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
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<td>SCCG</td>
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</table>

**C Diff target is 45 for 17/18. The CCG is met this target exactly in 2016-17.**

9 cases of C dif have been identified YTD. This is below the trajectory of 11 to the end of month 3 and therefore the target is being achieved.

Of the 7 cases in June, 4 were assigned to acute (Bart’s:1; KCH:3) and 3 to non acute (GST:1; KCH:2).
## Friends & Family Test response rates and recommendation

### A&E – patient response rate

<table>
<thead>
<tr>
<th></th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
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<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
</tr>
</thead>
<tbody>
<tr>
<td>Den. Hill</td>
<td>9%</td>
<td>10%</td>
<td>12%</td>
<td>6%</td>
<td>6%</td>
<td>3%</td>
<td>3%</td>
<td>4%</td>
<td>4%</td>
<td>5%</td>
<td>6%</td>
<td>5%</td>
<td>4%</td>
</tr>
<tr>
<td>GSTT</td>
<td>18%</td>
<td>18%</td>
<td>15%</td>
<td>14%</td>
<td>13%</td>
<td>14%</td>
<td>20%</td>
<td>21%</td>
<td>14%</td>
<td>18%</td>
<td>19%</td>
<td>26%</td>
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</table>

### Inpatients - patient response rate

<table>
<thead>
<tr>
<th></th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
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<tbody>
<tr>
<td>Den. Hill</td>
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<td>19%</td>
<td>22%</td>
<td>21%</td>
</tr>
<tr>
<td>GSTT</td>
<td>26%</td>
<td>26%</td>
<td>25%</td>
<td>26%</td>
<td>24%</td>
<td>23%</td>
<td>19%</td>
<td>22%</td>
<td>21%</td>
<td>19%</td>
<td>19%</td>
<td>18%</td>
<td>21%</td>
</tr>
</tbody>
</table>

### A&E - % recommending care

<table>
<thead>
<tr>
<th></th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
</tr>
</thead>
<tbody>
<tr>
<td>Den. Hill</td>
<td>69%</td>
<td>75%</td>
<td>79%</td>
<td>76%</td>
<td>84%</td>
<td>68%</td>
<td>71%</td>
<td>74%</td>
<td>85%</td>
<td>77%</td>
<td>70%</td>
<td>77%</td>
<td>82%</td>
</tr>
<tr>
<td>GSTT</td>
<td>86%</td>
<td>84%</td>
<td>84%</td>
<td>84%</td>
<td>84%</td>
<td>84%</td>
<td>87%</td>
<td>87%</td>
<td>87%</td>
<td>84%</td>
<td>84%</td>
<td>81%</td>
<td>84%</td>
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</table>

### Inpatients - % recommending care (no target)

<table>
<thead>
<tr>
<th></th>
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<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
</tr>
</thead>
<tbody>
<tr>
<td>Den. Hill</td>
<td>95%</td>
<td>95%</td>
<td>92%</td>
<td>93%</td>
<td>94%</td>
<td>96%</td>
<td>97%</td>
<td>94%</td>
<td>92%</td>
<td>93%</td>
<td>93%</td>
<td>92%</td>
<td>95%</td>
</tr>
<tr>
<td>GSTT</td>
<td>97%</td>
<td>96%</td>
<td>97%</td>
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<td>97%</td>
<td>97%</td>
<td>96%</td>
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</tbody>
</table>

In June the London average A&E recommendation was 86% (on an average response rate of 15%). Both trusts were below this figure in May 2017. The London average inpatient recommendation was 95% (on an average response rate of 28%). Both trusts were in line with this.
The ‘Work’ question asks how likely staff would be to recommend the NHS service they work in to friends and family as a place to work. The ‘Care’ question asks how likely staff are to recommend the NHS services they work in to friends and family who need similar treatment or care.

<table>
<thead>
<tr>
<th></th>
<th>2015/16</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>KCH 2015/16</td>
<td>48%</td>
<td></td>
</tr>
<tr>
<td>GSTT</td>
<td>79%</td>
<td>78%</td>
</tr>
<tr>
<td>SLaM</td>
<td>63%</td>
<td>66%</td>
</tr>
<tr>
<td>London</td>
<td>62%</td>
<td>63%</td>
</tr>
</tbody>
</table>

**Recommended – to work at**

<table>
<thead>
<tr>
<th></th>
<th>Q4 2015/16</th>
<th>Q1 2016/17</th>
<th>Q2 2016/17</th>
<th>Q3 2016/17</th>
<th>Q4 2016/17</th>
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<tr>
<td>KCH</td>
<td>48%</td>
<td>42%</td>
<td>48%</td>
<td></td>
<td>41%</td>
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<tr>
<td>GSTT</td>
<td></td>
<td>78%</td>
<td>75%</td>
<td></td>
<td>78%</td>
</tr>
<tr>
<td>SLaM</td>
<td>63%</td>
<td>66%</td>
<td>63%</td>
<td></td>
<td>64%</td>
</tr>
<tr>
<td>London</td>
<td>62%</td>
<td>63%</td>
<td>63%</td>
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<td>64%</td>
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</table>

Staff FFT not conducted in Q3 because the NHS Staff Survey takes place.

<table>
<thead>
<tr>
<th></th>
<th>2015/16</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>KCH 2015/16</td>
<td>78%</td>
<td>68%</td>
</tr>
<tr>
<td>GSTT</td>
<td>79%</td>
<td>94%</td>
</tr>
<tr>
<td>SLaM</td>
<td>71%</td>
<td>74%</td>
</tr>
<tr>
<td>London</td>
<td>76%</td>
<td>78%</td>
</tr>
</tbody>
</table>

**Recommended – to get care at**

<table>
<thead>
<tr>
<th></th>
<th>Q4 2015/16</th>
<th>Q1 2016/17</th>
<th>Q2 2016/17</th>
<th>Q3 2016/17</th>
<th>Q4 2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>KCH</td>
<td>78%</td>
<td>68%</td>
<td>82%</td>
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<td>67%</td>
</tr>
<tr>
<td>GSTT</td>
<td>79%</td>
<td>94%</td>
<td>94%</td>
<td></td>
<td>93%</td>
</tr>
<tr>
<td>SLaM</td>
<td>71%</td>
<td>74%</td>
<td>72%</td>
<td></td>
<td>75%</td>
</tr>
<tr>
<td>London</td>
<td>76%</td>
<td>78%</td>
<td>78%</td>
<td></td>
<td>77%</td>
</tr>
</tbody>
</table>

Staff FFT not conducted in Q3 because the NHS Staff Survey takes place.

**Note:** Response rate staff Q4: Kings 3.5% (down from 4.2% in Q2 but up from 1.3% in Q1). GST 7.3% (up from 5.5% in Q2), SLaM: 22.4%, London average 8.5%
Better Care Fund indicators

Delayed transfers of care – Delayed transfers of care from hospital (delayed bed days, Southwark residents)

<table>
<thead>
<tr>
<th></th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delayed transfers</td>
<td>319</td>
<td>360</td>
<td>306</td>
<td>372</td>
<td>321</td>
<td>409</td>
<td>446</td>
<td>482</td>
<td>604</td>
<td>491</td>
<td>527</td>
<td>530</td>
<td>473</td>
<td>474</td>
</tr>
</tbody>
</table>

Delayed transfers and implementation of the 8 high impact changes model are a key features of the recently issued BCF guidance which had been delayed since November. Plans are to be submitted by 11th September.

Targets for 2017/18 are in the process of being reset in the BCF national planning process. There will be a requirement for a separate target for council attributed delays and NHS delays as well as total days. The target being proposed for Southwark to contribute to the national target is equivalent to 439 delays in a month, of which social care delays would be no more than 196. In May there were 474 delayed days, of which 132 were social care delays. Overall there were 136 delays at SLAM, 145 at GSTT and 114 at Kings.

Care home admissions – Permanent admissions of older people (aged 65+) to residential/nursing care homes

<table>
<thead>
<tr>
<th></th>
<th>Mar</th>
<th>April</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
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</thead>
<tbody>
<tr>
<td>Target</td>
<td>13</td>
<td>13</td>
<td>13</td>
<td>13</td>
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<td>13</td>
<td>13</td>
<td>13</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>Admissions</td>
<td>8</td>
<td>14</td>
<td>11</td>
<td>9</td>
<td>10</td>
<td>11</td>
<td>13</td>
<td>6</td>
<td>13</td>
<td>14</td>
<td>7</td>
<td>12</td>
<td>4</td>
</tr>
</tbody>
</table>

• The 201617 target for new permanent care home admissions for older people was hit, with 124 admissions compared to the target of 155.
Better Care Fund indicators

Non elective admissions (CCG)

<table>
<thead>
<tr>
<th>Non-elective admissions</th>
<th>July</th>
<th>Aug</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan YTD</td>
<td>8040</td>
<td>10050</td>
<td>12060</td>
<td>14070</td>
<td>16080</td>
<td>18090</td>
<td>20100</td>
<td>22110</td>
<td>24117</td>
<td>1928</td>
</tr>
<tr>
<td>Actual YTD</td>
<td>8104</td>
<td>10061</td>
<td>12123</td>
<td>14107</td>
<td>16114</td>
<td>18233</td>
<td>20343</td>
<td>22139</td>
<td>24335</td>
<td>1842</td>
</tr>
<tr>
<td>Variance</td>
<td>64</td>
<td>11</td>
<td>63</td>
<td>37</td>
<td>34</td>
<td>143</td>
<td>243</td>
<td>29</td>
<td>218</td>
<td>-86</td>
</tr>
<tr>
<td>% variance year to date</td>
<td>0.8%</td>
<td>0.1%</td>
<td>0.5%</td>
<td>0.3%</td>
<td>0.2%</td>
<td>0.8%</td>
<td>1.2%</td>
<td>0.1%</td>
<td>0.9%</td>
<td>-4.5%</td>
</tr>
</tbody>
</table>

• The BCF is monitored against overall CCG Operating Plan non-elective trajectories for non-elective admissions agreed with NHSE, which allowed for 2.7% growth in 2016/17. The year end position shows that this target was overshot by less than 1%. Note: NHSE will provide an estimate based on resident rather than registered population which will be the published performance.

Reablement (% still at home 91 days after receiving reablement/rehab on discharge from hospital) (no update this month)

• The data for reablement relates to outcomes after 91 days for people discharged into reablement services. This shows an unexpected drop to 83.3% in Q4 against target of 90.5% (compared to Q2 and Q3 figures of 92% and 89% respectively). The average across the full year was 88.8%. Analysis of the reasons for the unexpected, sharp drop in Q4 has been undertaken and a key factor is an unexpected spike in the numbers of patients who died within 91 days. This has been linked to people with higher intensity needs coming into the service.

GP Survey data – people feeling supported to manage long term conditions (updated this month)

• Last published data (July 17) shows a decrease to 56.2% (from last year’s figure of 59.7%) and is below the London average of 58.1%. This remains below the stretch target of 60% which was based on an ambition to achieve top quartile in London. A benchmarking chart is show overleaf.

Local measure on patient experience of integrated care (no update this month)

• Local areas were required under the BCF to develop a local measure on service user experience of integrated care. In Southwark it was agreed to add a local question to the annual adult social care user survey targeted at people receiving health and social care services. “Do all the people treating and caring for you work well together to give you the best possible care and support?”. Two years data are now available on this. In the 2016 survey 81% said yes (419 responses, excluding don’t knows). In 2015 the figure was 78%, hence a measurable improvement has been achieved.
Better Care Fund indicators

In last 6 months, had enough support from local services or organisations to help manage long-term health condition(s) BCF target GP survey (16/17 published Jul 17)

target 60%  n=1485

56.2%
Quality Premium and Improvement and Assessment Framework

Page 31: Better Health
Page 32 - 33: Better Care
Page 34: Sustainability
Page 35: Leadership
Page 36 - 37: Quality Premium
<table>
<thead>
<tr>
<th>Indicator name</th>
<th>Frequency of reporting</th>
<th>Baseline</th>
<th>Time period</th>
<th>Current performance</th>
<th>Trend</th>
<th>Lead</th>
<th>Meetings providing additional oversight</th>
</tr>
</thead>
<tbody>
<tr>
<td>101a. Smoking: maternal smoking at delivery</td>
<td>Quarterly</td>
<td>2.9%</td>
<td>Q4 2016/17</td>
<td>3.5%</td>
<td>↑</td>
<td>CG</td>
<td>Council Healthy Weight Steering Group Children and Young People CDG Health and Wellbeing Board</td>
</tr>
<tr>
<td>102a. Child Obesity: Percentage of children aged 10-11 classified as overweight or obese</td>
<td>Annual</td>
<td>43.2%</td>
<td>2015/16</td>
<td>42.7%</td>
<td>↓</td>
<td>CG</td>
<td>Council Healthy Weight Steering Group Children and Young People CDG Health and Wellbeing Board</td>
</tr>
<tr>
<td>103a. Diabetes: Patients who have achieved all NICE recommended targets</td>
<td>Annual</td>
<td></td>
<td>2015/16</td>
<td>37.0%</td>
<td></td>
<td>CG</td>
<td></td>
</tr>
<tr>
<td>103b. Diabetes: People with diabetes diagnosed less than a year who attend structured education course</td>
<td>Annual</td>
<td></td>
<td>2015/16</td>
<td></td>
<td></td>
<td>CG</td>
<td></td>
</tr>
<tr>
<td>104a. Falls: injuries from falls in people aged 65 and over (Emergency admissions per 100,000 population)</td>
<td>Annual</td>
<td></td>
<td>2015/16</td>
<td></td>
<td></td>
<td>CG</td>
<td>Adults commissioning development group</td>
</tr>
<tr>
<td>105a. Personalisation and choice: utilisation of the NHS e-referral service to enable choice at first routine appointment</td>
<td>Monthly</td>
<td>27.8%</td>
<td>June 2017</td>
<td>27.6%</td>
<td></td>
<td>MH</td>
<td>Planned care programme board South East London – Local digital road map</td>
</tr>
<tr>
<td>105b. Personalisation and choice: Personal Health budgets per 100,000</td>
<td>Quarterly</td>
<td>6.3</td>
<td>Q4 2016/17</td>
<td>7.0</td>
<td></td>
<td>KMB</td>
<td>Adults commissioning development group</td>
</tr>
<tr>
<td>105c. Personalisation and choice: Percentage of deaths in hospital (annual rolling)</td>
<td>Quarterly</td>
<td>53.8%</td>
<td>Q3 2016/17</td>
<td>51.6%</td>
<td>↓</td>
<td>KMB</td>
<td>End of life care strategy group/Adults commissioning development group</td>
</tr>
<tr>
<td>105d. Personalisation and choice: People feeling supported to manage their long term conditions</td>
<td>Annual</td>
<td>54.4%</td>
<td>2015/16</td>
<td>57.6%</td>
<td>↑</td>
<td>MK</td>
<td>Primary care programme board</td>
</tr>
<tr>
<td>106a. Inequality in unplanned hospitalisation for chronic ACS conditions</td>
<td>Quarterly</td>
<td>1149</td>
<td>Q3 2016/17</td>
<td>1134</td>
<td></td>
<td>CG/ICDT</td>
<td>Adults commissioning development group</td>
</tr>
<tr>
<td>106b. Inequality in emergency admissions for urgent care sensitive conditions</td>
<td>Quarterly</td>
<td>2004</td>
<td>Q3 2016/17</td>
<td>1857</td>
<td>↓</td>
<td>CG/ICDT</td>
<td>Adults commissioning development group</td>
</tr>
<tr>
<td>107a. Anti-microbial resistance: appropriate prescribing of antibiotics in primary care</td>
<td>Quarterly</td>
<td>0.793</td>
<td>FY 2016/17</td>
<td>0.756</td>
<td>↓</td>
<td>KMB</td>
<td>Meds management committee</td>
</tr>
<tr>
<td>107b. Anti-microbial resistance: appropriate prescribing of broad spectrum antibiotics in primary care</td>
<td>Quarterly</td>
<td>10.9</td>
<td>FY 2016/17</td>
<td>8.2</td>
<td>↓</td>
<td>KMB</td>
<td>Meds management committee</td>
</tr>
<tr>
<td>108a. Carers: Quality of Life (The directly standardised average health status (EQ-5D™))</td>
<td>Annual</td>
<td>79.7%</td>
<td>2015/16</td>
<td>77.6%</td>
<td>↓</td>
<td>KMB</td>
<td></td>
</tr>
<tr>
<td>Indicator name</td>
<td>Frequency of reporting</td>
<td>Baseline</td>
<td>Time period</td>
<td>Current performance</td>
<td>Trend</td>
<td>Lead</td>
<td>Meetings providing additional oversight</td>
</tr>
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<tr>
<td>121a High quality care - Acute</td>
<td>Quarterly</td>
<td></td>
<td>Q4 16/17</td>
<td>61</td>
<td></td>
<td>KMB</td>
<td>Quality and safety sub-committee</td>
</tr>
<tr>
<td>121b High quality care – Primary care</td>
<td>Quarterly</td>
<td></td>
<td>Q4 16/17</td>
<td>58</td>
<td></td>
<td>KMB</td>
<td>Quality and safety sub-committee/ Primary Care Commissioning Committee</td>
</tr>
<tr>
<td>121c High quality care – Social Care</td>
<td>Quarterly</td>
<td></td>
<td>Q4 16/17</td>
<td>64</td>
<td></td>
<td>KMB</td>
<td>Adult safeguarding board</td>
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<tr>
<td><strong>Cancer</strong></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>122a Cancers diagnosed at early stages</td>
<td>Annual</td>
<td>50.6</td>
<td>2015</td>
<td>52.4</td>
<td></td>
<td>CG</td>
<td>Cancer Locality Group</td>
</tr>
<tr>
<td>122b 62 days waits</td>
<td>Quarterly</td>
<td>83.3</td>
<td>May 2017</td>
<td>72.2</td>
<td>↓</td>
<td>CG</td>
<td>Cancer Locality Group Cancer 62 Day Review Group</td>
</tr>
<tr>
<td>122c One year survival rates for all cancers</td>
<td>Annual</td>
<td>68.9</td>
<td>2014</td>
<td>70.3</td>
<td>↑</td>
<td>CG</td>
<td>Cancer Locality Group</td>
</tr>
<tr>
<td>122d Cancer patient experience</td>
<td>Annual</td>
<td>8.3</td>
<td>2016</td>
<td>8.6</td>
<td>↑</td>
<td>CG</td>
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</tr>
<tr>
<td><strong>Mental Health</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>123a IAPT recovery rate</td>
<td>Monthly</td>
<td>38%</td>
<td>July 2017</td>
<td>42%</td>
<td></td>
<td>CG</td>
<td>IAPT Monthly Contract meetings</td>
</tr>
<tr>
<td>123b Early access to psychosis treatment standard</td>
<td>Monthly</td>
<td>28.6%</td>
<td>May 2017</td>
<td>50%</td>
<td>↑</td>
<td>CG</td>
<td>CCG Monthly Contract monitoring meeting 4 borough commissioner’s group meeting</td>
</tr>
<tr>
<td>123c Children and young people’s mental health services transformation</td>
<td>Quarterly/TBC</td>
<td></td>
<td>Q4 2016/17</td>
<td>90%</td>
<td></td>
<td>CG</td>
<td>CYP Transformation board CYP Commissioning Development Group</td>
</tr>
<tr>
<td>123d Crisis care and liaison mental health services transformation</td>
<td>Quarterly/TBC</td>
<td>TBC</td>
<td>Q4 2016/17</td>
<td>72.5%</td>
<td></td>
<td>CG</td>
<td>A&amp;E Delivery Board/ Working Group CCG Monthly Contract meetings with SLAM</td>
</tr>
<tr>
<td>123e Out of area placements for acute mental health inpatient care – transformation</td>
<td>Quarterly/TBC</td>
<td>TBC</td>
<td>Q4 2016/17</td>
<td>100%</td>
<td></td>
<td>CG</td>
<td>CCG Monthly Contract monitoring meeting with SLAM Joint CCG/LA Panel meetings</td>
</tr>
<tr>
<td><strong>Learning Disability</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>124a Learning Disability: reliance on specialist inpatient care for people with a learning disability/autism</td>
<td>Quarterly</td>
<td>49 per million</td>
<td>Q2 2016/17</td>
<td>62 per million</td>
<td>↑</td>
<td>KMB</td>
<td>Transforming Care steering group</td>
</tr>
<tr>
<td>124b Learning Disability: proportion of people with a learning disability receiving an annual health check</td>
<td>Annual</td>
<td>31%</td>
<td>Mar 2017</td>
<td>50%</td>
<td>↑</td>
<td>KMB</td>
<td></td>
</tr>
<tr>
<td><strong>Maternity</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>125a Neonatal mortality and still births (per 1,000 births)</td>
<td>Annual</td>
<td>7.5</td>
<td>2015</td>
<td>8.2</td>
<td>↑</td>
<td>CG</td>
<td>CQRG</td>
</tr>
<tr>
<td>125b Women’s experience of maternity services</td>
<td>3 yearly</td>
<td>81.1</td>
<td></td>
<td></td>
<td></td>
<td>CG</td>
<td>CQRG</td>
</tr>
<tr>
<td>125c Choices in maternity services</td>
<td>Annual</td>
<td>69.5</td>
<td></td>
<td></td>
<td></td>
<td>CG</td>
<td></td>
</tr>
</tbody>
</table>
## Better Care (2 of 2)

<table>
<thead>
<tr>
<th>Indicator name</th>
<th>Frequency of reporting</th>
<th>Baseline</th>
<th>Time period</th>
<th>Current performance</th>
<th>Trend</th>
<th>Lead</th>
<th>Meetings providing additional oversight</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dementia</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>126a Estimated diagnosis rate for people with dementia</td>
<td>Monthly</td>
<td>76.3%</td>
<td>Jun 2017</td>
<td>76.2%</td>
<td></td>
<td>CG</td>
<td>Adult Commission Development Group</td>
</tr>
<tr>
<td>126b Dementia care planning and post-diagnostic support</td>
<td>Annual</td>
<td>76.3%</td>
<td>2015/16</td>
<td>80.7%</td>
<td>↑</td>
<td>CG</td>
<td>4 Boroughs Redesign Group / Adult Commission Development Group</td>
</tr>
<tr>
<td><strong>Urgent and emergency care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>127a Achievement of milestones in the delivery of an integrated urgent care service. Eight milestones in total to be achieved</td>
<td>Quarterly</td>
<td></td>
<td>Apr 2017</td>
<td>6/8</td>
<td></td>
<td>CG</td>
<td>111 Programme Board</td>
</tr>
<tr>
<td>127b Emergency admissions for urgent care sensitive conditions per 100,000 registered patients</td>
<td>Quarterly</td>
<td>2834</td>
<td>Q3 2016/17</td>
<td>2829</td>
<td></td>
<td>CG</td>
<td>A&amp;E Delivery Board/ Strategic Contract Meeting</td>
</tr>
<tr>
<td>127c Percentage of patients admitted, transferred or discharged from A&amp;E within 4 hours</td>
<td>Monthly</td>
<td>83.5%</td>
<td>Jun 2017</td>
<td>87.8%</td>
<td>↑</td>
<td>CG</td>
<td>A&amp;E Delivery Board/ Health and Wellbeing Board</td>
</tr>
<tr>
<td>127d Ambulance waits</td>
<td>Monthly</td>
<td>70.0%</td>
<td>Jun 2017</td>
<td>75.6%</td>
<td>↑</td>
<td>CG</td>
<td>A&amp;E Delivery Board</td>
</tr>
<tr>
<td>127e Delayed transfers of care attributable to the NHS per 100,000 population</td>
<td>Quarterly</td>
<td>4.4</td>
<td>Mar 2017</td>
<td>6.7</td>
<td>↑</td>
<td>CG</td>
<td>Health and Social Care Partnership Board A&amp;E Delivery Board Health and Wellbeing Board</td>
</tr>
<tr>
<td>127f Population use of hospital beds following emergency admission (total length of episodes per 1000 population)</td>
<td>Quarterly</td>
<td>533.4</td>
<td>Q3 2016/17</td>
<td>508.4</td>
<td>↓</td>
<td>CG</td>
<td>Strategic Partnership A&amp;E Delivery Board Emergency Care Board Contract Monitoring Board</td>
</tr>
<tr>
<td><strong>Primary medical services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>128a Management of long term conditions: emergency admissions chronic ambulatory care sensitive conditions per 100,000 registered population</td>
<td>Quarterly</td>
<td>1111</td>
<td>Q3 2016/17</td>
<td>1309</td>
<td>↑</td>
<td>CG/ICDT</td>
<td>Local Care Networks</td>
</tr>
<tr>
<td>128b Patient experience of GP services</td>
<td>6 monthly</td>
<td>78.6%</td>
<td>March 2017</td>
<td>79.2%</td>
<td>↑</td>
<td>CG</td>
<td>Primary Care Commissioning Committee</td>
</tr>
<tr>
<td>128c Primary care access</td>
<td>Bi Annual</td>
<td>TBC</td>
<td>March 2017</td>
<td>80.5%</td>
<td></td>
<td>CG</td>
<td>Primary Care Commissioning Committee</td>
</tr>
<tr>
<td>128d Primary care workforce (GP/PN WTE per 1,000 patients)</td>
<td>TBC</td>
<td>0.81</td>
<td>H1 2016</td>
<td>0.9</td>
<td>↑</td>
<td>KMB</td>
<td>Primary Care Commissioning Committee</td>
</tr>
<tr>
<td>129a Elective access: patients waiting 18 weeks or less from referral to hospital treatment</td>
<td>Monthly</td>
<td>84.7%</td>
<td>Jun 2017</td>
<td>82.8%</td>
<td>↓</td>
<td>CG</td>
<td>SEL A&amp;E delivery Board and Oversight Group</td>
</tr>
<tr>
<td>130a 7 day services: achievement of clinical standards in the delivery of 7 day services</td>
<td>TBC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>CG</td>
<td>SEL A&amp;E delivery Board and Oversight Group</td>
</tr>
<tr>
<td>131a NHS continuing care: People eligible for NHS Continuing Healthcare per 50,000 population</td>
<td>Quarterly</td>
<td>23.2</td>
<td>Q3 2016/17</td>
<td>22.6</td>
<td>↓</td>
<td>KMB</td>
<td>NHS Continuing Care discharge to assess board</td>
</tr>
<tr>
<td>Indicator name</td>
<td>Planned frequency of reporting</td>
<td>Baseline</td>
<td>Time period</td>
<td>Current performance</td>
<td>Trend</td>
<td>Lead</td>
<td>Meetings providing additional oversight</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------</td>
<td>--------------------------------</td>
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<td>-------------</td>
<td>---------------------</td>
<td>-------</td>
<td>-------------------------------</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td>141a. Financial sustainability</td>
<td>Annual</td>
<td>2016</td>
<td></td>
<td>MH</td>
<td></td>
<td>IGP</td>
<td></td>
</tr>
<tr>
<td>141b. In-year financial performance</td>
<td>Quarterly</td>
<td>Q4 2016/17</td>
<td></td>
<td>MH</td>
<td></td>
<td>IGP/Audit Committee</td>
<td></td>
</tr>
<tr>
<td>142a. Allocative efficiency: outcomes in areas with identified scope for improvement</td>
<td>TBC</td>
<td>TBC</td>
<td></td>
<td>MH</td>
<td></td>
<td>Commission development groups</td>
<td>L&amp;S QIPP Group Swk QIPP Group</td>
</tr>
<tr>
<td>142b. Allocative efficiency: Expenditure in areas with identified scope for improvement</td>
<td>TBC</td>
<td>TBC</td>
<td></td>
<td>MH</td>
<td></td>
<td>L&amp;S QIPP Group SWK QIPP Group</td>
<td></td>
</tr>
<tr>
<td>143a. New models of care: adoption</td>
<td>Annual</td>
<td>2016</td>
<td></td>
<td>MH</td>
<td></td>
<td>Strategic Partnership</td>
<td></td>
</tr>
<tr>
<td>144a. Paper free at point of care: local digital roadmap in place</td>
<td>Annual</td>
<td>TBC</td>
<td>Q3 2016/17</td>
<td>YES</td>
<td></td>
<td>MH</td>
<td>South East London Digital Road Map</td>
</tr>
<tr>
<td>144b. Digital interactions between primary and secondary care</td>
<td>Quarterly</td>
<td>61.2%</td>
<td>Q4 2016/17</td>
<td>61.0%</td>
<td></td>
<td>MH</td>
<td>South East London Digital Road Map</td>
</tr>
<tr>
<td>145a. Estates Strategy: Local Strategic Estates Plan (SEP) in place</td>
<td>Annual</td>
<td>YES</td>
<td>16/17</td>
<td>YES</td>
<td></td>
<td>MH</td>
<td>Southwark Strategic Estates Group</td>
</tr>
<tr>
<td>Indicator name</td>
<td>Baseline</td>
<td>Time period</td>
<td>Current performance</td>
<td>Lead</td>
<td>Meetings providing additional oversight</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
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<td>---------------------</td>
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<td>------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>161a. Sustainability and Transformation Plan</td>
<td></td>
<td>16/17</td>
<td></td>
<td>ME</td>
<td>STP – Committee in Common</td>
<td></td>
<td></td>
</tr>
<tr>
<td>162a. Probity and corporate governance</td>
<td>Fully Compliant</td>
<td>Q4 16/17</td>
<td>Fully Compliant</td>
<td>MH</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>163a. Workforce engagement - Staff engagement index</td>
<td>3.93</td>
<td>2016</td>
<td>3.87</td>
<td>KMB</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>163b. Workforce engagement - Progress against workforce race equality standard</td>
<td>0.19</td>
<td>2016</td>
<td></td>
<td>MK</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>164a. Effectiveness of working relationships in the local system</td>
<td>75.1</td>
<td>16/17</td>
<td>78.8</td>
<td>CG</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>165a. Quality of CCG leadership</td>
<td></td>
<td>16/17</td>
<td></td>
<td>AB</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Quality Premium: 2017/18 (1 of 2)

<table>
<thead>
<tr>
<th>Quality Premium target</th>
<th>Target</th>
<th>Baseline</th>
<th>Current Performance</th>
<th>Proportion of QP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancers diagnosed at early stage</td>
<td>2016 plus 4%</td>
<td>46.7% (2014)</td>
<td>-</td>
<td>17%</td>
</tr>
<tr>
<td>Overall experience of making a GP appointment (GP survey)</td>
<td>Improve 3% point on July 17 data</td>
<td>Jan 66.5% (London 68%)</td>
<td>69% (July 2017)</td>
<td>17%</td>
</tr>
<tr>
<td>NHS Continuing Healthcare: NHS CHC eligibility decision is made by the CCG within 28 days from receipt of the Checklist (or other notification)</td>
<td>&gt;80%</td>
<td>100%</td>
<td>100% (Q1)</td>
<td>8.5%</td>
</tr>
<tr>
<td>NHS Continuing Healthcare: NHS CHC assessments take place in an acute hospital setting.</td>
<td>&lt;15%</td>
<td>78%</td>
<td>60% (Q1)</td>
<td>8.5%</td>
</tr>
<tr>
<td>Mental Health: Improve inequitable rates of access to Children &amp; Young People’s Mental Health Services</td>
<td>32% (1,984)</td>
<td>15.3% (950)</td>
<td>18.8% (1164)* (Q4)</td>
<td>17%</td>
</tr>
<tr>
<td>Atrial Fibrillation Reported Prevalence: Increase register size</td>
<td>2,372</td>
<td>2,262 (QOF 2015/16)</td>
<td>2341 (15/08/2017)</td>
<td>15%</td>
</tr>
</tbody>
</table>

* This is a proxy figure based on accepted referrals into CAMHS services for treatment. The exact definition is complex including a requirement that there has been two contacts, and cannot be derived locally yet. This is a national issue on which further guidance will be produced. The current guidance recognises it is an experimental measure that will be further developed. It is expected that there will be a national publication of this indicator produced by taking data from the National Mental Health minimum data set which will help clarify the definition and performance levels.
## Quality Premium: 2017/18 (2 of 2)

<table>
<thead>
<tr>
<th>Quality Premium target</th>
<th>Target</th>
<th>Baseline</th>
<th>Proportion of QP</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reducing gram negative blood stream infections (BSI) across the whole health economy: reduction in all E. coli BSI reported at CCG level based</td>
<td>158</td>
<td>176 (Jan – Dec 2016)</td>
<td>5.7%</td>
<td>Data collection on hold. Awaiting response from NHS England about PID issues</td>
</tr>
<tr>
<td>Reducing gram negative blood stream infections (BSI) across the whole health economy: Collection and reporting of a core primary care data set for all E. coli BSI in Q2-4 2017/18.</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
<td>Data collection on hold. Awaiting response from NHS England about PID issues</td>
</tr>
<tr>
<td>Reduction of inappropriate antibiotic prescribing for UTI in primary care: reduction in the Trimethoprim:Nitrofurantoin prescribing ratio based on CCG baseline data</td>
<td>1.081</td>
<td>1.201 (Jun 2015 – May 2016)</td>
<td>5.7%</td>
<td>Approx. 50% of practices are already achieving the national target</td>
</tr>
<tr>
<td>Reduction of inappropriate antibiotic prescribing for UTI in primary care: reduction in the number of trimethoprim items prescribed to patients aged 70 years or greater</td>
<td>1705</td>
<td>1894 (Jun 2015 – May 2016)</td>
<td>5.7%</td>
<td></td>
</tr>
<tr>
<td>Sustained reduction of inappropriate prescribing in primary care: items per STAR-PU must be equal to or below England 2013/14 mean performance value</td>
<td>1.161</td>
<td>0.756 (2016/17)</td>
<td>5.7%</td>
<td>CCG is currently meeting this indicator</td>
</tr>
</tbody>
</table>
CCG Finance Report 2017/18
Month 4
(Period to end of July 2017)

Integrated Governance & Performance Committee
24th August 2017
## Financial Performance Duties

<table>
<thead>
<tr>
<th>Duty</th>
<th>YTD Target</th>
<th>YTD Performance</th>
<th>RAG</th>
<th>Annual Target</th>
<th>Forecast Performance</th>
<th>RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achieve planned surplus (Expenditure not to exceed income)</td>
<td>£3,248k</td>
<td>£3,248k</td>
<td>✔</td>
<td>£9,743k</td>
<td>£9,743k</td>
<td>✔</td>
</tr>
<tr>
<td>Capital resource does not exceed the allowance</td>
<td>£0k</td>
<td>£0k</td>
<td>✔</td>
<td>£0k</td>
<td>£0k</td>
<td>✔</td>
</tr>
<tr>
<td>Revenue resource does not exceed the allowance</td>
<td>£151,947k</td>
<td>£148,699k</td>
<td>✔</td>
<td>£471,338k</td>
<td>£461,595k</td>
<td>✔</td>
</tr>
<tr>
<td>Capital Resource use on specified matters does not exceed the allowance</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Revenue resource use on specified matters does not exceed the allowance</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Revenue administration resource use does not exceed the allowance</td>
<td>£2,167k</td>
<td>£2,166k</td>
<td>✔</td>
<td>£6,500k</td>
<td>£6,500k</td>
<td>✔</td>
</tr>
</tbody>
</table>

### Notes:

1. The above duties correspond to those reported in Note 18 of the 2016/17 Annual accounts, and represent the statutory duties of NHS Southwark Clinical Commissioning Group (‘the CCG’).
2. The CCG is expecting to receive a capital allocation for IT in 2017/18, and as a result will also be bound by the additional financial duty relating to the capital resource.
3. To support the delivery of the above, an in-year QIPP programme of £12,393k has been established. QIPP monitoring information is included later in this report.

*Note: a red negative sign indicates budget overspend*
Summary of Position (1 of 2)

• The CCG was underspent at the end of Month 4 by £3,248k for the year to date (ytd). This is in line with plan at this point in the year.

• The CCG has needed to utilise £396k of reserves to achieve this ytd position. There are adverse variances on Acute, Client Groups, Primary health Care Services and Corporate, which are partially offset against a favourable variance against Prescribing.

• The CCG is forecasting to meet the annual target surplus of £9,743k. This is equivalent to the brought forward surplus from 2016/17, which has been returned to the CCG in the form of a non-recurrent allocation (increased by £150k in Month 3, due to the return of the full achievement in 2016/17 of £10,213k) in line with national process, less £700k planned drawdown of prior year historic surplus. The surplus has then been adjusted for a planned in-year increase of £230k.

• The CCG is currently holding £6,647k of earmarked budgets and reserves. £2,017k of that relates to the 0.5% non-recurrent expenditure reserve, which national guidance has required CCGs to set aside and which is not currently available to the CCG to utilise. £300k relates to allocations received in Month 3, but not yet dispersed to the relevant Directorates. £464k is earmarked for Winter Resilience and will be made available as schemes are agreed, and £700k is set aside for the potential SEL use of drawdown.

• The CCG is expecting to receive GP Forward View and access funding in future months. Until such time as it is received the CCG has funded this expenditure temporarily from the Contingency reserve.

Note: a red negative sign indicates budget overspend
Summary of Position (2 of 2)

- SEL CCGs are in discussion with NHSE about system wide commitments, such as the implementation of the Trust Special Administrator Agreement.

- There is currently £5,448k of reserves uncommitted in the likely forecast position as at Month 4.

- In the worst case projection, the CCG would need to utilise £3,866k of reserves. This is the remainder of the £6,647k after deducting the £2,017k not available for CCGs to commit, the £300k Month 3 allocation yet to be dispersed to Directorates, and the £464k Winter Resilience Reserve. The worst case scenario would require the use of the £700k drawdown of historic underspend.

- Data available for this report:
  - 3 months Acute data is available for the current year for the two major contracts.
  - 2 month of GP Prescribing data is now available for the current year.
  - Continuing Care information is available for 4 months.

- Southwark CCG “Running Costs” are treated as a separate allocation so are shown as separate in the summary. Cross subsidisation of Running Costs by underspend on Programme Budgets is not permitted.

Note: a red negative sign indicates budget overspend
## CCG Programme Budget Summary 2017/18 - Month 4

<table>
<thead>
<tr>
<th>Programme Budget</th>
<th>Annual Budget (£000s)</th>
<th>Variance to Month 4 (£000s)</th>
<th>Predicted End of Year Variance (£000s)</th>
<th>End of Year Best Case Variance (£000s)</th>
<th>End of Year Worst Case Variance (£000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>219,138</td>
<td>-108</td>
<td>-220</td>
<td>-200</td>
<td>-4,920</td>
</tr>
<tr>
<td>Client Groups</td>
<td>76,739</td>
<td>-78</td>
<td>172</td>
<td>625</td>
<td>-1,075</td>
</tr>
<tr>
<td>Community &amp; Primary Health Services</td>
<td>52,286</td>
<td>-279</td>
<td>0</td>
<td>50</td>
<td>-279</td>
</tr>
<tr>
<td>Delegated Primary Care</td>
<td>43,208</td>
<td>-2</td>
<td>-1,400</td>
<td>0</td>
<td>-1,406</td>
</tr>
<tr>
<td>Transformation</td>
<td>1,430</td>
<td>6</td>
<td>149</td>
<td>149</td>
<td>0</td>
</tr>
<tr>
<td>Prescribing</td>
<td>33,081</td>
<td>90</td>
<td>100</td>
<td>5</td>
<td>-500</td>
</tr>
<tr>
<td>Better Care Fund (excluding schemes totalling £5.14m reported elsewhere: total BCF £21.08m)</td>
<td>15,940</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Corporate Costs</td>
<td>6,627</td>
<td>-24</td>
<td>0</td>
<td>155</td>
<td>-206</td>
</tr>
<tr>
<td>Earmarked Budgets &amp; Reserves</td>
<td>6,647</td>
<td>396</td>
<td>1,199</td>
<td>0</td>
<td>3,866</td>
</tr>
<tr>
<td>0.5% Non-recurrent reserve (uncommitted)</td>
<td>2,017</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Planned Surplus</td>
<td>9,743</td>
<td>3,248</td>
<td>9,743</td>
<td>9,743</td>
<td>9,743</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>464,839</strong></td>
<td><strong>3,248</strong></td>
<td><strong>9,743</strong></td>
<td><strong>10,527</strong></td>
<td><strong>5,223</strong></td>
</tr>
<tr>
<td><strong>Reserves not yet utilised in above position</strong></td>
<td></td>
<td></td>
<td><strong>5,448</strong></td>
<td><strong>6,647</strong></td>
<td><strong>2,781</strong></td>
</tr>
<tr>
<td><strong>Reserves not yet utilised in above position (Mth 3 for comparison)</strong></td>
<td></td>
<td></td>
<td><strong>6,031</strong></td>
<td><strong>7,262</strong></td>
<td><strong>3,006</strong></td>
</tr>
<tr>
<td>Drawdown of prior yr surpluses in 2017/18</td>
<td>700</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**Note:** A red negative sign indicates budget overspend
## CCG Running Costs Summary 2017/18 – Month 4

<table>
<thead>
<tr>
<th>Running Costs</th>
<th>Annual Budget (£000s)</th>
<th>Variance to Month 4 (£000s)</th>
<th>Predicted End of Year Variance (£000s)</th>
<th>End of Year Best Case Variance (£000s)</th>
<th>End of Year Worst Case Variance (£000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Running costs</td>
<td>6,500</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Month 3 (for comparison)</td>
<td>6,500</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

### Notes:
1. The running costs allocation is separate from the Programme budget and should be monitored separately.

2. The running costs budget has increased slightly in 2017/18 (£39k). There was a further increase in Month 3 due to:
   - £3k allocation for Market Rents adjustment
   - £1k allocation for HSCN funding

3. In line with national requirements, the running cost allocation per head of population has reduced from £25 in 2013/14, to £21.91 in 2017/18. Although the budget has increased slightly in 2017/18, there is a reduction in budget per head of population in 2017/18, due to an increase in the Southwark population size.

**Note:** a red negative sign indicates budget overspend
## Acute Financial Position 2017/18

<table>
<thead>
<tr>
<th>Acute Contract</th>
<th>Annual Budget (£000s)</th>
<th>Variance to Month 4 (£000s)</th>
<th>Predicted End of Year Variance (£000s)</th>
<th>End of Year Best Case Variance (£000s)</th>
<th>End of Year Worst Case Variance (£000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>King's College Hospital NHS Foundation Trust</td>
<td>87,237</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>-654</td>
</tr>
<tr>
<td>Guy's and St Thomas’ NHS Foundation Trust (excluding Community contract)</td>
<td>97,418</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>-731</td>
</tr>
<tr>
<td>Lewisham and Greenwich NHS Trust</td>
<td>3,539</td>
<td>-83</td>
<td>-331</td>
<td>-331</td>
<td>-486</td>
</tr>
<tr>
<td>University College London Hospital</td>
<td>2,071</td>
<td>-52</td>
<td>-200</td>
<td>-200</td>
<td>-290</td>
</tr>
<tr>
<td>London Ambulance</td>
<td>12,712</td>
<td>-42</td>
<td>-127</td>
<td>-127</td>
<td>-641</td>
</tr>
<tr>
<td>Other contracts and non-contracted activity</td>
<td>16,162</td>
<td>68</td>
<td>438</td>
<td>458</td>
<td>-2,117</td>
</tr>
<tr>
<td><strong>Total Acute</strong></td>
<td>219,138</td>
<td>-108</td>
<td>-220</td>
<td>-200</td>
<td>-4,920</td>
</tr>
<tr>
<td><strong>Month 3 (for comparison)</strong></td>
<td>221,439</td>
<td>39</td>
<td>154</td>
<td>222</td>
<td>-4,705</td>
</tr>
</tbody>
</table>

**Note:** a red negative sign indicates budget overspend
Notes on Acute Budgets

• The year to date position is based on Month 3 information adjusted where appropriate for areas where reporting doesn’t yet reflect contractual arrangement or doesn’t yet include agreed challenges. The Month 3 position is then pro-rated up to Month 4.

• The position at month 4 shows an adverse variance of £108k variance. Within this, there are adverse variances (based on SLAM data rather than the risk assessment used in previous months) relating to the London Ambulance Service, Lewisham & Greenwich NHS Trust and University College London Hospital NHS Foundation Trust as well as other, smaller contracts. These adverse variances are partially offset by underspends against non contracted activity budgets.

• King’s College Hospital NHS Foundation Trust – the ytd position shows performance in line with plan. There is an underlying underspend position of £357k. KCH are yet to reflect the new Identification Rule changes in their plan, so the CCG has manually updated this to enable a Points of Delivery (PoD) level analysis. On that basis, the reported position is driven by underspends on the following PODs: emergency (£622k), and other (£574k). The underspends are partially offset by significant adverse variances on elective (-£240k), critical care (-£698k), and drugs and devices (-£155k).

• The value of the forecast underlying underspend after being adjusted for various contractual adjustments is within the contract tolerances, and therefore the reported position is break-even.
Notes on Acute Budgets

- Guy’s & St Thomas’ NHS Foundation Trust – the ytd position shows performance in line with plan. There is an underlying underspend position, driven by underspends on the following PODs: elective (£759k), emergency (£276k), and maternity pathway (£455k). These underspends are partially offset by an overspend on Outpatient 1st (£103k) as well as some other smaller variances below £100k. The year-end likely forecast position is breakeven as the current level of underspend is not forecast to continue through the year.

- The predicted year end position for Acute budgets is based on the year to date position and forecast forward taking into account expected seasonality and expected growth in activity as the year progresses.

- The worst case scenario assumes that the outturn for King’s College Hospital NHSFT and Guy’s & St Thomas’ NHSFT will exceed the contract tolerance and will therefore result in a adverse variances. Also assumed in the worst case scenario is an estimated £1.75m cost of the TSA agreement.
## Client Group Financial Position 2017/18

<table>
<thead>
<tr>
<th>Programme Budget</th>
<th>Annual Budget (£000s)</th>
<th>Variance to Month 4 (£000s)</th>
<th>Predicted End of Year Variance (£000s)</th>
<th>End of Year Best Case Variance (£000s)</th>
<th>End of Year Worst Case Variance (£000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Contracts (excl. IAPT)</td>
<td>57,719</td>
<td>-22</td>
<td>500</td>
<td>500</td>
<td>-200</td>
</tr>
<tr>
<td>IAPT</td>
<td>3,400</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Learning Disabilities</td>
<td>1,661</td>
<td>10</td>
<td>30</td>
<td>30</td>
<td>-50</td>
</tr>
<tr>
<td>Continuing Healthcare Assessment &amp; Support</td>
<td>12</td>
<td>8</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Older Adults</td>
<td>3,192</td>
<td>-25</td>
<td>-74</td>
<td>45</td>
<td>-100</td>
</tr>
<tr>
<td>Palliative care</td>
<td>2,243</td>
<td>-20</td>
<td>26</td>
<td>100</td>
<td>-50</td>
</tr>
<tr>
<td>Children Services</td>
<td>1,910</td>
<td>-11</td>
<td>-32</td>
<td>50</td>
<td>-75</td>
</tr>
<tr>
<td>Young Persons with Disability (YPD)</td>
<td>5,768</td>
<td>-30</td>
<td>-570</td>
<td>-400</td>
<td>-600</td>
</tr>
<tr>
<td>Other Client Groups</td>
<td>834</td>
<td>11</td>
<td>292</td>
<td>300</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total Client Groups</strong></td>
<td><strong>76,739</strong></td>
<td><strong>-78</strong></td>
<td><strong>172</strong></td>
<td><strong>625</strong></td>
<td><strong>-1,075</strong></td>
</tr>
<tr>
<td><strong>Month 3 (for comparison)</strong></td>
<td><strong>76,615</strong></td>
<td><strong>6</strong></td>
<td><strong>0</strong></td>
<td><strong>475</strong></td>
<td><strong>-1,375</strong></td>
</tr>
</tbody>
</table>

**Note:** a red negative sign indicates budget overspend
Notes on Client Groups Budgets

• The SLaM contract for 2017/18 has been agreed and signed.

• QIPP savings of £1,333k have been applied to the South London and Maudsley NHS Foundation Trust (SLaM) contract and the CCG and the Trust are working closely to ensure effective delivery of the savings. There is a further £850k of QIPP savings allocated to other Client Groups budgets and as at Month 4, the full QIPP target of £2,183k is forecast to be met.

• As at Month 4, there is an adverse variance on Client Groups of £78k, which is mainly due to:
  – Mental Health Contracts: £22k adverse relating to the final instalment of the IAPT recovery plan agreed in the 2016/17 financial year.
  – Older Adults: £25k adverse – mainly due to 5 new service users, one of which is very high cost.
  – Palliative Care: £20k adverse – increase of 1 service user with backdated costs.
  – YPD: £30k adverse – 5 additional service users resulting in increase of £609k in the forecast outturn – it is expected that this increase in cost will be seen more clearly in Month 5.

• Residential placement costs are being reviewed and monitored closely by both the Commissioning and Finance teams, and ongoing discussions are taking place between the CCG and Southwark Council.
<table>
<thead>
<tr>
<th>Programme Budget</th>
<th>Annual Budget (£000s)</th>
<th>Variance to Month 4 (£000s)</th>
<th>Predicted End of Year Variance (£000s)</th>
<th>End of Year Best Case Variance (£000s)</th>
<th>End of Year Worst Case Variance (£000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>GSTT Community Contract (including BCF)</td>
<td>34,768</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Extended Primary Care Services</td>
<td>2,500</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Population Health Management</td>
<td>1,134</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>GP Forward View</td>
<td>7,363</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Primary Care Transformation</td>
<td>475</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other Primary Care Health Services</td>
<td>6,046</td>
<td>-279</td>
<td>0</td>
<td>50</td>
<td>-279</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>52,286</strong></td>
<td><strong>-279</strong></td>
<td><strong>0</strong></td>
<td><strong>50</strong></td>
<td><strong>-279</strong></td>
</tr>
<tr>
<td><strong>Month 3 (for comparison)</strong></td>
<td><strong>41,530</strong></td>
<td></td>
<td><strong>10</strong></td>
<td><strong>50</strong></td>
<td><strong>0</strong></td>
</tr>
</tbody>
</table>

*Note: a red negative sign indicates budget overspend*
Notes on Community & Primary Care Health Service: 2017-18

- GSTT Community Contract, Extended Primary Care Services and Population Health Management are currently performing in line with plan.

- The integrated GSTT contract has been reviewed and a revised split between Acute and Community is now included in these reports. The value of the realigned budgets is £2,692k and the revised values relating to the Community element of the contract are now detailed at service level.

- Other Primary Care Health Services are showing an adverse variance of £279k. This is due to the effect of cancelling a prior year invoice to Southwark Council and re-invoicing at the new agreed level.

- Extended Primary Care Services have been funded from CCG reserves until such time as the expected allocation highlighted on Page 3 of this report is received.

*Note: a red negative sign indicates budget overspend*
### Transformation 2017/18

<table>
<thead>
<tr>
<th>Programme Budget</th>
<th>Annual Budget (£000s)</th>
<th>Variance to Month 4 (£000s)</th>
<th>Predicted End of Year Variance (£000s)</th>
<th>End of Year Best Case Variance (£000s)</th>
<th>End of Year Worst Case Variance (£000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP Federations Business Plans</td>
<td>425</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Population Health Fellows</td>
<td>170</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Staffing Costs</td>
<td>835</td>
<td>6</td>
<td>149</td>
<td>149</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>1,430</td>
<td>6</td>
<td>149</td>
<td>149</td>
<td>0</td>
</tr>
<tr>
<td>Month 3 (for comparison)</td>
<td>1,905</td>
<td>0</td>
<td>0</td>
<td>90</td>
<td>0</td>
</tr>
</tbody>
</table>

- Transformation budgets are currently performing in line with plan.
- £475k of Transformation budget was affected by an NHSE coding requirement in Month 4. As a result of the coding requirement, this element of the Transformation budget now sits within the Community and Primary Care Health Services budgets reported on the previous page.
- There is currently one vacancy within the Transformation team and the underspend on this post is offset against agency spend within the directorate.

**Note:** A red negative sign indicates budget overspend
## Prescribing Financial Position 2017/18

<table>
<thead>
<tr>
<th>Programme Budget</th>
<th>Annual Budget (£000s)</th>
<th>Variance to Month 4 (£000s)</th>
<th>Predicted End of Year Variance (£000s)</th>
<th>End of Year Best Case Variance (£000s)</th>
<th>End of Year Worst Case Variance (£000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>North Southwark</td>
<td>16,110</td>
<td>45</td>
<td>20</td>
<td>0</td>
<td>-150</td>
</tr>
<tr>
<td>South Southwark</td>
<td>14,325</td>
<td>95</td>
<td>60</td>
<td>0</td>
<td>-150</td>
</tr>
<tr>
<td>Prescribing Incentive Scheme</td>
<td>200</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Drugs held centrally</td>
<td>850</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Personally Administered Drugs</td>
<td>655</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Admin and Other Prescribing</td>
<td>941</td>
<td>-50</td>
<td>20</td>
<td>0</td>
<td>-200</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>33,081</strong></td>
<td><strong>90</strong></td>
<td><strong>100</strong></td>
<td><strong>5</strong></td>
<td><strong>-500</strong></td>
</tr>
<tr>
<td><strong>Month 3 (for comparison)</strong></td>
<td><strong>33,081</strong></td>
<td><strong>-32</strong></td>
<td><strong>5</strong></td>
<td><strong>5</strong></td>
<td><strong>-500</strong></td>
</tr>
</tbody>
</table>

**Note:** a red negative sign indicates budget overspend
Notes on Prescribing Budgets

• Two months of data for GP Prescribing is available as at Month 4.

• As only two months of information is available and prescribing expenditure can be volatile over a short time period, it is difficult to accurately calculate the spend up to Month 3 (from two months of current data). As more information becomes available through the year, it is expected that these calculations will become more robust. In the meantime, the reported figures are based on estimates, using prior year expenditure, national budget profiles, local knowledge and current year QIPP schemes to calculate the ytd position and forecast outturn.

• As at Month 4, both North and South Southwark prescribing budgets are underspent. The budget is shown after being adjusted to show the expected saving resulting from the Collaborative QIPP Programme (formerly referred to as Capped Expenditure Programme, CEP).

• There is a £50k adverse variance on Admin and Other Prescribing partly relating to incorrectly coded payroll costs of £26k.

• From Month 4, budgets have been adjusted to take account of list sizes and historical data. This has affected the budgets reports reported for North and South Southwark, but has not changed the overall prescribing budget.
The Better Care Fund (BCF) is a pooled budget between the CCG and Southwark Council and is hosted by the Council.

The CCG’s contribution to the BCF in 2017/18 is £21,080k. This funds a number of schemes, some of which are led by Southwark Council, and some are led by the CCG.

Under the pooled budget arrangement, there is no requirement to physically transfer cash to the host for the pooled budget to exist. On that basis, the CCG only transfers the proportion of its contribution needed to fund the Council led schemes.

On that basis, the reporting of the BCF is split into two segments: the amount paid to the Council, and the CCG led schemes which are reported as part of the relevant directorate. The CCG led schemes have also been included as part of the BCF section of this report to provide transparency with regard to how the full CCG BCF contribution is spent.

<table>
<thead>
<tr>
<th>Programme Budget</th>
<th>Annual Budget (£000s)</th>
<th>Variance to Month 4 (£000s)</th>
<th>Predicted End of Year Variance (£000s)</th>
<th>End of Year Best Case Variance (£000s)</th>
<th>End of Year Worst Case Variance (£000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better Care Fund: CCG Contribution to Southwark Council led Schemes</td>
<td>15,940</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>15,940</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Month 3 (for comparison)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

• As at Month 4, the split of the BCF funding reported in these tables is indicative. While the CCG funding of £21,080k is confirmed, there is ongoing work with regard to funded schemes.

Note: a red negative sign indicates budget overspend
## Better Care Fund 2017/18 (2 of 2)

### BCF schemes reported as part of other expenditure areas

<table>
<thead>
<tr>
<th>BCF schemes reported as part of other expenditure areas</th>
<th>Annual Budget (£000s)</th>
<th>Variance to Month 4 (£000s)</th>
<th>Predicted End of Year Variance (£000s)</th>
<th>End of Year Best Case Variance (£000s)</th>
<th>End of Year Worst Case Variance (£000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community GSTT schemes: Admission Avoidance, Hospital at home, Enhanced Rapid Response</td>
<td>3,965</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Primary Health Services schemes: Self management, Enhanced primary care access</td>
<td>1,175</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>5,140</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
</tr>
</tbody>
</table>

**Month 3 (for comparison)**

| **Month 3 (for comparison)** | **5,140** | **0** | **0** | **0** | **0** |

### Total CCG contribution to BCF

<table>
<thead>
<tr>
<th>Total CCG contribution to BCF</th>
<th>Annual Budget (£000s)</th>
<th>Variance to Month 4 (£000s)</th>
<th>Predicted End of Year Variance (£000s)</th>
<th>End of Year Best Case Variance (£000s)</th>
<th>End of Year Worst Case Variance (£000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total CCG Contribution to BCF</td>
<td>21,080</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**Note:** a red negative sign indicates budget overspend
## Corporate Costs 2017/18

<table>
<thead>
<tr>
<th>Programme Budget</th>
<th>Annual Budget (£000s)</th>
<th>Variance to Month 4 (£000s)</th>
<th>Predicted End of Year Variance (£000s)</th>
<th>End of Year Best Case Variance (£000s)</th>
<th>End of Year Worst Case Variance (£000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP IT</td>
<td>674</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Development Costs for Dulwich Health Centre and Other Projects</td>
<td>300</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Estates Costs</td>
<td>2,026</td>
<td>0</td>
<td>0</td>
<td>50</td>
<td>-100</td>
</tr>
<tr>
<td>Medicines Optimisation</td>
<td>691</td>
<td>32</td>
<td>0</td>
<td>55</td>
<td>-50</td>
</tr>
<tr>
<td>Other Corporate</td>
<td>2,936</td>
<td>-56</td>
<td>0</td>
<td>50</td>
<td>-56</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>6,627</strong></td>
<td><strong>-24</strong></td>
<td><strong>0</strong></td>
<td><strong>155</strong></td>
<td><strong>-206</strong></td>
</tr>
<tr>
<td><strong>Month 3 (for comparison)</strong></td>
<td><strong>6,627</strong></td>
<td><strong>9</strong></td>
<td><strong>0</strong></td>
<td><strong>255</strong></td>
<td><strong>-200</strong></td>
</tr>
</tbody>
</table>

- These costs are not counted against the CCG Running Costs allocation.
- The overspend on Other Corporate relates to agency costs on one-off project roles.
- The budget increased in Month 3 due to allocations for NHS Wifi (£136k), Market Rents (£325k), Health and Social Care Network – HSCN (£116k) and infrastructure funding for STPs (£319k).
- Our Healthier South East London programme is reported in “Other Corporate”. The CCG contributes £647k to OHSEL funding.

*Note: a red negative sign indicates budget overspend*
• As of the 1 April 2015, the CCG entered into Level 2 co-commissioning of primary care with NHS England.

• There were 3 levels available to CCGs with regard to co-commissioning:
  • Level 1: Greater involvement in primary care decision-making
  • Level 2: Joint Commissioning – enables decisions
  • Level 3: Delegated Commissioning – enables decisions.

• The CCG has moved to Level 3 for the 2017/18 financial year.

• Level 3 is an opportunity for CCGs to take on full responsibility for the commissioning of general practice services.

Note: a red negative sign indicates budget overspend
• There is an issue with regard to the budget passed to the CCG by NHS England in that the allocation given to the CCG does not meet the required level of expenditure budget for primary care services.

• Included in the likely forecast is the assumption that reserves within the primary care budgets are all required for operational purposes and the gap between allocation and required funds cannot be met. At the current time, this gap is £1.4m after having applied the 1% non-recurrent headroom based on Primary Care Services allocation that NHS England confirmed could be used for this purpose.

Note: a red negative sign indicates budget overspend

---

### Primary Care Co-commissioning 2017/18

#### Medical Services

<table>
<thead>
<tr>
<th>Description</th>
<th>Annual Budget £000's</th>
<th>YTD Budget £000's</th>
<th>YTD Actual Expenditure £000's</th>
<th>YTD Variance £000's</th>
<th>Forecast Outturn £000's</th>
<th>Forecast Variance £000's</th>
<th>Best Case Forecast Variance £000's</th>
<th>Worst Case Forecast Variance £000's</th>
<th>2016/17 Outturn £000's</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional and Essential Services</td>
<td>34,661</td>
<td>11,554</td>
<td>11,541</td>
<td>13</td>
<td>34,622</td>
<td>39</td>
<td>0</td>
<td>0</td>
<td>32,935</td>
</tr>
<tr>
<td>QIPP Savings</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Enhanced Services</td>
<td>875</td>
<td>291</td>
<td>291</td>
<td>0</td>
<td>875</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1,745</td>
</tr>
<tr>
<td>Quality and Outcomes Framework (QOF)</td>
<td>2,900</td>
<td>966</td>
<td>966</td>
<td>0</td>
<td>2,900</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2,796</td>
</tr>
<tr>
<td>Premises Payment</td>
<td>5,011</td>
<td>1,670</td>
<td>1,675</td>
<td>-5</td>
<td>5,011</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4,844</td>
</tr>
<tr>
<td>Seniority</td>
<td>236</td>
<td>79</td>
<td>76</td>
<td>3</td>
<td>236</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other Administered Funds (Maternity etc)</td>
<td>395</td>
<td>132</td>
<td>132</td>
<td>0</td>
<td>395</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>218</td>
</tr>
<tr>
<td>Personally Administered Drugs</td>
<td>123</td>
<td>41</td>
<td>47</td>
<td>-6</td>
<td>123</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>139</td>
</tr>
<tr>
<td>Prior Year write back</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>-764</td>
</tr>
<tr>
<td>Other</td>
<td>-993</td>
<td>203</td>
<td>210</td>
<td>-7</td>
<td>446</td>
<td>-1,439</td>
<td>0</td>
<td>-1,406</td>
<td>107</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>43,208</strong></td>
<td><strong>14,936</strong></td>
<td><strong>14,938</strong></td>
<td><strong>-2</strong></td>
<td><strong>44,608</strong></td>
<td><strong>-1,400</strong></td>
<td><strong>0</strong></td>
<td><strong>-1,406</strong></td>
<td><strong>42,341</strong></td>
</tr>
</tbody>
</table>

**Month 3 (for comparison)**

| **43,208** | **11,202** | **11,223** | **-21** | **44,608** | **-1,400** | **0** | **-1,406** | **42,341** |

---
<table>
<thead>
<tr>
<th>Programme Budget</th>
<th>Annual Budget (£000s)</th>
<th>Variance to Month 4 (£000s)</th>
<th>Predicted End of Year Variance (£000s)</th>
<th>End of Year Best Case Variance (£000s)</th>
<th>End of Year Worst Case Variance (£000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Contingency (0.5%)</td>
<td>1,088</td>
<td>0</td>
<td>1,088</td>
<td>0</td>
<td>1,088</td>
</tr>
<tr>
<td>Non-Recurrent Expenditure (0.5%)</td>
<td>2,017</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Drawdown of Historic Surplus</td>
<td>700</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>700</td>
</tr>
<tr>
<td>Reception and clerical training – (Training Care Navigators and Medical Assistants) – non-recurrent</td>
<td>55</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Paramedic Rebanding Additional Funding – non-recurrent</td>
<td>245</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Winter Resilience</td>
<td>464</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Local Activity/ Risk Reserve</td>
<td>2,078</td>
<td>396</td>
<td>111</td>
<td>0</td>
<td>2,078</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>6,647</strong></td>
<td><strong>396</strong></td>
<td><strong>1,199</strong></td>
<td><strong>0</strong></td>
<td><strong>3,866</strong></td>
</tr>
<tr>
<td>Month 3 (for comparison)</td>
<td><strong>7,262</strong></td>
<td><strong>0</strong></td>
<td><strong>1,231</strong></td>
<td><strong>0</strong></td>
<td><strong>4,256</strong></td>
</tr>
<tr>
<td>Reserves not yet utilised in above position</td>
<td><strong>5,448</strong></td>
<td></td>
<td><strong>6,647</strong></td>
<td></td>
<td><strong>2,781</strong></td>
</tr>
</tbody>
</table>

**Note:** a red negative sign indicates budget overspend
The Planned Surplus increased in Month 3, due to an adjustment to the Surplus/Deficit Carry Forward. As at Month 2, this was included at the planned surplus as at Month 11 of the 2016/17 financial year. In Month 3, the allocation was adjusted to reflect the actual surplus achieved in 2016/17, so the allocation increased by £150k from £10,063k to £10,213k.

The Planned Surplus takes into account the following elements:
- £10,213k Surplus carried forward
- -£700k Drawdown of historical surplus
- £230k Planned in year surplus
### Running Costs 2017/18 (Separate Allocation)

<table>
<thead>
<tr>
<th>Budgets</th>
<th>Annual Budget (£000s)</th>
<th>Variance to Month 4 (£000s)</th>
<th>Predicted End of Year Variance (£000s)</th>
<th>End of Year Best Case Variance (£000s)</th>
<th>End of Year Worst Case Variance (£000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Costs</td>
<td>3,301</td>
<td>-265</td>
<td>-110</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>CSU Recharge</td>
<td>1,697</td>
<td>-31</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Office Accommodation</td>
<td>441</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>1,061</td>
<td>291</td>
<td>110</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>6,500</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
</tr>
<tr>
<td><strong>Month 3 (for comparison)</strong></td>
<td><strong>6,500</strong></td>
<td><strong>6</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
</tr>
</tbody>
</table>

- This is the separate allocation of £21.91 per head of population for running costs.
- Staff costs are overspent due to posts recharged to other organisations (£130k), a post which will be funded by the Better Care Fund (£23k). In addition there is a one-off payment in lieu of notice.
- The ‘Other’ costs include the CCG’s share of Office costs and Audit Fees.
- The CCG is currently negotiating the office space license for Tooley Street and costs are expected to increase which will likely require funding from CCG reserves.

**Note:** a red negative sign indicates budget overspend
<table>
<thead>
<tr>
<th>Capital Projects</th>
<th>Annual Budget (£000s)</th>
<th>Actual Spend to Month 4 (£000s)</th>
<th>Variance to Month 4 (£000s)</th>
<th>Predicted End of Year Variance (£000s)</th>
<th>End of Year Best Case Variance (£000s)</th>
<th>End of Year Worst Case Variance (£000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No allocation at Month 4</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Total</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Month 3 (for comparison)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

- As at Month 4, no capital funding has been released to the CCG. The CCG is expecting a capital allocation for the 2017/18 financial year and this will be reported in this section as when it is released to the CCG.

**Note:** a red negative sign indicates budget overspend
### QIPP Monitoring

#### Southwark CCG QIPP 2017-18

**Annual Plan**

<table>
<thead>
<tr>
<th>Category</th>
<th>Plan (£000s)</th>
<th>YTD Plan (£000s)</th>
<th>YTD Actual (£000s)</th>
<th>YTD Variance (£000s)</th>
<th>YTD RAG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>6,355</td>
<td>2,118</td>
<td>2,118</td>
<td>0</td>
<td>✔️</td>
</tr>
<tr>
<td>Mental Health</td>
<td>2,183</td>
<td>728</td>
<td>728</td>
<td>0</td>
<td>✔️</td>
</tr>
<tr>
<td>Primary Care Prescribing</td>
<td>1,700</td>
<td>567</td>
<td>567</td>
<td>0</td>
<td>✔️</td>
</tr>
<tr>
<td>Community Services</td>
<td>1,000</td>
<td>333</td>
<td>333</td>
<td>0</td>
<td>✔️</td>
</tr>
<tr>
<td>Continuing Health Care</td>
<td>1,000</td>
<td>333</td>
<td>333</td>
<td>0</td>
<td>✔️</td>
</tr>
<tr>
<td>Corporate</td>
<td>155</td>
<td>52</td>
<td>52</td>
<td>0</td>
<td>✔️</td>
</tr>
<tr>
<td><strong>Southwark CCG QIPP Target 2017/18</strong></td>
<td><strong>12,393</strong></td>
<td><strong>4,131</strong></td>
<td><strong>4,131</strong></td>
<td>0</td>
<td>✔️</td>
</tr>
</tbody>
</table>

**Forecast**

<table>
<thead>
<tr>
<th>Category</th>
<th>Outturn (£000s)</th>
<th>Variance (£000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute</td>
<td>6,355</td>
<td>0</td>
</tr>
<tr>
<td>Mental Health</td>
<td>2,183</td>
<td>0</td>
</tr>
<tr>
<td>Primary Care Prescribing</td>
<td>1,700</td>
<td>0</td>
</tr>
<tr>
<td>Community Services</td>
<td>1,000</td>
<td>0</td>
</tr>
<tr>
<td>Continuing Health Care</td>
<td>1,000</td>
<td>0</td>
</tr>
<tr>
<td>Corporate</td>
<td>155</td>
<td>0</td>
</tr>
<tr>
<td><strong>Southwark CCG QIPP Target 2017/18</strong></td>
<td><strong>12,393</strong></td>
<td>0</td>
</tr>
</tbody>
</table>

- Total QIPP savings plans of £12,393k are in place for 2017/18.
- The CCG is forecasting to deliver the QIPP programme in full in 2017/18. The majority of the Acute and Mental Health QIPP plans are contractually agreed with the relevant providers and on that basis, there is a reduced risk to the CCG of underachieving the QIPP plans for 2017/18.

Note: a red negative sign indicates budget overspend.
# Financial Risks & Mitigations (1 of 2)

<table>
<thead>
<tr>
<th>Risks</th>
<th>Full Risk Value (£'000s)</th>
<th>Probability of risk being realised (%)</th>
<th>Potential Risk Value (£m)</th>
<th>Commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute SLAs</td>
<td>1.50</td>
<td>75.00%</td>
<td>1.13</td>
<td>Overperformance, block contracts in place on main contracts</td>
</tr>
<tr>
<td>Community SLAs</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health SLAs</td>
<td>0.50</td>
<td>75.00%</td>
<td>0.38</td>
<td>Excess bed usage</td>
</tr>
<tr>
<td>Continuing Care SLAs</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>QIPP Under-Delivery</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performance Issues</td>
<td>0.50</td>
<td>50.00%</td>
<td>0.25</td>
<td></td>
</tr>
<tr>
<td>Primary Care</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescribing</td>
<td>0.50</td>
<td>50.00%</td>
<td>0.25</td>
<td></td>
</tr>
<tr>
<td>Running Costs</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Risks</td>
<td>3.45</td>
<td>75.00%</td>
<td>2.59</td>
<td>HRG4+ above allocation, LGT TSA and SEL use of drawdown</td>
</tr>
<tr>
<td><strong>TOTAL RISKS</strong></td>
<td>6.45</td>
<td></td>
<td>4.59</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mitigations</th>
<th>Full Mitigation Value (£'000s)</th>
<th>Probability of success of mitigating action (%)</th>
<th>Expected Mitigation Value (£m)</th>
<th>Commentary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uncommitted Funds (Excl 1% Headroom)</td>
<td>1.30</td>
<td>100.00%</td>
<td>1.30</td>
<td>£1,088k in reserves and £216k in Primary Care budgets</td>
</tr>
<tr>
<td>Contingency Held</td>
<td>1.30</td>
<td>100.00%</td>
<td>1.30</td>
<td></td>
</tr>
<tr>
<td>Contract Reserves</td>
<td>2.78</td>
<td>100.00%</td>
<td>2.78</td>
<td></td>
</tr>
<tr>
<td>Investments Uncommitted</td>
<td>0.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Uncommitted Funds Sub-Total</strong></td>
<td>4.08</td>
<td></td>
<td>4.08</td>
<td></td>
</tr>
<tr>
<td>Actions to Implement</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Further QIPP Extensions</td>
<td>0.00</td>
<td></td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td>Non-Recurrent Measures</td>
<td>0.00</td>
<td></td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td>Delay/ Reduce Investment Plans</td>
<td>0.00</td>
<td></td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td>Other Mitigations</td>
<td>0.00</td>
<td></td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td>Mitigations relying on potential funding</td>
<td>0.95</td>
<td></td>
<td>0.95</td>
<td></td>
</tr>
<tr>
<td><strong>Actions to Implement Sub-Total</strong></td>
<td>0.95</td>
<td></td>
<td>0.95</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL MITIGATION</strong></td>
<td></td>
<td></td>
<td>5.03</td>
<td></td>
</tr>
</tbody>
</table>

**NET RISK / HEADROOM** 4.59

| Forecast Outturn Surplus/Deficit | 9.74 |
| RISK ADJUSTED CONTROL TOTAL     | 10.19 |
The value of the potential risks reported on the previous page is in addition to the forecast outturn position. The purpose of this table is to report on risks and mitigations that are not included in the forecast – i.e. to illustrate anything that puts the reported forecast outturn at risk.

The best case impact is £4.08m: no risks materialise and funds remain uncommitted.

The worst case impact is that the current forecast would be adversely affected by £2.37m: all risks occur, no further actions are available and uncommitted funds all used to mitigate risks.

Contract Reserves reported in the “Mitigations” table on the previous page exclude the 0.5% non-recurring headroom that CCGs are required to plan for and at the current time are not permitted to commit expenditure against. Also excluded from the total mitigations are the following reserves on the basis that they are earmarked for use in year:
- £300k Month 3 allocations not yet dispersed to Directorates
- £464k Winter Resilience reserve
Cash Position 2017/18

The Maximum Cash Drawdown (after payments made on behalf of NHS Southwark CCG by NHS Business Services Authority – PPA & HOT) is £435,757k. The actual and forecast drawdown of cash is shown in the table below.

<table>
<thead>
<tr>
<th>Cash Drawdown</th>
<th>Monthly Drawdown £000s</th>
<th>Cumulative Drawdown £000s</th>
<th>Proportion of Annual Cash Resource Limit</th>
<th>KPI - 1.25% of cash balance as drawdown £000s</th>
<th>Month end cash Bank Balance £000s</th>
<th>Achievement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ACTUAL</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Apr-17</td>
<td>36,100</td>
<td>36,100</td>
<td>8.4%</td>
<td>451</td>
<td>298</td>
<td></td>
</tr>
<tr>
<td>May-17</td>
<td>36,500</td>
<td>72,600</td>
<td>16.9%</td>
<td>456</td>
<td>384</td>
<td></td>
</tr>
<tr>
<td>Jun-17</td>
<td>37,000</td>
<td>109,600</td>
<td>25.5%</td>
<td>463</td>
<td>371</td>
<td></td>
</tr>
<tr>
<td>Jul-17</td>
<td>36,700</td>
<td>146,300</td>
<td>34.0%</td>
<td>459</td>
<td>395</td>
<td></td>
</tr>
<tr>
<td><strong>Forecast</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aug-17</td>
<td>33,000</td>
<td>179,300</td>
<td>41.7%</td>
<td>413</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sep-17</td>
<td>36,300</td>
<td>215,600</td>
<td>50.2%</td>
<td>454</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oct-17</td>
<td>35,000</td>
<td>250,600</td>
<td>58.3%</td>
<td>438</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nov-17</td>
<td>36,000</td>
<td>286,600</td>
<td>66.7%</td>
<td>450</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dec-17</td>
<td>35,000</td>
<td>321,600</td>
<td>74.8%</td>
<td>438</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jan-18</td>
<td>36,100</td>
<td>357,700</td>
<td>83.2%</td>
<td>451</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feb-18</td>
<td>36,100</td>
<td>393,800</td>
<td>91.6%</td>
<td>451</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mar-18</td>
<td>36,060</td>
<td>429,860</td>
<td>100.0%</td>
<td>451</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Annual Total</strong></td>
<td></td>
<td><strong>£429,860</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- The cash KPI was achieved in Month 4, showing continued successful management of the cash position to achieve the target cash balance.
Under the Better Payments Practice Code (BPPC), CCGs are expected to pay 95% of all creditors within 30 days of the receipt of invoices. This is measured both in terms of the total value of invoices and the number of invoices by count. The CCG met the in-month targets in Month 4, showing a continuation of the strong performance that has been exhibited over the past 2 years. The CCG continues to meet all of the overall targets at Month 4.

<table>
<thead>
<tr>
<th>NUMBERS FOR THE MONTH</th>
<th>NHS</th>
<th>NON-NHS</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>151</td>
<td>694</td>
<td>845</td>
<td></td>
</tr>
<tr>
<td>148</td>
<td>664</td>
<td>812</td>
<td></td>
</tr>
<tr>
<td>288</td>
<td>699</td>
<td>987</td>
<td></td>
</tr>
<tr>
<td>287</td>
<td>666</td>
<td>953</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>VALUES FOR THE MONTH (£000s)</th>
<th>NHS</th>
<th>NON-NHS</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>29,896</td>
<td>7,743</td>
<td>37,639</td>
<td></td>
</tr>
<tr>
<td>29,769</td>
<td>7,661</td>
<td>37,430</td>
<td></td>
</tr>
<tr>
<td>32,201</td>
<td>6,533</td>
<td>38,734</td>
<td></td>
</tr>
<tr>
<td>32,166</td>
<td>6,321</td>
<td>38,487</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>VALUES percentage for the month</th>
<th>NHS</th>
<th>NON-NHS</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>98.01%</td>
<td>95.68%</td>
<td>96.09%</td>
<td></td>
</tr>
<tr>
<td>99.65%</td>
<td>95.28%</td>
<td>96.56%</td>
<td></td>
</tr>
<tr>
<td>99.57%</td>
<td>98.94%</td>
<td>99.44%</td>
<td></td>
</tr>
<tr>
<td>99.89%</td>
<td>96.76%</td>
<td>99.36%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NUMBERS percentage cumulative</th>
<th>NHS</th>
<th>NON-NHS</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>97.94%</td>
<td>95.62%</td>
<td>96.09%</td>
<td></td>
</tr>
<tr>
<td>98.47%</td>
<td>95.55%</td>
<td>96.21%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>VALUES percentage cumulative</th>
<th>NHS</th>
<th>NON-NHS</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>99.58%</td>
<td>98.00%</td>
<td>99.20%</td>
<td></td>
</tr>
<tr>
<td>99.67%</td>
<td>97.76%</td>
<td>99.24%</td>
<td></td>
</tr>
</tbody>
</table>
The majority of the non-NHS debt relates to Southwark Council (Section 75 and Section 256 agreements relating to the 2016/17 financial year). The total value of these invoices is £2.85m. This has reduced from £4.9m in Month 3 and the difference relates to payments received. Further work has occurred leading to a solution relating to a further £1.2m of this debt. The NHS debt 121-180 days relates mainly to NHS Greenwich CCG for OHSEL charges and NHS Waltham Forest CCG.

The current and 31-60 day aged NHS debt relates to SEL CCGs and relates to charges for OHSEL for 2017/18 and an invoice to GSTT for STP Workforce Programme Delivery.
Financial sanctions imposed by the CCG

As part of the NHS standard contract, the CCG is required to report quarterly on financial fines and penalties imposed on providers for failure to achieve national standards. The sanctions are routinely calculated and form part of regular monitoring of contracts, recognising the national requirements against each indicator.

The standards are split into 2 main categories:

• Operational Standards: include requirements for 18 weeks referral to treatment, A&E waiting times, Cancer standards, mixed sex accommodation, cancelled operations.

• National Quality Standards: include requirements for MRSA, C-Diff, over 52 week waiters, Ambulance handovers, duty of candour, required data, trolley waits in A&E.

Please note: the full list of standards is not included in the financial sanctions tables. Only those standards that have incurred financial sanctions are reported.

The December 2015 document “Delivering the Forward View: NHS Planning Guidance 2016/17 – 2020/21” states on page 12: “Providers who are eligible for sustainability and transformation funding in 2016/17 will not face a double jeopardy scenario whereby they incur penalties as well as losing access to funding; a single penalty will be imposed.” On that basis there are not expected to additional financial sanctions imposed by the CCG.
### Revenue Resource Limit (1 of 2)

<table>
<thead>
<tr>
<th>Description</th>
<th>Admin (£000s)</th>
<th>Programme (£000s)</th>
<th>Total (£000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial CCG Programme Allocation 2017/18</td>
<td></td>
<td>444,110</td>
<td>443,410</td>
</tr>
<tr>
<td>Running Costs Allowance 2017/18</td>
<td></td>
<td>6,496</td>
<td>6,496</td>
</tr>
<tr>
<td>Brought forward surplus from 2016/17 less drawdown</td>
<td></td>
<td>9,513</td>
<td>9,513</td>
</tr>
<tr>
<td><strong>2017/18 Opening Allocations</strong></td>
<td>6,496</td>
<td>453,623</td>
<td>460,119</td>
</tr>
</tbody>
</table>

**In year Allocations:**

<table>
<thead>
<tr>
<th>Description</th>
<th>Admin (£000s)</th>
<th>Programme (£000s)</th>
<th>Total (£000s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Liaison and Diversion/CYP Co-commissioning – non-rec (Month 3)</td>
<td></td>
<td>166</td>
<td>166</td>
</tr>
<tr>
<td>London Transformation Fund Allocation – non-rec (Month 3)</td>
<td></td>
<td>2,000</td>
<td>2,000</td>
</tr>
<tr>
<td>Reception and clerical training - (Training Care Navigators and Medical Assistants) – non-rec (Month 3)</td>
<td></td>
<td>55</td>
<td>55</td>
</tr>
<tr>
<td>Diabetes Treatment and Diabetes Treatment and Care Transformation Fund – non-rec (Month 3)</td>
<td></td>
<td>225</td>
<td>225</td>
</tr>
<tr>
<td>NHS WiFi – non-rec (Month 3)</td>
<td></td>
<td>136</td>
<td>136</td>
</tr>
<tr>
<td>Market rents adjustment – non-rec (Month 3)</td>
<td>3</td>
<td>325</td>
<td>328</td>
</tr>
<tr>
<td>Paramedic Rebanding Additional Funding 2017-18 – non-rec (Month 3)</td>
<td></td>
<td>245</td>
<td>245</td>
</tr>
<tr>
<td>TB allocations Qtr 1 – non-rec (Month 3)</td>
<td></td>
<td>17</td>
<td>17</td>
</tr>
<tr>
<td>Health &amp; Social Care Network (HSCN) – non-rec (Month 3)</td>
<td>1</td>
<td>116</td>
<td>117</td>
</tr>
<tr>
<td>Acute hospital urgent &amp; emergency liaison mental health services - non-rec (Month 3&amp;4)</td>
<td></td>
<td>248</td>
<td>248</td>
</tr>
<tr>
<td>Infrastructure funding for STPs – non-rec (Month 3)</td>
<td></td>
<td>319</td>
<td>319</td>
</tr>
<tr>
<td>GP Forward view for SEL CCGs</td>
<td></td>
<td>7,363</td>
<td>7,363</td>
</tr>
</tbody>
</table>

**Total Confirmed Allocation at Month 2**                                    | 6,500         | 464,838           | 471,338       |
Revenue Resource Limit (2 of 2)

- There has been a number of changes to the Start Allocation in Month 4.
  - GP Forward View Extended access for SEL CCGs (£7,039k incoming)
  - GP Forward View Embedded resources (£324k incoming)
  - Acute Hospital urgent and emergency liaison mental health services (£124k incoming)

Adjustments are expected in future months for:
- Healthy London Partnership contribution (£460k outgoing)
- Levies contribution (£168k outgoing)

Adjustments are not reflected in the table on the previous page until such time as they have been agreed and confirmed through the NHSE standard process.
Recommendations

1. To note the budgets and position for the ‘Programme Budgets’ and the ‘Running Costs’ as at end of July 2017.
2. To note the forecast position for the year for both ‘Programme Budgets’ and the ‘Running Costs’.
3. To note specifically the forecast for Delegated Primary Care which includes the forecast effect of the allocation shortfall to the CCG.
4. To note the worst case scenario forecast for Acute which includes the full impact of potential issues relating to the TSA agreement.
5. To note the risks and mitigations in addition to those mentioned above.

Christine Caton
Interim Chief Financial Officer
NHS Southwark CCG
14 August 2017
Summary of Risks in July 2017

Summary of Risks on the Board Assurance Framework

<table>
<thead>
<tr>
<th>Extreme risks</th>
<th>High risks</th>
<th>Moderate risks</th>
<th>Low risks</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>13</td>
<td>3</td>
<td>0</td>
<td>28</td>
</tr>
</tbody>
</table>

Summary of Risks on the Directorate Risk Registers

<table>
<thead>
<tr>
<th>Extreme risks</th>
<th>High risks</th>
<th>Moderate risks</th>
<th>Low risks</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>15</td>
<td>6</td>
<td>1</td>
<td>23</td>
</tr>
</tbody>
</table>

Note: This summary is based on residual risk scores
There are currently **12** extreme risks on the BAF as follows:

<table>
<thead>
<tr>
<th>No.</th>
<th>Ref</th>
<th>Directorate</th>
<th>Risk Title</th>
<th>Initial Risk Score</th>
<th>Residual (current) risk score</th>
<th>Controls</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>IC-06</td>
<td>Integrated Commissioning</td>
<td>Risk that providers do not deliver <strong>contractually agreed trajectories for Referral to Treatment</strong> specifically delivery of recovery plan to meet Referral to Treatment waiting time targets by March 2018.</td>
<td>5x4=20</td>
<td>5x4=20</td>
<td>RTT recovery plans included in KCH and GSTT contracts for 2017/18. Backlog reduction programme of transferring backlog patients from King's Denmark Hill to other providers for Ophthalmology is in place. GSTT commenced ENT outsourcing in January 2017, and Orthopaedics is expected to begin outsourcing to BMI once contracts have been agreed. Work with federations to plan and implement incentivised GP peer review scheme. ICDT are working with KCH to increase outpatient and day case capacity. Services currently being insourced are outpatient appointments and day cases for Ophthalmology, Dermatology, and General Surgery. Planned care workstream in place.</td>
</tr>
</tbody>
</table>

<p>| 2.  | IC-07 | Integrated Commissioning   | Risk that providers do not deliver <strong>contractually agreed trajectories for A&amp;E NHS constitutional standards</strong>, specifically delivery of recovery plan to meet A&amp;E 4 hour waiting time targets by March 2018. | 5x4=20             | 5x4=20                        | Trajectories for delivery of NHS constitution standards agreed with providers in 2017/18 and supplied to NHSE and NHSI. Additional non-elective activity has been commissioned as part of contracting round. In addition to System Oversight Group monitoring, Southwark CO attends NHSI's monthly escalation meetings with Lambeth CCG and Bromley CCG Chief Officers and NHSE for assurance on recovery plan. A&amp;E recovery plans and Discharge to Assess and Trusted Assessor Workstreams in place. Winter money allocation |</p>
<table>
<thead>
<tr>
<th>No.</th>
<th>Ref</th>
<th>Directorate</th>
<th>Risk Title</th>
<th>Initial Risk Score</th>
<th>Residual (current) risk score</th>
<th>Controls</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.</td>
<td>IC-34</td>
<td>Integrated Commissioning</td>
<td>Risk that providers do not deliver 62 day target for urgent cancer referrals.</td>
<td>4x5=20</td>
<td>4x5=20</td>
<td>Governance oversight: SEL wide Cancer Improvement Recovery Plan submitted to and agreed by NHSE in Sept 2016. The 2017/18 plan includes transformation bid actions, diagnostic bid actions and new actions from internal trust plans. SEL funding secured via bids to Cancer diagnostic fund and transformation fund. Work ongoing to ensure full utilisation of e-RS for cancer 2 week wait referrals. A5 patient information cards provided to all GP practices to help to inform patients that they are on an urgent pathway and key contact details.</td>
</tr>
<tr>
<td>4.</td>
<td>IC-35</td>
<td>Integrated Commissioning</td>
<td>Risk that adverse CQC inspection outcomes for general practices in Southwark will negatively impact on quality of care provided to the registered populations.</td>
<td>4x5=20</td>
<td>4x4=16</td>
<td>Full details on CQC outcomes for practices included in full BAF. Primary Care Commissioning team reviews status of practices and improvement actions on a weekly basis. Primary Care Commissioning Committee receives updates on progress against contractual actions and CQC status changes monthly. CCG, with input for GP federations, have endorsed prioritised practices for resilience funding using London set criteria.</td>
</tr>
<tr>
<td>No.</td>
<td>Ref</td>
<td>Directorate</td>
<td>Risk Title</td>
<td>Initial Risk Score</td>
<td>Residual (current) risk score</td>
<td>Controls</td>
</tr>
<tr>
<td>-----</td>
<td>------</td>
<td>-------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
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<td>--------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>5.</td>
<td>IC-45</td>
<td>Integrated Commissioning</td>
<td>Risk to the sustainability of GP practices across north and south Southwark due to workforce, workload, financial pressures and infrastructure, impacting on quality outcomes for Southwark primary care patients.</td>
<td>4x5=20</td>
<td>4x4=16</td>
<td>The CCG supports practices through a range of actions on Workforce, care design, practice infrastructure and workload.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>CCG working with federations to develop different workforce models including practice based pharmacists, and to develop training practices, nurse mentors and placements for pre reg. nurses.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Roll out of GP Forward View (GPFV) resilience funding. Focus on ensuring the resilience funding plan is delivered.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Full detail in BAF.</td>
</tr>
</tbody>
</table>
### Extreme Risks on BAF.. (4)

<table>
<thead>
<tr>
<th>No.</th>
<th>Ref</th>
<th>Directorate</th>
<th>Risk Title</th>
<th>Initial Risk Score</th>
<th>Residual (current) risk score</th>
<th>Controls</th>
</tr>
</thead>
</table>
| 6.  | IC-31| Integrated Commissioning| Risk that the provider does not **deliver achievement of IAPT 50% recovery rate** in year as well as by end March 2018. This will impact on CCG IAF outcome and reputational impact as a result of CCG failing to meet NHS constitutional targets. | 4x4=16             | 4x4=16                        | Meeting with national team to discuss supporting this process held in May. The national Intensive Support Team (IST) will complete a full diagnostic review of the service. The review will produce recommendations for improvement, and the national team will offer support to implement those recommendations.  
SLaM identified inconsistency in national and local data.  
Meeting with national support team also examined reasons for differences with national published data, and team will offer further support to improve IAPT data managements issues.  
Implementation and ongoing review of recovery plan. The national IST review will offer assurance to the recovery plan. More details on BAF.                                                                                     |
| 7.  | IC-49| Integrated Commissioning| Risk that **budget reductions in adult social care impact** disproportionately on key hospital discharge, re-ablement and intermediate care services, adding additional pressures to acute bed capacity. Council facing year on year cuts. | 5x4=20             | 5x4=20                        | Partnership arrangements in place to promote joint working; designed to help to ensure there is a transparent discussion about funding decisions that have a whole system impact, enabling joint plans to be made to mitigate the impact of budget reductions wherever possible. 
Areas of joint working to mitigate potential impact of cuts identified by CCG for discussion with council. Concerns raised at senior leadership meeting with council and high level joint working group set up to consider the "Southwark £" and an Integrated Delivery and Planning Group (IDPG). Specific discussions being formally held on high risk savings areas, for example Integrated Community Equipment Stores (ICES) on which an agreement has been reached. Full detail in full BAF. |
### Extreme Risks on BAF.. (5)

<table>
<thead>
<tr>
<th>No.</th>
<th>Ref</th>
<th>Directorate</th>
<th>Risk Title</th>
<th>Initial Risk Score</th>
<th>Residual (current) risk score</th>
<th>Controls</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.</td>
<td>IC-47</td>
<td>Integrated Commissioning</td>
<td>Risk that <strong>reduction in Council funding impacts on children and young people’s services</strong> e.g. Early Help Service, Parental Mental Health, Functional Family Therapy Teams and Early Years Speech and Language, meaning that these services cannot be delivered within existing arrangements and model</td>
<td>4x4=16</td>
<td>4x4=16</td>
<td>Review and Engagement: On Early Years SLT, CCG Director of Commissioning and Director of ICDT holding regular meetings with GST and the Council to manage the impact of the Council cut. SMT agreed on 17 July strategy to move CCG funding away from education statutory responsibilities in order to protect health responsibilities and the Early Years service (key to prevention). Further legal advice sought and confirmation from council that statutory duties will be met. On CAMHS, the CDG agreed on 8 June a project plan to carry out a joint rapid review of services as next step in managing the potential impact of council funding reductions. Letter received from the Council in relation to their intended use of £315k from the CCG to help protect services during the transformation: prioritisation of Carelink, Functional Family Therapy and part of Early Help CAMHS and restating their position that they have no budget for CAMHS in 17/18 other than they receive via the CCG.</td>
</tr>
<tr>
<td>9.</td>
<td>IC-22</td>
<td>Integrated Commissioning</td>
<td>Risk that <strong>public health grant reductions</strong> will continue to reduce provider funding which will impact on the delivery of public health prevention for adults and children e.g. stop smoking, sexual health, health checks, health visiting and school nursing.</td>
<td>4x4=16</td>
<td>4x4=16</td>
<td>CCG monitors outcomes of the Population Health Management Contract on a monthly basis; CCG reports performance to the Health and Social Care Partnership Board on a quarterly basis; CCG/Council report progress of integrated child pathway development through the CYP CDG to JCSC on a quarterly basis. CCG working with GSTT and LA to finalise budget and s.75 specification of services for 17/18. Full detail in full BAF.</td>
</tr>
<tr>
<td>No.</td>
<td>Ref</td>
<td>Directorate</td>
<td>Risk Title</td>
<td>Initial Risk Score</td>
<td>Residual (current) risk score</td>
<td>Controls</td>
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</tr>
<tr>
<td>10.</td>
<td>IC-53</td>
<td>Integrated Commissioning</td>
<td>Risk that the <strong>GP Practice funding transferred to the CCG under delegated commissioning</strong> will curtail the CCG’s ability to commission sustainable GP practice services and the premium focus to improve access, prevention and continuity of care</td>
<td>5x4=20</td>
<td>4x4=16</td>
<td>CCG undertook full delegated commissioning of GP practice services from 1 April 2017. Primary care budgets received. The CCG has required verification from NHSE regarding how the CCG will assure NHSE of stabilising GP practices with a deficit of £1.83m in the GP practice delegated budget – now reduced to £1.406m. GP practice budgets been verified by finance team. CCG has calculated final PMS Premium at £17.29 per weighted patient</td>
</tr>
<tr>
<td>11.</td>
<td>FM-01</td>
<td>Finance and Business</td>
<td>Risk of failure to deliver <strong>financial targets 17/18 and financial sustainability</strong></td>
<td>4x5=20</td>
<td>3x5=15</td>
<td>In addition to robust financial governance and reporting arrangements, there are risk share arrangements with SEL CCGs. Acute contracts: GST and KCH contracts signed which limit risks to the CCG. On-going work at STP level including all SEL commissioners, NHS provider organisations and Councils to ensure on-going sustainability of the health and social care systems in south east London as reported above. NHSE has indicated 1% reserve to remain frozen. Primary Care budgets received, Southwark has a £1.406m shortfall to be met from overall budget. May IGP committee received an update on financial risks. Agreement to use £216k Primary Care Contingency budget to further mitigate this shortfall. There is ongoing work to identify recurrent solutions to this issue.</td>
</tr>
<tr>
<td>No.</td>
<td>Ref</td>
<td>Directorate</td>
<td>Risk Title</td>
<td>Initial Risk Score</td>
<td>Residual (current) risk score</td>
<td>Controls</td>
</tr>
<tr>
<td>-----</td>
<td>------</td>
<td>--------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>--------------------</td>
<td>-------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>12.</td>
<td>FM-06</td>
<td>Finance and Business</td>
<td><strong>Our Healthier South East London programme delivery</strong> - Risk that current planning and strategic approach is not sufficiently robust to manage pressures and deliver sustainable financial position in the context of lower levels of growth in the period to 2020/21</td>
<td>5x4=20</td>
<td>3x5=15</td>
<td>SEL Strategy Programme governance structure in place supported by full programme team and external contracted support. Governance structure includes: Clinical Advisory Group, Community-based Care (CbC) Working Group, Capital Finance and Estates Group. Community based Care workshops are also on-going. Engagement with patients and clinicians is on-going. Continued oversight maintained by CCG Governing Body, Commissioning Strategy Committee, and Audit committee. Sustainability and Transformation Plan: Work on Sustainability Transformation Plan (STP) progressing well, governance structures revised. Version 2 STP plan submitted to NHSE on 21 October. Capped Expenditure Process (CEP): All organisations in SEL are in discussion about how to reduce the risks inherent in their plans and ensure that overall we deliver the control totals for SEL. Discussions are continuing with NHSE and NHSI on further financial plans submitted on 5th June. Risk title and content updated to align with other SEL CCG BAFs.</td>
</tr>
</tbody>
</table>
No new risks on the BAF for this month
## Risks closed on the BAF for this month

### 2 risks were closed on the BAF

<table>
<thead>
<tr>
<th>No</th>
<th>Ref</th>
<th>Directorate</th>
<th>Risk Title</th>
<th>Initial Risk Score</th>
<th>Residual (current) risk score</th>
<th>Reason for closure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>IC-43</td>
<td>Integrated Commissioning</td>
<td>Risk that providers do not deliver the diagnostics national target. Effect would be longer waiting times for patients, and reputational impact as a consequence of failing to meet NHS Constitutional Standards</td>
<td>3x3=9</td>
<td>2x3=6</td>
<td>Improvement in performance tracked and recognised in letter from secretary of state.</td>
</tr>
<tr>
<td>2.</td>
<td>IC-54</td>
<td>Integrated Commissioning</td>
<td>London-wide recommissioning of GUM and RSH services under a new Integrated Tariff that is lower than earlier might result in loss of provider interest, potential financial implications on the CCG and temporary transitional disruption to service provision. Previously included services like genital dermatology and medical gynaecology will need new negotiations.</td>
<td>4x5=20</td>
<td>2x5=10</td>
<td>This risk is closed as negotiations with the trust are now complete and approach agreed</td>
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</table>
No risks were escalated or de-escalated on the BAF
### Changes to risks on DRRs

The following changes were made to risks on the DRRs in this month.

<table>
<thead>
<tr>
<th>No.</th>
<th>Ref</th>
<th>Directorate</th>
<th>Risk Title</th>
<th>Changes/ Notes</th>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>TP-13</td>
<td>Integrated Commissioning</td>
<td>King's College Hospital stop accepting paper test referrals resulting in GP federations being unable to offer routine appointments through EPCS</td>
<td>Archived: Viapath have agreed to the workaround until long term solution found with EMIS. This has been mitigated and therefore the risk reduced for archiving.</td>
</tr>
<tr>
<td>2.</td>
<td>FB-22</td>
<td>Finance and Business</td>
<td>CCG has a gap in access to Health &amp; Safety advice for its employees creating a risk that the CCG is not aware of gaps in its employer duties which might impact on staff safety and potential for litigation.</td>
<td>Archived: Closure of risk as no further gaps identified.</td>
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<tr>
<td>3.</td>
<td>FB-30</td>
<td>Finance and Business</td>
<td>Implementation of Digital Roadmap and Digital Maturity Index</td>
<td>Archived: Closure of risk as not up to date, no gaps or assurances detailed.</td>
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<td>No.</td>
<td>Ref</td>
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<td>Risk Title</td>
<td>Changes/ Notes</td>
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| 4.  | FB-34| Finance and Business | Risk of disruption and loss of knowledge in the department - the Chief Finance Officer will be away from the office for a prolonged period of time | **New Risk:** Controls include appointment of interim CFO with knowledge of the local area and its surrounding Boroughs  
Handover period was completed with the Chief Finance Officer Workstream leads identified for the non-Finance aspects of role                                                                                     |
| 5.  | QS-26 | Quality and Nursing | Failure to achieve a 10% reduction in reported E coli bacteraemia cases for patients registered with a Southwark GP               | **New Risk:** Controls include action plan that is monitored quarterly by the LSL Infection Control Committee.  
Webinar with NHSE arranged to review IG implications with CSU                                                                                                                                         |
| 6.  | QS-27 | Quality and Nursing | Lack of reviews of people receiving NHS Continuing Healthcare leading to unmet needs and lack of financial control               | **New Risk:** Controls include weekly review list being sent to all reviewing teams; Allocation worksheets ensures that referrals are sent regularly; Prioritisation framework in place for providers; Clinical commissioners carrying out some reviews |
| 7.  | QS-28 | Quality and Nursing | Failure to achieve NHS Continuing Healthcare Discharge to Assess Trajectory within the urgent and emergency care improvement plan | **New Risk:** Controls include L&S CHC D2A board overseeing development of systems and processes to support delivery of the trajectory; The SEL CHC review group chaired by Swk Dir of Quality and Chief Nurse oversees the SEL STP delivery of this trajectory; A&E delivery board have agreed funding from winter pressure monies to support delivery of this trajectory.  
Risk classified as extreme                                                                                                                                                                               |
BAF Heat Map August 2017

IMPACT (CONSEQUENCE/SEVERITY)

Almost certain

Likely

Possible

Unlikely

Rare

1 Negligible

2 Minor

3 Moderate

4 Major

5 Catastrophic

Risk ID Objective | Risk Topic (see BAF for full risk title) | Change since last month
--- | --- | ---
FM-01 | Financial targets & financial sustainability | |
FM-02 | Non-achievement of QIPP impacts delivery of financial plan | |
FM-04 | SECSU performance and quality of support to CCG | |
FM-05 | OHSEL Programme delivery impacting on CCG’s strategic plans | |
FM-07 | Clinical model for Dulwich hospital project | |
IC-06<sup>4</sup> | Referral to Treatment (RTT) performance targets | |
IC-07<sup>4</sup> | A&E 4 hour waiting time targets | |
IC-13<sup>1</sup> | Community Nursing – low staffing levels | |
IC-22<sup>4</sup> | Public Health funding cuts impacting on public health services | |
IC-30<sup>4</sup> | Adult Mental Health transformation implementation | |
IC-31<sup>4</ sup>| IAPT 50% recovery rate targets in year as well as by end 2018 | |
IC-34<sup>5</sup> | 62-day cancer referral target non-delivery | |
IC-35<sup>5</sup> | CQC outcomes for some north Southwark practices | |
IC-43<sup>4</sup> | London Ambulance Service trajectories achievement for Southwark | |
IC-45<sup>4</sup> | Sustainability of GP practices - financial, workforce issues | |
IC-47<sup>2</sup> | Reduction in council funding of Children & Young People services | |
IC-48<sup>2</sup> | Diagnostics waiting time target | |
IC-49 | Adult Social Care budget reductions impacting on hosp discharge | |
IC-50 | E-referral implementation national targets | |
IC-53 | Delegated commissioning funds will curtail the CCG’s ability to commission sustainable GP practice services | |
IC-54 | Re-commissioning of GUM/HIV services | |
QS-02<sup>1</sup> | Effective systems for Safeguarding Children | |
QS-03<sup>1</sup> | Effective systems for Adult Safeguarding | |
QS-11<sup>1</sup> | London Transforming Care performance targets | |
QS-15<sup>1</sup> | KCH financial impact on quality | |
TP-02<sup>2</sup> | Operational and financial stability of GP federations | |
TP-08<sup>2</sup> | Challenges in Implementation of outcomes based contracts | |
TP-15 | GP member practices engagement | |
TP-16 | Comply with Equality duties | |
TP-12 | Risk of slow progress on FYFV plans due to staff not making the connection between their roles and plan delivery | |
Recommendations

The IGP is requested to note and approve the contents of the report specifically:

1. Note that risks were closed during the month by directors in their monthly risk review meetings; there were no new risks or escalations/de-escalations;

2. Note the current extreme risks for the CCG and the BAF risk profile depicted in the Heat Map;

3. Receive assurance on the proactive management of risks facing the CCG;

4. Approve the report and recommend it to the Governing Body.
### NHS Southwark Clinical Commissioning Group

#### Board Assurance Framework

**August 2017**

### Quality and Safety

**Act to comply promptly, ensure and improve the quality and safety of all commissioned services.**

- Work towards the delivery of NHS Constitution standards for the CCG’s local health economy.
- Ensure that the organization’s quality/assurance and risk management interventions are comprehensive, accountable and transparent.

#### CCG CORPORATE OBJECTIVES 2017-18

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<thead>
<tr>
<th>Objective</th>
<th>Date</th>
<th>Description</th>
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<tbody>
<tr>
<td>Quality and Safety</td>
<td>14/06/2017</td>
<td>Support early and effective involvement of local health economy, deliver Value for Money (VfM) and all statutory responsibilities.</td>
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<tr>
<td>Transformation</td>
<td>14/06/2017</td>
<td>Work towards the delivery of NHS Constitution standards for the residents of Southwark, taking remedial action with providers where there is variance from agreed standards or recovery trajectories.</td>
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### Risk Controls

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<tr>
<th>Risk Title</th>
<th>Description</th>
<th>Rating</th>
<th>Risk Control(s)</th>
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### SMART Actions with some Risk Actions & outcomes for completion of action

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<tr>
<th>Risk</th>
<th>Target Risk Score</th>
<th>Score (Likelihood x Impact)</th>
<th>Action</th>
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### Risk Identification and Assessment

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<th>Risk Id</th>
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<td>QS-01</td>
<td>14/06/2017</td>
<td>Support the on-going development and delivery of the South East London Sustainability and Transformation Plan.</td>
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<td>QS-02</td>
<td>14/06/2017</td>
<td>Implement year 1 of the CCG’s Five Year Forward View to establish a population based approach to commissioning. This includes the further development of GP Federation and Local Care Networks and the CCG acting on behalf of its constituent practices across the local health economy.</td>
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<td>QS-03</td>
<td>14/06/2017</td>
<td>Transforming Care provides a national model for across the local health economy. This includes the development of a new model of commissioning and the delivery of a new local health economy.</td>
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### Implementation of Risk Controls

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<th>Implementation and monitoring</th>
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**Audit Framework**

**Risk Title & Description (Cause & Impact)**

<table>
<thead>
<tr>
<th>Date</th>
<th>TRM Action</th>
<th>residual Risk Score</th>
<th>TRM Actions with cause of Risk &amp; deadline for completion of action</th>
<th>Target Date</th>
<th>Evidence of outcome</th>
<th>Summary of Topical Impact</th>
</tr>
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<tbody>
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<td>11/07/2017</td>
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<td>2</td>
<td>SMT update.</td>
<td>07/08/17</td>
<td>TRM Action is in line with local, national and regional</td>
<td>3:2:4</td>
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**Gaps in mitigation/ assurance**

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**Risk Owner**

- Julian Westcott
- Mark Kewley
- Malcolm Hines
- Watts

**Risk Score**

- 1
- 2
- 3
- 4
- 5

**Residual Risk Score**

- 2
- 3
- 4
- 5

**Residual Risk Score (Likelihood x Impact)**

- 2
- 3
- 4
- 5

**Residual Risk Score (Likelihood x Impact x Exposure)**

- 3
- 4
- 5

**Residual Risk Score (Likelihood x Impact x Exposure x Duration)**

- 4

**Residual Risk Score (Likelihood x Impact x Exposure x Duration x Frequency)**

- 5
Risk Title & Description (Cause & Impact):

- Patients and staff experience delays in treatment due to service shortages, which limits health outcomes (profiling data shows a decline in patient satisfaction over the last quarter).
- Patients and staff experience delays in treatment due to service shortages, which limits health outcomes (profiling data shows a decline in patient satisfaction over the last quarter).

Risk Controls:

- Increase staffing levels to meet demand.
- Implement new technology to streamline processes.
- Improve communication channels with patients.

Likelihood (L) x Impact (I) = Risk Score (R):

- L: 4 (Moderate)  I: 4 (High) R: 16 (Very High)
- L: 3 (Low)  I: 3 (Medium) R: 9 (High)

Assurance:

- Monthly, integrated performance reports to SMT/Committee and governing body.
- Minimize risks of SMT/Committee and governing body.
- Regional performance monitoring reports to NHS England.

Potential Impact on KPIs:

- Decrease in patient satisfaction scores.
- Increase in patient waiting times.

Risk Share on QIPP delivery in place with trusts, which limits CSU risk significantly.

Additional stretch target from SMT planning: IH.

Mgmt action to work with governing body on achieving stretch: IH.

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Risk Share on QIPP delivery in place with trusts, which limits CSU risk significantly.

Additional stretch target from SMT planning: IH.

Mgmt action to work with governing body on achieving stretch: IH.
Risk Controls

An effective governance of AHP Intensive Support Team has been established. The model of running the Intensive Support Team (IST) is being reviewed for potential improvements. The System Performance Team will provide oversight of the IST and A&E Delivery Board will monitor IST performance.

Q2 & Q3

Risk Mitigation

Evaluating the systemic and departmental actions taken to address the risk of IST contract review meeting monthly to monitor IST Performance that will take place on 17/18 August. Proposals to review the Southwark IAPT model have been agreed by CSC in relation to ability to deliver the required recovery rate within the current structure. Provider and commissioners will work to reduce the monthly target and consider the need to deliver higher intensity step 3 treatments. The provider also recently undertook a detailed analysis of recovery start times using hour and is preparing a report for the biology department.

Pillar 2: People

In addition, providers and commissioners have agreed that Winter monies and additional non-elective activity has been commissioned as part of the contracting round. System Resilience allocations have been authorised to support providers across the system to reduce pressure at ED with oversight by the A&E Delivery Board.

- Reconfiguration of SLaM Move on Support Teams and implementation of an enhanced primary care model for mental health.
- Serological services on 17/18 August.
- Proposal for the IST to visit high performing practices (low referral rates, high use of A&G, peer review in place) and high clinical risk on a regular basis.
- The System Performance Team will be providing support to clinical Lead practice visits for both high performing practices and low performing practices (high referral rates, low use of A&G, peer review in place).
- The national Intensive Support Team (IST) review to be completed by mid-August 2017. The national IST review to be completed by mid-August 2017. The national IST review to be completed by mid-August 2017.

Pillar 3: Place

Publications:

- Inter-Ministerial and Health and Wellbeing strategies published for consultation on 8th August. Consultation and consultation and October 2017 including consultation for their implementation by 10th September

Risk Owner

Catherine Hindmarsh

Risk Category

Governance

Risk ID

IC-07

Risk Description

Gaps in mitigation/ assurance

Risk ID

IC-07

Risk Category

Governance

Risks:

- Slippage in June to 41.9%.
- Since August 2016 target moving in the right direction towards achieving 50% recovery rate. Previous data shows this achieved in March with 51%.
- Although there had been some slippage in June to 41.9%.
- The national Intensive Support Team (IST) review to be completed by mid-August 2017.
- Work on-going with both Trusts to review recovery plans for IST and A&E Recovery plans for both GSTT and KCH
- Although not confirmed yet.
- The IST contract will be reviewed before the end of June 2017, to include feedback from IST meetings and IST in order to refine their performance.
- The System Performance Team will be providing support to clinical Lead practice visits for both high performing practices and low performing practices (low referral rates, high use of A&G, peer review in place) and high clinical risk on a regular basis.
- The national IST review to be completed by mid-August 2017.
- The IST contract will be reviewed before the end of June 2017, to include feedback from IST meetings and IST in order to refine their performance.
- The System Performance Team will be providing support to clinical Lead practice visits for both high performing practices and low performing practices (low referral rates, high use of A&G, peer review in place) and high clinical risk on a regular basis.
- The national IST review to be completed by mid-August 2017.
Risk ID: IC-35
Date: 17/07/2017
Risk Score: 4
Residual Risk: 4

Risk Description:
- The CQC inspection has been completed.
- Providers do not deliver the required levels of care as stated in the CQC report.
- Risk that providers do not deliver consistently good care, in line with the CQC report.

Risk Control:
- Leadership in place to improve care quality.
- Implementing Wi-Fi in Southwark practices.
- CCG met with Overview and Scrutiny Committee in February and March to progress support for securing health accommodation in future estates proposals.

Impact:
-adverse CQC inspection will negatively impact on service performance.

Resilience:
- CCG monitors GP practice quality through its Quality Assurance Framework including monitoring against SEL and similar boroughs in London (statistical neighbours).

Assurance:
- CQC inspection outcome.

Risk Actionee: Caroline
Deadline: 08/08/2017

Risk that providers do not deliver consistently good care, in line with the CQC report.

Risk ID: IC-34
Date: 08/08/2017
Risk Score: 5
Residual Risk: 5

Risk Description:
- The LAS will be working to increase hear and treat activity by 2%.
- Implementing Wi-Fi in Southwark practices.
- CCG met with Overview and Scrutiny Committee in February and March to progress support for securing health accommodation in future estates proposals.

Impact:
-Demand on the LAS will increase.

Resilience:
- CCG monitors GP practice quality through its Quality Assurance Framework including monitoring against SEL and similar boroughs in London (statistical neighbours).

Assurance:
- CQC inspection outcome.

Risk Actionee: Sarah
Deadline: 08/08/2017

Risk that providers do not deliver consistently good care, in line with the CQC report.

Risk ID: IC-33
Date: 08/08/2017
Risk Score: 4
Residual Risk: 4

Risk Description:
- London wide significant quality and financial pressures.
- CCG working with federations to develop different workforce models including practice based pharmacists and practice based pharmacists.

Impact:
- High staff turnover.

Resilience:
- CCG working with federations to develop different workforce models including practice based pharmacists and practice based pharmacists.

Assurance:
- CQC inspection outcome.

Risk Actionee: Carla
Deadline: 08/08/2017

Risk that providers do not deliver consistently good care, in line with the CQC report.
## Governance

**Risk Title & Description (Cause & Effect)**

**Risk Actionee & deadline**

<table>
<thead>
<tr>
<th>Date</th>
<th>Summary</th>
<th>Responsible</th>
<th>Assurance</th>
<th>Risk Controls</th>
<th>BRAVE Actions with name of Risk Owner &amp; deadline for completeness of action</th>
<th>Target Date/ Continuation Impact</th>
<th>Nature of Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>17/07/2017</td>
<td>Council have appointed an executive for SLT to manage the transition of two members of staff out. Internal communications to ensure that all stakeholders are aware of the new executive lead.</td>
<td>Caroline Gilmartin</td>
<td>Improved BCF grant will provide an extra £7.2m for Southwark. The CCG will be seeking to work with the council to ensure this has maximum impact in order to mitigate the social care savings risk.</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>Improving risk for the Council on their AOS commented savings opportunity.</td>
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<td>17/07/2017</td>
<td>Lambeth BCF implementation plan to meet the CGJS targets not yet finalised.</td>
<td>Caroline Gilmartin</td>
<td>Council have appointed an executive for SLT to manage the transition of two members of staff out. Internal communications to ensure that all stakeholders are aware of the new executive lead.</td>
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<td>2</td>
<td>Improving risk for the Council on their AOS commented savings opportunity.</td>
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<td>17/07/2017</td>
<td>CCG Implementation plan to work through the e-RS Steering Sub Group to publish the e-RS strategy and work with Lambeth to publicise.</td>
<td>Caroline Gilmartin</td>
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<td>17/07/2017</td>
<td>Letter from Secretary of State regarding future funding of SLT in special schools.</td>
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**Notes**

- Council have appointed an executive for SLT to manage the transition of two members of staff out. Internal communications to ensure that all stakeholders are aware of the new executive lead.
- High level “Southwark £” Integrated Delivery and Planning Group (IDPG), including lead council members to make sure system strategies including slugs: BMI, SSM, CCG and ICDT.
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<th>SMART Actions withIC-54</th>
<th>Target Risk Score</th>
<th>Direction of Travel</th>
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<tbody>
<tr>
<td>Quality and Safety</td>
<td>NHSE control what budget they hand to O&amp;Y which will impact on the delivery of public health promotion for adults and children e.g. stop smoking, sexual health, mental health, health visiting and school nursing</td>
<td>Minutes of Health and Social Care partnership (Group meetings)</td>
<td>Reviews of health promotion for adults and children, mental health promotion for adults and children, health visiting and school nursing</td>
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Southwark Integrated Governance & Performance Committee

22 June 2017
Room 132, 160 Tooley Street

MINUTES

Present:
Andrew Nebel (AN) Lay Member, SCCG - Chair
Robert Park (RP) Lay Member, SCCG
Dr Richard Gibbs (RG) Lay Member, SCCG
Kieran Swann (KS) Head of Governance and Assurance, SCCG
Caroline Gilmartin (CG) Director of Integrated Commissioning, SCCG
Kate Moriarty-Baker (KMB) Acting Director of Quality and Chief Nurse, SCCG
Dr Mike Khan (MKh) Secondary Care Doctor Member, SCCG
Dr Noel Baxter (NB) Clinical Lead, SCCG
David Smith (DS) Head of System Performance, SCCG
Julian Westcott (JW) Head of Finance, SCCG
Jacquie Foster (JF) Head of Quality, SCCG
Andrew Bland (AB) Chief Officer, SCCG
Dr Yvonneke Roe (YR) Clinical Lead, SCCG
Joy Ellery (JE) Lay Member, SCCG
Richard Whitfield (RW) Assurance Manager, SCCG (minutes)
Dr Nancy Küchemann (NK) Clinical Lead, SCCG
Dr Emily Gibbs (EG) Clinical Lead, SCCG
Dr Jonty Heaversedge (JH) Chair, SCCG
Sadhna Murphy (SM) Chief Pharmacist, SCCG

In attendance
Brid Nicholson (BN) Southwark Infection Control Nurse Lead
Harriet Agyepong (HA) Associate Director, Performance Improvement, ICDT
Carl Glenister (CGI) System Performance Manager

Apologies:
Linda Drake (LD) Clinical Lead, SCCG
Sheetal Mukkamala (SM) Governance and Risk Manager, SCCG
Malcolm Hines (MH) Chief Financial Officer, SCCG
Aarti Gandesha (AG) Manager, Healthwatch Southwark
Dr Robert Davidson (RD) Clinical Lead, SCCG
Mark Kewley (MK) Director of Transformation, SCCG
1. **Welcome**
   The Chair welcomed members to the meeting.

2. **Introduction and Apologies**
   Apologies were noted.

3. **Declaration of Interest**
   All members were asked to declare any change in conflicts of interest and raise any conflicts relating to items on the agenda. None were raised.

   The register was circulated for signing.

4. **Minutes of the Previous Meeting and Action Log**
   The minutes were noted as a comprehensive record. The action log was reviewed and it was noted that all due actions were complete.

5. **Matters Arising**
   **STP assurance**

   AB updated the committee regarding the CCG 2017/18 assurance rating. As with other CCGs in South East London, Southwark received a letter from NHS England stating that the plan is currently not assured as it does not reflect an agreed plan to contribute to closing the STP footprint control total gap. It is expected that this will be resolved by 30 June to enable the CCG to move to an assured rating. The letter highlights that action is required for the CEP template proposals to close £36m STP financial gap is to be reflected in CCG’s Operating Plan finance plan.

   AB highlighted that Southwark CCG’s share is an additional £2.8 million. Southwark has no unidentified QIPP which places the CCG in a relatively positive position to respond to this. AB stated that there is a costed proposal based on schemes, including the enhancement of TAP, getting it right first time and tighter controls on oversees payments. South East London are not having to consider the “difficult choices”.

   AB stated that due to the joint approaches across South East London, it would be very difficult to justify taking a unilateral decision distinct from the rest of the STP.

   RG asked what the recurrent situation is regarding the CEP.
JW stated that in theory this money will be carried forward to 2018/19. AB highlighted that there is also the SEL risk share which may be enacted in year have an impact on the ability to carry this forward.

AB stated that the full breakdown of how the £15 million will be achieved will be circulated on Monday 26 June to the Governing Body.

### Integrated Community Equipment Store (ICES)

AB updated the committee about the ICES contract, which comes to an end on 30 June and correspondence with the local authority regarding renewing the contract with the provider. Currently there is a 40:60 split with the local authority, responsible for the greater portion of payment.

There is not yet agreement regarding the correct ratio of contract value, and Southwark CCG has proposed a reversal to 60:40 as an interim agreement while work is completed to identify the correct ratio. This would enable a new integrated contract to be signed on 30 June, extending the current arrangements of an integrated contract.

The local authority have indicated a willingness to sign an individual contract on 30 June if agreement is not reached.

A letter will be sent to the Council with details of the proposed breakdown of 60:40 as an interim approach. Should this not be agreed, the issue will be raised by Richard Gibbs to Councillor Livingston as part of their roles of joint working group chair.

### Ophthalmology single point of referral

AN introduced the ophthalmology single point of referral business case, highlighting that this business case has been reviewed by the Commissioning Strategy Committee, and they are in support of the recommendation. The business case has been brought to Integrated Governance and Performance Committee for final sign off.

AN gave all members the opportunity to comment or ask questions.

No conflicts of interests were identified as prospective providers of the service would be community optometrists.

The committee approved the establishment of a single point of referral for all ophthalmology referrals in Southwark on an 18 month trial basis.

The committee approved the introduction of a single provider contract for the Minor Eye Condition Scheme (MECS) on an 18 month trial basis.
### CCG Finance Report (M2)

JW presented the report which highlights the CCG’s financial performance for the 2017/18 year to date. This is shown for the organisation as a whole, and also for each area of the CCG’s commissioning responsibility. The report highlights areas of financial risk and mitigations. JW provided the following summary:

The CCG was underspent at the end of Month 2 by £1,604k for the year to date (ytd). This is marginally above the planned pro rata effect of £1,599k, and is a result of an underspend on running costs.

The CCG has utilised £84k of reserves to achieve this ytd position. This is to offset adverse variances in the reported position. There are partially offsetting favourable and adverse variances in Acute, Primary Health Services, Transformation and Corporate (favourable) Client Groups (adverse). There are partially offsetting favourable and adverse variances in Client Groups (favourable), and Prescribing (adverse).

The CCG is forecasting to meet the annual target surplus of £9,593k. This is equivalent to the brought forward surplus from 2016/17, which has been returned to the CCG in the form of a non-recurrent allocation (£10,063k), in line with national process, less £700k planned drawdown of prior year historic surplus. The surplus has then been adjusted for a planned in-year increase of £230k.

The CCG is currently holding £4,878k of earmarked budgets and reserves. £2,017k of that relates to the 0.5% non-recurrent expenditure reserve, which national guidance has required CCG’s to set aside and which is not currently available to the CCG to utilise. £700k is set aside for the potential SEL use of drawdown.

The CCG is expecting the return of £2m non-recurrent transformation funds from NHS England, this is earmarked to fund the Local Activity Risk Reserve. Also expected is GPFV and access funding that the CCG has funded temporarily from reserves until the allocation is received.

SEL CCGs are in discussion with NHSE about system wide commitments, such as the implementation of the Trust Special Administrator Agreement.

There is currently £4,878k of reserves uncommitted in the likely forecast position as at Month 2. In the worst case projection, the CCG would need to utilise £2,861k of reserves. This is the remainder of the £4,878k after deducting the £2,017k not available for CCG’s to commit.

JW highlighted the financial risks and mitigations. This includes the TSA agreement and primary care.

AN welcomed questions and comments from the committee.

RG noted that the value of the aged debtors and queried why these were still outstanding.

JW stated that some of the debt was disputed as related to BCF risk reserves, which is a joint programme with the local authority.
JH asked if enough focus was being directed towards finding additional QIPP and identifying robust commissioning intentions for 18/19 and beyond. JH stated the willingness of clinical leads to support this process and his concern that the CEP process is transactional focussed rather than transformational.

JW stated that there are working groups focussing on 2018/19, approaches include addressing high users of services.

CG stated that there is an inevitable merging of QIPP and CEP. She highlighted the expectation that this would become part of the wider RightCare approach being led by her directorate.

NK asked for further details about the schemes being discussed with medicines optimisation (P14).

JW stated that prescribing spend is not currently known for months 1 and 2. The figure referenced is the anticipated value based on historical trends on prescribing spend. **Action:** JW to review the wording of this point in the report

The committee noted the following:

- The budgets and position for the ‘Programme Budgets’ and the ‘Running Costs’ as at end of May 2017.
- The forecast position for the year for both ‘Programme Budgets’ and the ‘Running Costs’.
- The worst case scenario forecasts for both Acute and Delegated Primary Care which include the full impact of potential issues relating to the TSA agreement and the allocation shortfall respectively.
- The risks and mitigations in addition to those mentioned above, and specifically the mitigation that relies on the return of £2m non-recurrent transformation funds from NHSE.
## CCG Quality Update

KMB provided an update to the committee on current quality and safety issues, outlining quality assurance and improvement activity. KMB highlighted:

- the work of the medicines optimisation team, including the population based approach to PIS, 16/17 performance and the success of the AF virtual clinic approach and national recognition;
- the second inadequate CQC rating of the Burgess Park and the partnership work being undertaken alongside the LA and Four Seasons to ensure both the on-going safety and quality of care provided to clients in the home, and support the discussions and negotiations around the provision and provider of care at this home. KMB highlighted the risk associated with the current status;
- the additional assurance sought by the CCG from KCH on delayed identification of stroke in ED and assessment of harm for long waiters, and process of identifying low harm;
- the QSC held system-wide learning workshop which reviewed Quality Alerts Raised About General Practice (QARGs);
- A total of 50 serious incidents were logged onto STEIS by NHS Southwark CCG providers in May 2017, 8 of which affected Southwark residents. The most common incident type of incident was treatment delay (6 at Denmark Hill, 3 at PRUH) however this does not automatically mean the cause was insufficient capacity. Initial work to understand issues arising from treatment delays during 2016/17 indicates that information gap / poor communication is relevant, accounting for around 40% of the delayed referrals. Findings will be raised back to King’s.

AN welcomed questions from the committee.

RP asked whether low moral or general staff turnover had been identified as a contributor to the delayed identification of stroke and other incidents.

NB stated that this was a reasonable possibility, though noted that the stroke cases were missed due to unusual presentation of symptoms. He stated that other SIs may have been impacted by delays in treatment but that this will be identified as part of the RCA.

NB highlighted that staffing may be a suitable subject for a future deep dive at QSC.

The committee noted the contents of the quality report and the activities undertaken by the quality directorate, and received assurance that issues identified are being fully addressed.
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<tr>
<th>10</th>
<th><strong>CCG Risk Report &amp; Board Assurance Framework (M2)</strong></th>
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<td>AN presented the report, highlighting the changes to key risks and risk ratings arising from the latest review of the risk register. He stated the number of extreme, high, moderate and low risks on the month 1 BAF and the number of operational risks per directorate. There continues to be 13 extreme risks, as there were in May.</td>
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<td>AN highlighted that two risks were escalated on the BAF related to financial impact of recent developments: primary care budget transfers and finding additional savings through the Capped Expenditure Process. He stated that two risks were de-escalated: London-wide GUM/RSH service procurement and that on assurances for Aylesbury Medical Services; and that two risks on the BAF were closed.</td>
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<td>AN highlighted the two new risks added to directorate risk registers: ICT-01 (Cyber Security Risk to CCG ICT Infrastructure); IG-11 (IG and ICT Security Risk Associated with moving some part so CCG IT infrastructure to cloud platform). Following IGP and SMT discussions, IC-51 (the risk that single LTC's (e.g. Diabetes, COPD, Heart Failure) create significant work programme for commissioning) has been de-escalated.</td>
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<td>AN welcomed questions from the committee.</td>
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<td>JH queried whether risk IC-35 (relating to CQC inspections) should still be identified as such a high risk considering that these have now been completed and that other specific details are captured in other risks.</td>
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<td>CG stated that there is still concern regarding the impact of the CQC inspections and that further rounds will be taking place.</td>
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<td><strong>The Committee noted the current extreme risks for the CCG and the BAF risk profile depicted in the Heat Map. The Committee noted the appropriate management of risks and approved the report and recommend it to the Governing Body for assurance.</strong></td>
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<th>11</th>
<th><strong>CCG IAF Assurance Report (M1)</strong></th>
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<td>CGI provided details of the cancer deep dive, which had been agreed as the area for specific focus within the assurance pack.</td>
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<td>CGI stated that oversight of the actions to deliver improvement in cancer waiting times sits within the SEL Cancer Alliance Board Structure. He highlighted the importance of reviewing at a SEL level rather than at an individual trust level, in particular due to the impact of late inter-hospital transfers on a trust’s performance. He highlighted the number of groups that provide oversight and focus at primary and secondary care.</td>
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<td>CGI updated the committee regarding the outcome of the transformation bid. Funding was agreed. However some of the stipulations made were deemed inappropriate, including a simplistic view of the 62 day standard. HA stated that a response from NSHE is still being awaited.</td>
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<td>HA highlighted that agreed trajectories had recently been changed, following a meeting</td>
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regulators. This shows that SEL is not predicting to hit the target until March 2018. HA stated that closing the gap is reliant on trusts working together across SEL and beyond, which can be difficult due to the low level of influence outside of London. **Action – HA to circulate updated plan**

AN welcomed questions from the committee.

RP expressed his disappointment that performance has not improved following the level of focus over recent years.

JH asked whether there was agreement that adequate actions were being taken, and if there was confidence that an improvement will be seen.

HA stated that a number of issues relating to diagnostics and staffing have recently been addressed. She also identified that GST are changing their IT which will have a benefit impact. The response to the transformation bid from NHSE and NHSI will also be key.

CG agreed with HA and stated that there is clarity about the trajectory and why the target will not be met until March 2018. She stated that at this moment she was confident that all issues identified locally are being fully addressed.

The committee noted the contents of the M1 IAF Assurance Report and received assurance that issues identified are being fully addressed locally for Southwark, but recognised that problems for cancer services at GST were impacted by factors outside the borough.

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**Infection Control Annual Report**

BN presented the NHS Southwark CCG Annual Infection Control Report. The purpose of this report is to provide assurance to Southwark Clinical Commissioning Group in relation to the prevention and control of healthcare associated infections (HCAIs) and communicable disease as mandated in the Health and Social Care Act (2008). The annual report was overseen by the Director of Quality and Chief Nurse, who is the Executive Director for infection prevention and control in Southwark CCG.

BN highlighted the following:

- The Infection Control team was expanded and a GP clinical associate (to support antimicrobial management stewardship) was employed in June 2016. An Infection Prevention Specialist joined the team in December 2016.
- Performance against national targets was good. NHS Southwark CCG met its 2016/17 Antibiotic Quality Premium target and was nominated second place at the London Procurement Partnership awards for their primary care audit programme.
- The 2016/17 Clostridium difficile target was met at 45 reported cases.
- The primary care audit programme for GP practice was re-commenced and advice and support given to sites undertaking building and refurbishment projects. General practice training continued to be provided by GSTT Community Services.
- Several projects were completed to explore discreet infection issues and improve
The best possible health outcomes for Southwark people

- A key priority for Southwark CCG is to meet the targets set out in the Antibiotic Quality Premium for 2017/18. A comprehensive work plan has been developed to support this and includes activities to reduce E. coli bacteraemia infection.

KMB added that a review of IPC arrangement across L&S is currently being undertaken. KMB highlighted the QP requirements for the current year, including the collection of a primary care data set for e-coil bacteraemia.

The committee noted the contents of the NHS Southwark CCG Annual Infection Control Report and that assurance had been provided in relation to the prevention and control of healthcare associated infections (HCAIs) and communicable disease as mandated in the Health and Social Care Act (2008).

**Continuing Healthcare Assurance Report**

MG presented the Continuing Healthcare assurance report, highlighting that the CCG has a specific non-delegable statutory duty to arrange assessment for and provision of CHC services having regard to the National Framework for NHS Continuing Healthcare and;

CHC is currently an assurance priority for NHS England with specific emphasis on Reducing the proportion of CHC assessments carried out in acute hospitals, Complying with the 28-day target for the completion of CHC assessments, Increasing the proportion of CHC patients receiving personal health budgets.

MG stated the outturn for CHC for 2016-2017 for all client groups was £10.7M and, in total, 506 Southwark patients received CHC during the year. There is a large variation in the needs of the different people.

There is a long term trend towards greater numbers of people receiving CHC driven by demographic changes as well as greater awareness of CHC throughout the health and social care sector.

The CCG is a member of the CHC AQP a collaborative framework agreement between 29 London CCGs and 162 care homes with nursing in London and surrounding areas for the provision of non-specialist nursing home care for people receiving CHC.

The CCG’s proportion of CHC care home placements made on the AQP framework was the second highest in London for 2016-2017 at 78%. Due to limitations in care home supply during the financial year only on other CCG in the STP area succeeded in achieving more than 66% of placements in AQP care homes.

The CCG has a three-year contract for the provision of generalist home care with Medacs Ltd with an option to extend by a further two years. The contract was issued following a competitive tender in September 2014 and has three months left to run of the original term. The key outcomes for the contract are a low rate of refusals of care packages and improved patient and carer experience. During the year 67% of care packages were provided through the Medacs contract. The main reason for using other providers was to maintain continuity with a care package previously provided by Social Care.
Reviews of CHC eligibility are carried out by provider services at GSTT and St Christopher’s Hospice. Of reviews required during 2016-2017 sixty-two are outstanding. The CHC team is working together with providers to support the completion of reviews and forward planning by sending monthly updates to each team outlining the reviews to be carried out.

MG highlighted the current year initiatives, which include discharge to assess with a target of reducing the number of CHC assessments being carried out in acute hospitals to less than 15%. This is a challenge due to the limited options locally and the low number of self-funders, meaning that means testing is required by the LA.

AN welcomed comments and questions

KMB highlighted her concerns regarding the impact of discharge to assess being an additional burden on community service capacity.

The committee noted the content of the report and that this provided assurance that the CCG’s arrangements for NHS Continuing Healthcare (CHC) are lawful, effective, represent value for money and are responsive to NHS England assurance priorities.

| 14 | Minutes – Information Governance Steering Group  (March 2017) |
|    | Minutes – Quality and Safety Programme Board (March 2017) |
|    | Minutes – Safeguarding Executive (May 2017) |
|    | No questions were raised by members. |
|    | The Committee noted the minutes. |

| 15 | Any Other Business |
|    | No items were raised. |

| 16 | Date of next meeting |
|    | 3 – 5.30pm, Thursday 27 July 2017 |
Southwark Integrated Governance & Performance Committee

27 July 2017
Room 132, 160 Tooley Street

MINUTES

Present:
Dr Noel Baxter (NB) Clinical Lead, SCCG
Andrew Bland (AB) Chief Officer, SCCG
Angela Brown (ABr) Designated Nurse, Looked after children (item 10)
Christine Caton (CC) Acting Chief Financial Officer, SCCG
Clarisser Cupid (CC) Designated Nurse, Safeguarding children (item 10)
Dr Robert Davidson (RD) Clinical Lead, SCCG
Joy Ellery (JE) Lay Member, SCCG
Jacquie Foster (JF) Head of Quality, SCCG
Aarti Gandesha (AG) Manager, Healthwatch Southwark
Caroline Gilmartin (CG) Director of Integrated Commissioning, SCCG
Dr Jonty Heaversedge (JH) Chair, SCCG
Dr Mike Khan (MKh) Secondary Care Doctor Member, SCCG
Mark Kewley (MK) Director of Transformation, SCCG
Dr Nancy Küchemann (NK) Clinical Lead, SCCG
Andrew Nebel (AN) Lay Member, SCCG - Chair
Gerry Owen (GO) Project Director – Healthcare Advisory Services (item 11)
Robert Park (RP) Lay Member, SCCG
Dr Yvonneke Roe (YR) Clinical Lead, SCCG
Rebecca Scott (RS) Dulwich Programme Manager, SCCG (item 11)
David Smith (DS) Head of System Performance, SCCG
Kieran Swann (KS) Head of Governance and Assurance, SCCG
Richard Whitfield (RW) Assurance Manager, SCCG (minutes)

Apologies:
Linda Drake (LD) Clinical Lead, SCCG
Sheetal Mukkamala (SM) Governance and Risk Manager, SCCG
Malcolm Hines (MH) Chief Financial Officer, SCCG
Dr Richard Gibbs (RG) Lay Member, SCCG
Kate Moriarty-Baker (KMB) Interim Director of Quality and Chief Nurse, SCCG

Chair: Dr Jonty Heaversedge
Chief Officer: Andrew Bland

The best possible health outcomes for Southwark people
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<tr>
<td>1</td>
<td>Welcome</td>
<td>The Chair welcomed members to the meeting.</td>
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<td>2</td>
<td>Introduction and Apologies</td>
<td>Apologies were noted.</td>
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<td>3</td>
<td>Declaration of Interest</td>
<td>All members were asked to declare any change in conflicts of interest and raise any conflicts relating to items on the agenda. None were raised from those in attendance and it was noted that those members of IGP with a potential conflict for the dermatology business case were not present and had not had access to these papers. The register was circulated for signing.</td>
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<td>4</td>
<td>Minutes of the Previous Meeting and Action Log</td>
<td>The minutes were noted as a comprehensive record. The action log was reviewed and it was noted that all due actions were complete.</td>
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<td>5</td>
<td>Matters Arising</td>
<td>AN asked for an update on discussions with the Council regarding the ICES. CG confirmed that a section 75 agreement is currently being written and an interim agreement reached with the council. The funding contributions will be revisited in December 2017 when further evidence is available.</td>
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<td>6</td>
<td>CCG IAF Assurance Report (M2)</td>
<td>AB brought to the attention of the committee the letter from NHS England stating the outcome of the 2016/17 CCG annual IAF assessment as ‘good’ and the letter stating that Southwark’s final operating plan assurance rating is ‘assured’. AB highlighted that the CCG received ratings of ‘outstanding’ for dementia, ‘good’ for mental health and ‘requires improvement’ for cancer. South East London has the lowest ratings overall for all STP footprints, with more CCGs requiring improvement than any other area in London. RP agreed that the CCG needs to take note where it is in the bottom quarter nationally, highlighting in particular management of long term conditions and primary care. AB agreed and also highlighted the time-lag in some metrics and this needs to be taken into</td>
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consideration when any improvements are assessed over the next year. AB added that the letter includes a list of clinical areas which are recognised as areas for improvement and a further summary of the dashboard would be circulated this week to the Governing Body.

AN requested an update on the key constitutional standards.

AB stated that performance against the 4 hour standard at both GST and KCH remains below the national 95% target. He stated that GSTT are below plan. King’s (including Denmark Hill) are showing signs of steady improvement over recent months and weeks.

CG stated that there has been discussion from the trust that high temperatures may be driving high activity for both trusts and LAS

JE cautioned that at this stage the pattern of improvement may be due to variation rather than the start of an upwards trajectory. She highlighted the high handover time at KCH, which has led to a large number of hours being lost.

DS stated that further beds have opened at DH, and the UCC is operational, other beds have closed as part of the process of reconfiguration. There is still further work required with the bed management system, including the consideration of approaches taken at neighbouring hospitals such as QEH.

DS highlighted the variation in performance against cancer standards (including the 62 day standard) and that large swings can be due to a change of a small number of patients. DS stated that he had seen unvalidated data which indicates an improvement for recent weeks an expectation that KCH will meet the standard in September and that GST remain above trajectory.

JF highlighted that cancer is flagged as the number one priority for the Trust by the GST CQRG. A star chamber approach is being taken chaired by the trust COO.

DS highlighted that there remains a lack of clarity regarding the availability of funding from NHS England under STP Transformational Funding. Without this confirmation capital plans cannot go ahead.

AB highlighted the approaches of insourcing and outsourcing that have been taken by KCH and GST respectively to address waiting times. RP asked about assurances on quality of services delivered through these approaches. JF stated that contractually they are in line with all other services commissioned from the trusts.

AN highlighted the need to review the data in more detail over a longer period of time to see trends and delivery against plan. It was agreed to schedule the following deep dives: RTT (October), A&E (November), Cancer (December). Action: RW to schedule with DS the deep dives

CG highlighted IAPT performance and that a paper has been taken to CSC with options for improvement. An audit which takes into account the tier 4 patients and addresses data issues indicates a recovery rate of 55-60%.

RP highlighted that the names of committees providing assurance across IAF indicators may
The best possible health outcomes for Southwark people
CCG Quality Update

JF presented the quality update which provides a snapshot of current quality issues and activities, which may not have been through other committees.

JF highlighted the rising number of Violence and Aggression incidents against NHS staff, noting that this also impacts on recruitment.

To address this KCH have set up a Challenging Behaviour Group co-chaired by their Chief Nurse and Liaison Psychiatrist and are discussing revamped conflict resolution training to be delivered by SLaM; GSTT have re-launched their policy on handling aggressive patients, and LAS are reviewing incident categories to improve data collection as they recognise this is a bigger issue than indicated by the information they currently have. Additionally KCH have recruited a first cohort of 10 (DH) and 8 (PRUH) volunteers with the aim of giving patients in ED more practical and emotional support and potentially reducing levels of tension.

JF stated that at June and July CQRGs KCH, SLaM and GSTT each updated CCGs regarding progress to implement requirements arising from the CQC paper Learning, Candour and Accountability (December 2016). The report was written following the findings of low number of reviews into deaths at Southern Health NHS Foundation Trust and inadequate involvement of family and carers. The CQC report led to more specific guidance being issued from the National Quality Board/NHSE, Learning from Deaths’ (March 2017), which requires action from Trusts. The LeDeR work comes under this wider initiative. SCCG has established processes in place to oversee management of serious incidents in its providers and particularly to focus on extracting and promoting learning to prevent recurrence. The three Trusts are all on track to meet the requirements of the NQB.

JF stated that the highest number of bed days lost to delayed transfers of care and medically fit for discharge patients are from those who choose (patient and next of kin) not leave hospital when medical advice is that they are ready to do so. Consequently work to improve Going Home is very pertinent. Healthwatch Southwark and Lambeth have recently jointly won the national Healthwatch England Working Together award for their Going Home work which includes the patient video and 2016 event codesigned and hosted by NHS Lambeth and NHS Southwark CCGs. AN congratulated Healthwatch on their award.

DS highlighted the importance of choice policy which supports patient decision making.

JF highlighted that there were 41 serious incidents logged on STEIs by NHS Southwark CCG providers in June, slightly higher than the monthly average of 33; 9 of these affected Southwark residents. The most common incident types continue to be treatment delays and slip/trip/falls.

Of the 41 SI declared, 4 were Never Event incidents – one at KCH DH, one at PRUH and two at GSTT. These will be fully investigated and closed only when evidence is received of each action having been completed.

AG asked whether the volunteer scheme at KCH would be evaluated.

JF stated that she would contact the trust to find out and feed this back.
YR highlighted the impact that self-discharges might have, and whether work to understand the reason for this would be useful.

The committee noted the contents of the quality report and the activities undertaken by the quality directorate, and received assurance that issues identified are being fully addressed.

### CCG Risk Report & Board Assurance Framework (M3)

KS presented the CCG’s risk report (ENC Bi) for the month of July 2017 presenting the highlights of updates to risks for the CCG.

KS stated that the BAF and risk registers have been updated by all risk owners and then reviewed by the CCG directors in their monthly risk meeting with the Governance and Assurance Manager. No risks were escalated or de-escalated on the BAF this month. There were no new risks identified.

KS asked if the committee agreed to the following three risks on the BAF being closed and added to the archive: – i) IC-52 Aylesbury Medical Services risk closed following the termination of the dermatology contract and intend to award to another provider, ii) FM-26 Governance, financial, reputational, resources, engagement and conflict of interest risks related to the CCG’s delegated commissioning of Primary Care responsibilities following successful establishment of the governance structures; primary care budgets issues are live and covered under IC-53; iii) IC-46 - Risk that quality outcomes for Southwark general practices continue to reduce/ remain the lowest; closed as it has been merged with IC-45.

This was agreed by the committee

The committee noted that risks were newly identified and changes to risks during the month by directors in their risk review meetings.

The committee received assurance on the proactive management of risks facing the CCG.

The committee noted the current extreme risks for the CCG and the BAF risk profile depicted in the Heat Map.

The committee approved the report and recommend it to the Governing Body for assurance.

### Annual Looked After Children Commissioning Report

ABr presented the report highlighting in particular the annual change in performance for number of children with health surveillance checks up to date; number of children with immunisations up to date; number of children who received an intervention for substance misuse problem and; the number of children with an SDQ score.
ABr highlighted that the specially commissioned Carelink CAMHS service has continued to provide high-quality care to children and young people, their carers as well as the offer of professional outreach to the network around the children and young people. Carelink have a strong tradition of high quality research into the mental health and well-being for children – notably, the SUSI project which is showing very positive outcomes at an early intervention stage for our youngest and most vulnerable children.

Additionally, children looked after by Southwark continue to benefit from high-quality services available at acute hospitals (KCH &GSTT) as well as community health provision including sexual health services. Access to well-being services made available through free gym and swim and other local initiatives is maintained. Another strength lies in the positive service user feedback. Ensuring the voice of the children and young people is captured is a continuous driver throughout the work done by services commissioned by the CCG. There is close work with Speakerbox as well as integration of this within individual health assessments and LAC reviews.

Some challenges to the continued delivery of high-quality care for all LAC is the equity of care delivered to those children who are placed outside the borough boundaries, including those children who require mental health services. The delivery of statutory health assessment within timescales remains a challenge for the provider service.

Great opportunities are present in developing an understanding of the vulnerabilities of children and young people. A refreshed JSNA (joint strategic needs assessment) to include looked after children, has been requested. A more systemic understanding of young people at risk of sexual exploitation and/or are missing from their placements is emerging through the work of specific operational meetings/panels. Joint work has led to greater understanding of the health needs of late adolescent LAC and the possible impact this may have on the stability of their tenancy. Building on the work of the CYPHP project with respect to the needs of children placed OOB affords good opportunities to understand this population.

RP asked if there was an understanding of the impact of geography on looked after Southwark children – in particular those who are cared for outside the borough.

ABr stated that there is some work looking at the needs of those outside of Southwark. CC highlighted that different boroughs may have different criteria but there is a process of writing to all boroughs where a Southwark child is placed highlighting health and safeguarding concerns.

CG highlighted the importance of close working with the local authority and having a clear commissioning framework and an understanding of an overall pathway. She highlighted the link with children on the edge of care.

CC agreed about the importance of this and the role that the children and young people commissioning development group has.

NK highlighted that the action plan does not directly address the issues of capacity and Carenotes referenced in the report.

ABr stated that a review of the service is in progress. The date this is expected to be completed will be provided to IGP members. ABr has confirmed that the initial diagnostic
report is in progress by GSTT Transformation Team. This will inform the next steps

The committee reviewed the content of the content of the Annual Looked After Children Commissioning Report and noted that:

- Feedback from the recent OFSTED inspection of the local authority is integrated into the action plan for 2017/2018.
- Overall statutory performance is satisfactory.
- Further work is required to improve the timeliness of initial health assessments
- The issues reflected in overall performance of the provider service (Southwark LAC Health Service) have been noted by the CCG. They are being monitored via provider assurance pathways. The CCG has committed additional resource.
- The CCG is engaged in robust scrutiny of issues pertinent to the health of looked after children in partnership with the local authority and the wider health economy.

**Dulwich – Stage 2 business case – strategic, finance and management cases**

RS presented the work in progress stage 2 business case. Significant progress has been made on the case and this paper asks the IGP to approve the strategic, financial and management cases. The strategic and management cases have been updated but remain largely unchanged since stage 1. The financial case too has been updated and further refined and sets out the case demonstrating that the scheme is affordable to the CCG.

The remaining sections, although largely updated, are subject to further amendment following the completion of some further detailed work on the design and the construction costs. This review work will be completed by mid-August.

Although this work is not expected to significantly change the overall cost of the scheme to the CCG, there will be at that point a number of assessments by technical and financial advisors and by the district valuer. This is to assure us that the scheme is fit for purpose and consistent with the participant’s’ requirements, and that the capital cost, the financial modelling and the ongoing revenue costs all represent value for money.

Once those assurances have been received and the various legal agreements have been confirmed the business case can be finalised, and once approved will be submitted to the PAU for review and passage through the NHS England capital investment processes.

RS highlighted that the Dulwich Programme Board has reviewed the case to date and asks the IGP to approve the strategic, finance and management cases. In doing so the IGP would be agreeing that the project is affordable to the CCG and therefore the local health economy, subject to confirmation that:

- there are no significant changes to the cost of the scheme, and the DPB propose that significant is a change of over £100k per annum in the LRA rental costs.
- it is in accordance with the CCG’s Participants’ Requirements
- it can be demonstrated to be value for money.
The IGP is also asked to give delegated authority to the CFO, Programme Board Chair and IGP Chair to approve and submit the final completed business case when ready, to NHSE.

AN asked when confirmation would be provided by the developers regarding delivery against the £15 million envelope.

GO stated that they have committed to delivering for £15 million. They will confirm plans for how they will do this by 14 August when the VSM assessments will be made.

CG stated that the Dulwich programme is imperative to development of primary care services in this part of the borough and she strongly supports it from a service perspective.

CC confirmed that the finance team had worked with the project team on this section and that MH had confirmed to her that it was affordable to the CCG.

IGP agreed that the project is affordable to the CCG and therefore the local health economy, subject to confirmation that:

- There are no significant changes to the cost of the scheme, and the DPB propose that significant is a change of over £100k per annum in the LRA rental costs.
- It is in accordance with the CCG’s Participants’ Requirements and
- It can be demonstrated to be value for money.

The committee confirmed delegated authority to the CFO, Programme Board Chair and IGP Chair to approve and submit the final completed business case when ready, to NHSE.

Policies: Lone Working, Security, Avoiding Violence & Aggression, Maternity, paternity and adoption; COI; Gifts and Hospitality.

KS presented the policies which had been circulated to the committee and the COI policy approved by Richard Gibbs, Governing Body lead for governance and conflict of interest. The lone working policy is new, and was written in recognition that a number of members of staff now work offsite regularly. A number of staff have been engaged in its development and advice has been taken from the health and safety executive. The policy includes the availability of safety lanyards to staff.

KS highlighted that a shared parental leave policy is also in development, which will follow national guidance.

CG supported the policy and stated that it was proportionate to the working arrangements that are in place for CCG staff.

The committee agreed the following policies: Lone Working, Security, Avoiding Violence & Aggression, Maternity, paternity and adoption; COI; Gifts and Hospitality.
## Community dermatology procurement business case

DS presented the community dermatology procurement business case. This has previously been presented and discussed in detail with members of the Governing Body. It was discussed at the North and South Locality meetings which provided some comments for clarification, but will mean that sign off of the specification by Chair’s action will be required.

NB highlighted that as primary care is not currently set up to review SIs and other quality issues in the same way as acute trusts. This is an opportunity to ensure that contractual requirements are in place and requested this be considered in the documentation.

AN asked for clarification about the timelines.

DS confirmed that the specification would be confirmed in the next 10 days with the procurement to be launched in the second week of August.

The committee accepted the recommendation of this business case that the CCG procure a mandated single point of referral for dermatology referrals on a three year contract with an option to extend for two years.

The committee agreed to allow Chair’s action for changes to the specification in line with feedback at the locality meetings.

## Minutes – Quality and Safety Sub-Committee (April 2017)

Minutes – Medicines Management Committee (Jan; Apr; Jun 2017)

No questions were raised by members.

The Committee noted the minutes.

## Any Other Business

No items were raised.

## Date of next meeting

3 – 5.30pm, Thursday 24 August 2017
COMMISSIONING STRATEGY COMMITTEE

Minutes

1 June 2017

Present

Richard Gibbs (RG) Lay Member (meeting chair)
Caroline Gilmartin (CG) Director of Integrated Commissioning
Joy Ellery (JE) Lay Member
Noel Baxter (NB) CCG Clinical Lead
Ami David (AD) CCG Secondary Care Nurse Member
Nancy Küchemann (NK) CCG Clinical Lead
Robert Park (RP) Lay Member
Robert Davidson (RD) CCG Clinical Lead
Malcolm Hines (MH) Chief Financial Officer and Deputy Chief Officer
Linda Drake (LD) CCG Practice Nurse Lead
Penny Ackland (PA) Chair of Southwark LMC
Aarti Gandesha (AG) Healthwatch Southwark
Mark Kewley (MK) Director of Transformation
Michael Khan (MKh) Secondary Care Doctor Member
Kate Moriarty-Baker (KMB) Director of Quality and Chief Nurse (acting)
Jacques Mizan (JM) CCG Clinical Lead
Richard Whitfield (RWh) Assurance Manager (minutes)

Apologies

Andrew Bland (AB) Chief Officer
Andrew Nebel (AN) Lay Member
Richard Pinder (RPi) Consultant in Public Health, Southwark Council
Yvonneke Roe (YR) CCG Clinical Lead
Kieran Swann (KS) Head of Governance & Assurance
Emily Gibbs (EG) CCG Clinical Lead
Jonty Heaversedge (JH) CCG Chair
Kevin Fenton (KF) Director of Health and Wellbeing, Southwark Council

Present

Rosemary Watts (RWa) Head of Membership and Engagement
David Smith (DS) Head of System Performance
Mike Salter (MS) Interim Chief Pharmacist
Gillian Branford (GF) Assistant Director Partnership Commissioning Team
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<tr>
<th>1</th>
<th><strong>Introductions, apologies and declarations of interest</strong></th>
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<tr>
<td></td>
<td>RG welcomed all members to the meeting. Apologies were noted.</td>
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<td></td>
<td>All members were asked to declare any change in conflicts of interest and raise any conflicts relating to items on the agenda. None were declared.</td>
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<td>The register was circulated for signing.</td>
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<th>2</th>
<th><strong>Minutes of the last meeting</strong></th>
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<td>The minutes of April 2017 were reviewed and agreed as an accurate record. The action log was reviewed.</td>
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<td>MK updated that a retrospective review of LCNs scheduled for the June 2017 GB seminar ahead of further developmental sessions with ACDG, CCG SMT and CSC in summer 2017.</td>
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<td>MH updated that the CCG ran a RightCare session in April 2017 and has set out the governance arrangements for the development of this work through the Planned Care Group and CDGs. MH stated that a discussion with governing body would be planned.</td>
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<td>It was agreed that action to date did not fully address the action for the development of a proposal (or process map) for the prioritisation of investment / new QIPP / RightCare. <strong>Action:</strong> RWh to update the action log to state in progress. Action to remain open for MH.</td>
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<td>RW updated that the GSTT patient friendly policy had been shared with Southwark practices. The committee agreed to close this action.</td>
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<td>CG stated that a written update on progress with joint commissioning had not yet been completed and circulated. This is due to a number of new joint meeting and initiatives being in their infancy. CG stated that an updated would be circulated prior to the next meeting with support from MK. <strong>Action:</strong> CG/MK to write and circulate update on joint commissioning</td>
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<th><strong>Matters arising</strong></th>
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<td>Locality attendance data by practice was reviewed by members following a request at the April meeting. RW highlighted the discrepancy in mailing lists between the north and South of the borough. Concerns were raised regarding some of the practices which had low attendance rates.</td>
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<td>Feedback from SLaM on the Older Adults Action Proposal was reviewed by the committee. The proposal is concerned with the reconfiguration of older inpatient services across four boroughs, in order to consolidate and make efficient geographical changes.</td>
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<td>JE raised concerns regarding staffing, in particular whether reconfiguration had taken into consideration of the impact patient choice could have on staff requirements.</td>
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<td>The committee noted both the SLaM and Older Adults Action Proposal and the locality attendance numbers.</td>
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Ophthalmology single point of referral

DS presented the business case to establish a single point of referral for all ophthalmology referrals in Southwark. The single point of referral would triage all referrals that were not sent directly to MECS, and direct them to the most appropriate setting i.e. either MECS or acute providers. It is estimated that 36 per cent of those referrals sent to the single point of access would be directed to MECS. Thus, introduction of the single point of referral would result in all ophthalmology patients being seen quicker, whilst reducing demand on secondary care providers and increasing utilisation of MECS.

King’s College Hospital NHS Foundation Trust (KCH) and Guy’s and St. Thomas’ NHS Foundation Trust (GSTT) have seen an increase in the number of ophthalmology referrals, with patients waiting within excess of 14 weeks to be seen. Many those who are referred to secondary care could have been in the community setting i.e. via MECS and currently MECS is underutilised.

DS highlighted that in the new service patients would be guaranteed to be seen within a week and normally within 48 hours. DS stated that this would be an 18 month pilot, partly to further build the case and also to allow for potential harmonisation in services across South East London, where CCGs are at different stages of development.

The proposal is for a single provider contract model which would allow Southwark CCG to contract a company to work with all practice providers in the area without having to manage individual contracts. The company would sub-contract with the current optical practice providers. The single provider contract would enable more optometric practices to be brought on to MECS, the arrangement of training and education, and would ensure compliance with information governance, data management and e-RS requirements. Lambeth CCG have recently set-up a similar model.

DS summarised that implementing the proposed model would not only reduce acute activity but would lead to greater provision of community care, improved waiting times and patient experience, and be financially beneficial and in support of QIPP plans.

CG clarified that the recommendation to CSC is that they endorse the direction of travel, with the business case then being taken to IGP for sign off as appropriate.

RG asked if members had any questions

NK asked if the proposal is for the same provider to coordinate the MECS service as well as provide triage. DS stated that it could be the case but the business case does not necessitate this.

NK highlighted concerns about funding potentially leaving the NHS and queried if £10 was sufficient funding for each triage. DS stated that local optometrists who already work in the scheme would be doing the screening and therefor funding would remain in the local health economy. DS highlighted that optometrists had reviewed the patients waiting more than 12 weeks at KCH and found that 40% could go to local optometrists.

JE asked if MECS would be able to refer directly to the acute trust. DS confirmed that they
could and that this would be done via ERS.

RP queried if this would be cash releasing due to the contractual arrangements with both KCH and GST. DS stated that it was cost neutral and that funding has been made available by NHS England for demand management. This forms part of our obligations within the QIPP plans agreed with the trusts.

RD asked if the intention is for referrals to be reviewed daily and asked for details of clinical oversight of the process. DS confirmed that referrals would be reviewed daily and that consultants from the trusts would provide oversight and assurance.

MK asked if there was potential for outcome based commissioning within the contract rather than cost and volume. DS stated that optometrist generated activity was not included in the contract. There is also a recognition of significant unmet demand which may increase referrals to the trust. DS highlighted the potential in the future for shared care arrangements with the trust which would be better suited to outcome based incentives, however it would be difficult to incentivise in this way under initial plans.

CG highlighted the intention to roll out in line with Lambeth, but that there would be set points of evaluation which would enable review of incentives and contractual approaches. It was agreed that these approaches should be considered in the evaluation.

PA enquired if this would affect current approaches to directing patients directly to optometrists. DS stated that this does not and therefore should continue. The service would be aimed at those patients where primary care is unable to determine if other services are appropriate instead.

The committee noted their support for the direction of travel and business case and that it would be presented to IGP for formal sign-off.

GP prescribing IT tool procurement

MS provided an overview of the GP prescribing IT tool and the work completed to date. Investment in an IT Prescribing Decision Support Tool has been agreed as part of the 2017/18 Medicines Optimisation QIPP. Overall the CCG Medicines Optimisation Team (MOT) has a QIPP of £1.7m for 17/18.

It is anticipated that the introduction of an IT Prescribing Decision Support Tool will achieve a potential QIPP saving of £100k in year. Feedback at both presentations by the IT suppliers suggested that use of such a tool in areas where they have not been previously used could offer initial annual savings of between 4-6 times the investment.

MS highlighted the benefits of an IT prescribing tool: It provide prescribers access- at point of prescribing - to both local and national best practice guidance, quality and cost recommendations, safety alerts and updates; they are seen as an aid to help standardise the prescribing process. They have been recommended for use by NHS England as part of the strategy to achieve medicines optimisation; it will help to reduce unwarranted variation in
prescribing; it can be used to influence and manage prescribing in General Practice; it can support delivery of the QIPP agenda against the prescribing budget.

The MOT sought advice from the CCG’s procurement support team. This procurement advice included the use of an NHS Shared Business Services purchasing framework currently available for prescribing decision support systems. The framework has two suppliers that are provider of IT Prescribing tools.

MS stated that the CCG has explored the tools offered by both suppliers and following demonstrations and review of the tools, has established that only one of the tools (Optimise RX) is able to provide all the desired specifications that the CCG require which include specifically that the tool must be able to link to READ codes in GP practices making it intuitive to deliver patient specific messages, is integral to existing IT systems in primary care and provides a customer support service that is proactive and does not require additional capacity from within the existing MOT.

RG asked for questions and comments from the committee

PA asked if there was an option to embed local prescribing directly into EMIS. KMB stated that this approach would require additional resource for building and ongoing management, though the cost of the system was lower. Optimise RX is available to be switched on within EMIS and ongoing support and management would be provided by the company.

NK asked about the ability to monitor the impact of the system prior to switching on and whether this could provide useful data and information. MS confirmed that this would be available at various levels. This would not be used for performance management purposes but for intelligence and to facilitate support.

MS confirmed that the licence would require renewal annually, and that the providers would update guidance in line with renewed national and local guidance with a timescale of 3-5 days. He also highlighted that, because it is linked to READ codes, there is potential to use it to highlight where patients are due for review or blood tests due to the time they have been on medication.

CG stated her support for the tool and that she has experience of similar systems in other boroughs. She also highlighted the links to RightCare, CEG and finance.

The committee agreed:

1. To note the rationale and proposals for the introduction of an IT prescribing decision support tool as part of the MOT QIPP plans for 2017/18

2. To note the engagement already undertake within primary care on this proposal

The committee noted its support for:

1. The recommendation for the procurement of Optimise RX as the preferred tool

2. The procurement of this preferred tool via a tender waiver process
**Revision in Prescribing Guidelines for General Practice:**

**Provision of malaria chemoprophylaxis and travel vaccines in line with national NHS guidance.**

MS provided an overview of the proposal to consult with patients and the public to formally stop prescribing of malaria chemoprophylaxis medicines on the NHS in Southwark and more robustly encourage adherence to national guidance regarding availability of selected travel vaccines on the NHS in Southwark.

MS stated that historical arrangements are in place across Southwark, Lambeth and Lewisham CCGs which encourage prescribing of malaria chemoprophylaxis on NHS FP10 prescriptions. These arrangements were introduced in 1996 by the then LSL Health Authority as a mechanism to tackle the number of malaria cases locally. The arrangements were collectively reviewed across the three boroughs in 2011 and it was agreed that it would continue (although the availability of Malarone on the NHS was restricted as a result of the review). There has been no further review since then. However, in view of the financial constraints in the NHS, the appropriateness of the local arrangements have come into question.

MS highlighted that this was originally proposed as a potential QIPP area to the Southwark Medicines Management Committee (MMC) in September 2016. The MMC requested further detail developed in collaboration with public health and the other two boroughs. Following a meeting with public health reps and Lambeth/ Lewisham CCG reps, further detail and an options appraisal proposal was presented back to the MMC in January 2017. The MMC unanimously supported the option to withdraw the local arrangements and revert to national policy (that malaria chemoprophylaxis is available on private prescription only). The proposal to withdraw the arrangements is supported by public health colleagues. However, they have requested that they are allowed to monitor the effects of withdrawing the malaria arrangements over the next 18 months.

Lambeth, Southwark and Lewisham are the only three areas nationally offering malaria prophylaxis through the NHS. Local Public Health colleagues have been involved in the proposal to discontinue prescribing of malaria chemoprophylaxis medicines on FP10 prescription.

They are in agreement for Southwark to revert to national policy and align with CCGs across the country for antimalarial chemoprophylaxis prescriptions, following an evidence review process. They have noted that the numbers of cases of malaria are falling and the risk assessment conducted today is different to that conducted 20 years ago when the arrangements were first introduced by Lambeth Southwark and Lewisham Health Authority.

It was noted that Southwark has the highest number of malaria cases in London but this is despite the current arrangements being in place. Southwark, Lambeth and Lewisham are the only boroughs in the country that support prescribing on the NHS. Data are lacking to support whether the current local arrangements for antimalarial prophylaxis on the NHS have had a positive impact on malaria case numbers, especially compared to other similar areas where such arrangements are not in place (e.g. Hackney and Tower Hamlets).

MS stated that certain vaccines are not available on the NHS for travel purposes, these should be written privately. However, prescribing data indicates there has been some
The best possible health outcomes for Southwark people

inadvertent prescribing of these vaccines on the NHS. It should be noted that prescribing of these vaccines on the NHS has never been encouraged. The proposal is to more robustly encourage adherence to implementation of national policy which does not support the provision of selected vaccines for travel purposes on an FP10 NHS prescription.

Currently, there are certain vaccines that should not be prescribed on the NHS for travel purposes, which locally are being provided. Following Public Health consultation in 2016, on the prescribing of travel vaccines, support has been given to standardise and align local provision of specific travel vaccines that can be provided under the NHS or as private service, to national policy.

RG requested questions and comments from the committee

LD highlighted that often giving travel vaccinations is an opportunity to give patients advice about travel, including sex, traffic and sun protection. In particular the cohort of young men may not often be seen by primary care in other circumstances. LD stated that we would need to think about alternative approaches to replace this opportunity.

NK highlighted her concerns about stopping prescribing malaria chemoprophylaxis medicines on the NHS: that it appears counterintuitive to change guidance due to a lack of evidence rather than maintain the status quo while data is collected. She is also concerned that this could impact people who are poorest and from ethnic minorities.

MS re-emphasised that public health had been unable to provide the evidence that prescribing was of benefit and targeting the right people, or if medication is being taken. Therefore it is not possible to show a return on investment.

KMB stated that the evidence is not there to justify Southwark continuing as an outlier in guidance.

PA emphasised the importance of close monitoring

RP asked if there was any evidence that shows if people returning with malaria had taken antimalarials. LD stated that, in her experience, it was people who had not taken antimalerials due to not thinking they were at risk who contracted malaria. LD emphasised the importance of education.

The committee reviewed the above proposals, taking into account the three Borough – wide decision to align current prescribing practice with national policy, and provided comments.

The committee formally endorsed support for the initiatives and approval for the consultation and engagement phase to commence with patients and the public to (i) formally stop prescribing of malaria chemoprophylaxis medicines on the NHS in Southwark and (ii) more robustly encourage adherence to national guidance regarding availability of selected travel vaccines on the NHS in Southwark

The committee noted that there are concerns raised by clinicians which would be revisited after consultation and may give cause to reject the stopping of prescribing of
The best possible health outcomes for Southwark people

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**Treatments for acute self-limiting conditions and minor ailments treatments**

MS stated that currently the prescribing spend on over the counter (OTC) medications in Southwark is in excess of £2m. There is a national drive to support patients to self-care and buy over the counter medications for minor ailments and/or self-limiting conditions where appropriate.

This proposal supports the Southwark Five Year Forward View to foster a culture of patient led self-care. It is anticipated that the proposals will not only reduce NHS expenditure on OTC products but will also reduce unnecessary demands on GP appointment times and enable better clinical and cost effective utilisation of NHS prescribing budgets. It is also anticipated that it will promote better use of community pharmacists to provide professional advice to support the management of acute and self-limiting conditions.

The list of 24 therapeutic areas included in the OTC QIPP proposal were reviewed by the committee. MS highlighted that there is some overlap with the pharmacy first scheme but the intention is to ensure that this is not destabilised.

RG asked for questions and comments, in particular if these had been highlighted at the recent locality meetings.

NB stated that the north locality meeting had voiced concerns about the overlap with pharmacy firsts and the difficult conversation that would be needed with patients. Highlighting that stricter rules which enable GPs to state they are unable to prescribe OTC drugs would support these conversations. KMB stated that this has already been done elsewhere and therefore there is learning, support and FAQs which will be available to GPs.

JM stated that there needed to be a realistic expectation of how this will impact on self-care. The driver for people coming to their GP in these situations is a lack of self-efficacy so it is unlikely to reduce the demand. The evidence financially is much stronger. CG stated that concerns were also raised regarding the impact this could have on the poorest in the community.

CG stated that this is part of a national drive, which has already shown significant savings in neighbouring CCGs.

RG provided clarity that there is a legal obligation to take into account the outcome of public consultation.

The committee reviewed the above proposal, taking into account the sector-wide agreed therapeutic areas to be included for promoting OTC self-care purchases, and provided comments.

The committee formally endorsed support for the initiative and approval for the consultation and engagement phase to commence with patients and the public to formally stop prescribing of over the counter self-care medicines on the NHS in Southwark as appropriate.
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<th><strong>Locality Reports: April 2017; May 2017</strong></th>
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<td><strong>North Locality Report</strong></td>
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<td>NB reported back from the meeting. There had been discussion regarding the revision of primary care prescribing guidance (referred to under this agenda item earlier). It was reported that the following items were discussed in May: t-quest and e-RS; GSTT patient friendly access policy; DXS.</td>
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<td>NB highlighted a specific query raised regarding the SLAM home treatment team now asking for a joint consultation with GPs when discharging patients.</td>
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<td>NK stated that she had recently met with the home treatment team during a site visit. They had emphasised the importance of discharging well, and that having a joint meeting is best practice.</td>
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<td>NB stated that there was an action from the locality meeting for a communication piece to be brought back to the locality meetings regarding this. This is being led by RW, NK and DA.</td>
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<td><strong>South Locality Report</strong></td>
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<td>JM reported back from the meeting. There had been discussion regarding the revision of primary care prescribing guidance (referred to under this agenda item earlier). It was reported that the following items were discussed in May: DXS; Lifeline; incorrect discharge summaries being received by practices; rejected referrals from SLaM.</td>
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<td>Regarding discharge summaries being addressed incorrectly, NB updated that this had been raised at the GST CQRG as part of discussions regarding e-RS. In order to implement this fully (and in line with contractual obligations) there is a necessity for all members of staff at the trust to use smart-cards. This will automatically lead to demographics and GP details automatically being updated for patients.</td>
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<th><strong>CCG 360° stakeholder survey results</strong></th>
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<td>RW presented the results of the 360° stakeholder survey. RW summarised that overall, the CCG’s results are positive with scores consistently higher than the national, regional and cluster average in most areas. Areas where the CCG has improved scores compared to the previous year include engagement, understanding reasons for commissioning decisions, leadership, knowledge of plans and priorities, quality improvement and patient outcomes.</td>
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<td>Fewer member practices responded to the survey compared to 2016 – 33 compared to 38. However, member practice scores rose in a number of areas when considering absolute numbers and these include decision-making clinical leadership, understanding of implications of CCG’s plans and familiarity with the CCG’s financial situation.</td>
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<td>Areas where scores are lower than last year include confidence in the CCG to act on feedback it receives about quality of services and agreement that representatives from member practices are able to take a leadership role within the CCG.</td>
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RW requested discussion from members to help formulate the action plan which will be discussed at the June locality meetings before being agreed at the June Integrated Governance and Performance Committee.

RG asked for questions and comments from the committee.

MH referenced the importance of defining what a leadership role is and that this may have impacted on the response to the question relating to the opportunity to be involved in clinical leadership. MH estimated 40-50 clinicians who are currently involved with roles relating to the CCG.

RW stated that it had been highlighted that there would be more frequent quality updates at the locality meeting and that RW, JM, MK and JH will be working towards having a public open space prior to the locality meetings.

MK referenced the previous action plan and asked if clinicians felt that practice visits had led to improved relationships. It was felt that this had not led to a different relationship.

CG highlighted the importance of locality meetings in building relationships with member GPs and their practices.

The Committee noted the results of the survey and it was assured that a programme for developing an action plan is in place.

### Healthwatch Southwark Priorities for 2017-18

AG presented the Healthwatch Southwark priorities. She explained the process that had been undertaken with local people, voluntary and community organisations and statutory organisations (including NHS Southwark CCG) to understand what their work should be going forward. She also emphasised the role played by information from Healthwatch’s information and signposting database.

The five priority areas for 2017/18 are: Timely access to GPs; Going home; Southwark’s nursing homes; Impact of caring on carers; Help in a mental health crisis.

AG stated that once these have been launched, Healthwatch will inform the CCG. It was noted that the work relating to timely access to GP practices had already been taken to the practice managers forum and PPGs.

AG highlighted the work related to mental health in crisis and the plans to speak with people who have been through the services, as well as staff. The intention is to understand the pathway that people are following and which they should be following.

RG asked for questions and comments from the members.

CG noted that there has been a lot of engagement with Healthwatch in the development of the priority areas, and there is very clearly a lot of alignment with CCG plans. With the representation on committees, the arrangements are in place for positive mutual contribution.
The committee noted the Healthwatch priorities and that there is alignment with the CCG’s priorities and work programme.

**Mental Health Primary Care model**

CG presented the proposed mental health model of service delivery for SLaM community teams. She highlighted the background to this proposal relating to the implementation of the Social Care review by Southwark Council which has resulted in twenty two social workers being fully removed from SLaM secondary mental health services. This led to the disaggregation of an integrated mental health and social care model. This has significantly impacted on the management of patient caseloads within community teams, due to an increased level of case load per staff member. CG reminded CSC that concerns were expressed by the CCG at the time of implementation of these recommendations.

In working through the implications of the changes to their workforce, the mental health commissioning team have agreed with SLAM that the development of a low intensity team will help with enabling discharges from case-loads and free up capacity in other teams so they are more effective. Most importantly though the creation of this team services is a step towards an enhanced model of mental health provision for primary care.

RG asked for questions or comments from members

NB asked if work had been completed to understand the starting point in primary care regarding understanding and skill to manage this cohort once discharged. NK stated that part of the role of the team will be to gather this intelligence and establish community links.

AD asked for clarification on whether perinatal mental health patients were included. CG confirmed that they are not.

AG highlighted that many people become attached to their CMHT, and that their understanding of being fit for discharge may differ from clinicians’. CG stated that this model will not be about forcing people to change their care, but it will create additional capacity in the system.

NK provided a case study of a typical patient, the way that the team would support primary care with the management of the patient and then be available to provide ongoing support to primary care clinicians.

MK highlighted the opportunity for co-design and that this could be one of a number of building blocks for LCNs, offering tiers of care. He emphasised the need to be explicit with describing services as community services and part of Local Care Networks.

The committee agreed the proposal to create redesigned health only community mental health teams, currently described as a Low Intensity Team (LIT) or a Supporting Transition and Medication Project team (STAMP), to enable the safe transition of patients to primary care (title of the team is a work in progress). Noting that this will be implemented in advance of the development of a full PC model.

The committee endorsed the programme being led by the partnership commissioning
team to work with providers across SLaM, social care, the voluntary sector and service users and carers to co-design an enhanced primary mental health model which is based on sustainable coordinated care in the community.

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| 11 | **Date of next meeting**: 6 July 2017, 2-5pm. |
COMMISSIONING STRATEGY COMMITTEE

Minutes

6 July 2017

Present

Jonty Heaversedge (JH) CCG Chair (meeting Chair)
Caroline Gilmartin (CG) Director of Integrated Commissioning
Noel Baxter (NB) CCG Clinical Lead
Ami David (AD) CCG Secondary Care Nurse Member
Robert Park (RP) Lay Member
Robert Davidson (RD) CCG Clinical Lead
Malcolm Hines (MH) Chief Financial Officer and Deputy Chief Officer
Linda Drake (LD) CCG Practice Nurse Lead
Penny Ackland (PA) Chair of Southwark LMC
Mark Kewley (MK) Director of Transformation
Michael Khan (MKh) Secondary Care Doctor Member
Kate Moriarty-Baker (KMB) Director of Quality and Chief Nurse (acting)
Andrew Nebel (AN) Lay Member
Richard Pinder (RPI) Consultant in Public Health, Southwark Council
Yvonneke Roe (YR) CCG Clinical Lead
Kieran Swann (KS) Head of Governance & Assurance
Emily Gibbs (EG) CCG Clinical Lead
Richard Gibbs (RG) Lay Member

Apologies

Aarti Gandesha (AG) Healthwatch Southwark
Andrew Bland (AB) Chief Officer
Joy Ellery (JE) Lay Member
Nancy Küchemann (NK) CCG Clinical Lead

Present

Smriti Singh (SS) SEL Transforming Care Programme Director

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<td>The register was circulated for signing.</td>
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### Minutes of the last meeting

The minutes of June 2017 were reviewed and agreed as an accurate record. The action log was reviewed.

MH updated progress on establishing a process for QIPP development and CG described some of the work underway on delivery of the RightCare programme. JH asked about how we will progress the work on QIPP development and CG talked about some of the work being completed with Lambeth CCG as part of planned care group.

CG agreed to complete an update on RightCare and circulate a briefing paper – **Action CG.**

It was agreed to present a process map on how the CCG was testing and developing new QIPP opportunities. A paper will go to IG&P in July or August – **Action CG / MH.**

The action on sharing details of joint commissioning governance was noted to be in development. **Action – CG and MK agreed together to draft a paper to be considered at the Joint CSC next month.**

### Locality Reports: June 2017

#### North Locality Report

NB provided the update from the north meeting and said that the meeting was attended by the community nursing lead from GSTT. He reported that they discussed communication; community nursing IT; access to local care records in the community; and referral processes into district nursing and community matron services.

NB said that there was a presentation on eRS delivered by the CCG and trust and issues around electronic booking were discussed. He also reported on the update provided by CG on the SEL CCG Review.

CG commented on some of the IT issues experienced by community services and commented that the forum was an opportunity to enable primary care to understand challenges experienced by community nursing colleagues. She also highlighted a discussion on CMHTs and said she would report back.

#### South Locality Report

LD reported back from the south meeting and highlighted the group’s discussion on e-RS; the SEL CCG Review; as well as a discussion with the community nursing service. LD reflected on the positive and constructive discussion with community services. She reported an issue on drug management that was discussed at the meeting and said that this was taken as an action by the community team.

LD reported on a discussion about Accountable Care Systems and noted a suggestion that the Council of Members might usefully pick up on this topic. JH and MK agreed an action to consider how we further describe the development of ASCs to the CCG membership – **Action JH/MK.**
JH agreed a further action to review the structure of CoM meetings with the CoM Chair and consider planning an update on ACS as part of the forward plan. – Action JH.

**SELTCP Year 1 progress report**

SS presented the paper, which provided an update on the Transforming Care agenda and the work of the South East London Transforming Care Partnership (TCP).

SS described one of the purposes of the paper as being to increase south east London CCGs’ understanding of the Transforming Care agenda. She described the background to the work and the history of delivering the TCP agenda in south east London. She further explained the comprehensive assurance by NHS England of delivery of the TCP programme nationally.

SS said that the paper included a series of recommendations that she asked the committee to approve in order to support effective delivery of the South East London TCP’s programme. SS described the report recommendations in detail. The committee reviewed and discussed the following recommendations:

- Move towards south east London-wide commissioning of specialist inpatient provision, for the Transforming Care cohort.
- Set up joint working across south east London CCGs and councils on accommodation based services (e.g. supported living or residential care) for the Transforming Care cohort. This may include setting up a brokerage function across south east London for the Transforming Care cohort.
- Establish intensive outreach support for those in crisis can help prevent admissions and re-admissions in particular. CCGs are asked to support and provide resource for a south east London project to review current community-based provision for people with LD or autism, with a view to reconfiguring existing services to ensure that there is intensive, community-based support across all of south east London.
- Establish a Strategic Board with representation from each statutory sector organisation and from mental health and LD commissioning, social care (adults), social care (children and young people), SEND, housing and primary care. CCGs are asked to nominate individuals from their CCG and to help the TCP to approach their local council for nominations.
- Support the TCP to embed the vision of the Transforming Care agenda in south east London CCGs and the STP.

CG endorsed recommendation one and asked that there remains a commissioner focus on delivering improved value in this area.

The committee discussed local authority involvement in this process and the commissioning of inpatient beds. KMB explained how this worked in south east London. The committee discussed responsible commissioner arrangements for this cohort of patients and the associated funding of these individuals’ care. The committee also discussed financial risk for CCGs on delivering this recommendation and MH said that a growth in the Southwark budget
is built into the CCG’s 5 year plan by way of financial mitigations of some of the cost pressures related to high complexity inpatients.

MK asked about whether this approach should be described as an ACS and whether that would raise an opportunity to attract specialised commissioning resource for this cohort of patients. He asked whether the model could also attract transitional funding from other partner agencies for establishing a new model of provision.

RD pointed to recommendation three and suggested that this was dependent on the effectiveness of a crisis response team. He asked whether the patient numbers involved would make this a viable service in SEL and questioned how this would work to reduce inpatient admissions. SS described the plan to take this forward and acknowledged the challenges.

PE asked about the required input to management of these patients from GPs. KMB suggested it would necessitate specialist rather than GP input to the management of this patient group.

The committee discussed the governance arrangements in place and being set up as is demanded under recommendation four.

The committee were advised that the recommendations will help delivery the reduction in inpatient numbers required and also help to deliver broader Transforming Care agenda, i.e. the vision set out by the national programme, ensuring better services for people with LD and/or autism.

The Committee approved the recommendations included in the report.

**IAPT service redesign**

CG introduced the item and described some of the background to the commissioning of the service and the performance challenges related to the service, particularly the below standard rates of recovery from this service. CG described the additional funding made available to the service and the remedial action plan agreed to improve service performance over the course of the last year.

CG described the purpose of the paper as being to support a discussion about whether the Southwark Talking Therapies (STT) services model should be redesigned with respect to patients with complex “step 4” needs. She said that the paper presented a number of options for the future service model of IAPT services.

CG talked through the prospective options for taking a different approach to step 4 patients in the service:

- **a.** No change – clearly this will not address the recovery and capacity issue
- **b.** The STT service continues to assess step 4 level referrals but refers these patients on to more intensive services such as the Integrated Psychological Treatment Team (IPTT)
- **c.** All step 4 patients are assessed and treated outside of the IAPT service by the
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<td>borough assessment and liaison service and the IPTT</td>
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<td>d. The service continues with its current case mix but the step 4 patients are recorded as intensive (non-IAPT) services reflecting the actual level of complexity involved.</td>
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<td>CG fed back that NK had provided some comments on the proposal and endorsed options 3 and 4 above.</td>
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<td></td>
<td>JH asked whether the purpose of the proposal was to create a different service offer to better meet the needs of those patients with more complex presentations. CG confirmed that it was and noted that this approach was developed and supported by the provider.</td>
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<td>RG noted that option d would bring the CCG into line with the national definition of which patients should access IAPT services. He also said that option c would ensure the high complexity patients receive the appropriate care and he suggested that the clinicians on the committee may wish to comment on the appropriateness of the proposed pathway.</td>
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<td>The committee discussed the pathway for step 4 patients and how they access IAPT and IPTT services. CG relayed SLaM's assurance that they had sufficient capacity within IAPT and IPTT services to pick up step 4 patients in an altered model and she said that the CCG would work up a capacity plan with the provider to ensure the right patients were seen in the most appropriate service.</td>
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<td>YR asked about lower intensity provision and patients being re-referred to IAPT services and the committee discussed on-going self-care for patients post discharge from the service. MK described some of the work being completed between SLaM and Pembroke House on group follow-up sessions for low-intensity patients.</td>
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<td>RD commented that getting the referral and triage right was essential. He asked for this to be a focus of work with the provider. He also asked for the CCG to consider the variation on the number of patients accessing the service each month.</td>
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<td>The Committee agreed to support the proposal and agreed that the CCG should work with the provider to identify the cohort of complex patients and continue the development of this pathway for them.</td>
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<td>No further items were raised.</td>
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|   | Date of next meeting: 7 September 2017, 2-5pm. |
1.0 Introduction

RP introduced NHS Southwark Clinical Commissioning Group’s (CCG) second Primary Care Commissioning Committee (PCCC) in public. It was noted that the CCG had taken on delegated commissioning of general practice services from the 1 April 2017. The Committee introduced themselves.

1.1 Declarations of Interest

RP explained that the CCG had a rigorous conflict of interest policy and that at every meeting all members would be asked to note any changes to their declarations of interests and if there was they had a conflict with an agenda item. It was explained that Richard Gibbs, as the CCG’s conflict of interest guardian who had sent his apologies, had advised prior to the meeting that the GP members of the Committee would have to declare if they had a conflict of interest with the Grange Road Practice, Avicenna Health Centre or Lordship...
Lane Surgery. It was noted that the PMS premium agenda item did not include the funding of general practice and that the Committee was noting a decision that had been made prior to the Committee regarding the process of the PMS premium.

The Committee declared if they had any conflicts or changes to their declaration of interests and the COI register was circulated for completion. EG, JH and PA declared that they did not have any conflicts of interests with the Grange Road Practice, Avicenna Health Centre or Lordship Lane Surgery. The COI register was circulated and updated by all members and those in attendance.

2.0 Public Open Space

RP invited questions from the public.

Elizabeth Rylance-Watson asked if the evaluation of the extended primary care services completed by Deloitte has gone to the CCG Governing Body and Oversight and Scrutiny Committee for the councillors to review. CG confirmed that the evaluation will be going to the CCG’s Integrated Governance and Performance Committee. It was explained that the CCG is developing an action plan from the recommendations and that the evaluation will be shared with stakeholders.

Addendum: since this meeting it has been confirmed that the extended primary care services evaluation will be reported to the July PCCC.

AG noted that the Healthwatch questionnaire asked questions to appraise patient’s knowledge of the extended primary care access services. CG noted that the CCG was aware access for patients in Southwark was an issue and that the CCG had included this in commissioning intentions and work with the LMC to ensure that access is part of the new PMS contract specification. CG said that the CCG is aware there were more improvements needed to GP practice access for our local population.

3.0 Minutes of the last meeting – 25 April 2017

The minutes were agreed as an accurate record

3.1 Actions taken since the last public meeting

RP noted that the nature of primary care contracting meant that on occasions, Committee decisions needed to be made in between Committee meetings in public. It was explained
that the terms of reference allowed for urgent planned and unplanned decisions to be taken outside of formal committee meetings.

It was explained that 3 of the decisions made in between public meetings included the Avicenna Health Centre, the Grange Road Practice and the PMS premium contract specification and that more detailed papers had been provided for these decisions for transparency and to allow questions if required.

The Committee noted the decisions made before the committee in public.

**4.0 Primary Care Finance Report - Month 12 2016-17**

MH explained that month 12 accounts were being presented as they had been recently closed and audited. It was noted that there was an overspend of £14k for the year. MH confirmed that budgets for the new financial year had been recently received from NHS England and that at the next meeting in public, a report will summarise the in-year position. It was confirmed that the next meeting in public will be July to avoid having public meetings during holiday periods.

**5a Quality Report – CQC inspection update**

JY provided a summary of the report noting that 5 practices had CQC reports published since the last committee meeting. JY highlighted the practice ratings and highlighted that Dr Aru’s practice was no longer in special measure, although has a new rating of requires improvement overall. It was explained that the CCG continues to support practices make improvements prior and following CQC inspections.

JY explained that we are in the middle of a change to CQC inspections. It was noted going forward the CQC will use data and information to determine how regularly practices are inspected and that inspections range from desk top assessments to more detailed visits depending on data regarding the practice and previous inspection ratings.

CG explained that the CCG is aware that practices found the CQC inspection process intensive and that it has been a driver for some instability in general practice in Southwark but that practices had received support from the CCG to address key areas.
AG asked for confirmation on how many practices were in special measures. JY confirmed three practices were in special measures; the Avicenna Health Centre, Falmouth Road Practice and Dr Hossain at the Lister Health Centre.

AG asked for more information regarding the funded support that Lordship Lane Surgery had received through the GP Forward View funding and asked if other practices had received similar support. JY confirmed that last year the GP federations had practice resilience plans which were funded through the GP Forward View funding. These plans included all practices in special measures and some rated as requires improvements completing the sustainable general practice programme. It was noted that there were several providers of the programme including the Royal College of GPs. It was noted that the CCG also visited and supported all practices in requires improvement and special measures.

AG asked if the CCG’s work on the themes of CQC visits showed themes within each of the CQC domains. KMB confirmed there was a lot of analytical information which informed the resource tool. KMB explained that the resource tool included themes and also noted examples of good practice. It was noted that the tool had been shared with practices and discussed at the practice nurse and practice managers’ forums.

RL asked for clarification on CQC themes and if the CCG was then organising support in response to these themes. KMB confirmed that the CCG had introduced an audit programme of general practice infection control processes and recruited an infection control nurse to work across Lambeth and Southwark. It was explained that a safeguarding forum had been set up for practices and was now well attended. It was noted that other themes included recruitment process and staff training. KMB confirmed that the resource tool and the information on CQC themes can be reported at the next Committee meeting.

**Action – KMB to report the themes from Southwark general practice CQC inspections and the resource tool developed to support practice make improvements at the next meeting.**

PA explained that practices requiring improvements or rated as inadequate can also receive support from the LMC. PA expressed some concerns regarding the consistency of inspections.

CG said that the pressures facing general practice were recognised but that the CCG welcomed the first uniform inspection process of general practice that had been completed nationally. CG noted that some practice had been able to make improvements over a short
amount of time to improve their ratings and the inspection process provided learning for practices. It was noted that the CCG had provided overarching support to practices to make improvements.

AY noted that practices could also ask Londonwide LMC’s GP support team for support and that looking at themes from practices rated as good or outstanding practices provides information about best practice. AY explained that the Royal College of GPs had a tool to support practices which focuses on using data to make improvements.

RP noted that the majority of practices rated as inadequate were generally smaller practices and therefore practices required support to work at scale to support improvements. JH noted that practices operating in isolation tended to be rated as inadequate. JH explained that the work the CCG is doing with GP federations to connect practices will support quality improvement and sustainability of patient care.

5b Quality Report – SE London Quality and Performance Report

JW explained the report was in the format previously presented to the Primary Care Joint Committee and that subsequent versions may vary. It was noted that some data is available on an annual basis and therefore not always up to date. JW explained that she would focus on the areas with new data for review.

JW noted the previous in-depth discussions regarding CQC inspections in Southwark and noted the SE London report gave a SE London context.

JW explained that it was a contractual obligation for practices to submit friends and family test (FFT) results every month but this had not been consistent across practices. It was noted that NHS England, the CCG and LMC were trying to support practices to submit this data. In March 2017 9 practices in Southwark did not return FFT data, an improvement on the previous period. It was noted that Southwark’s satisfaction scores were below the national and SE London average.

JW highlighted that the separate agenda item on PMS contract specification included the CCG’s commissioning intention to attach some of the PMS premium value to supporting practices to improve submission of FFT data and address concerns/points raised by patients.
JW made a correction to the report and noted that there were 0 performance issues that were highly likely to lead to contractual action in Southwark.

It was noted that the number of partnership changes was increasing. In Southwark there had been 3 partnership changes and 1 GP retirement.

AG asked how the CCG ensures that practices are utilising the qualitative data collected through the FFT. It was confirmed this information would form part of the quality facilitator’s role within the CCG and the quality directorate were working with the transformation team to review patient experience data.

6.0 Grange Road Surgery: contract commissioning decision

CG explained that the practice was initially inspected by the CQC in October 2015 and was subsequently rated as inadequate and placed in special measures. It was explained that the 2 GP partners then retired and resigned from the contract. NHS England and the CCG appointed Nexus Health Group as the temporary care taker provider for the practice, following a procurement process, to ensure continuity of access to services for patients. This temporary arrangement was put in place to enable continuity of patient care and so commissioning intentions could be reviewed for the registered list in the longer term. It also allowed the caretaker provider to ensure improvements were made and that the practice has subsequently been rated good following a follow up CQC inspection.

CG explained that the decision to ask patients to register with other practices had been made following, an options appraisal, engagement with Healthwatch and the LMC and was informed by Londonwide procurement guidance which indicates that a list size of less than 6000 patients is not financially viable as a contract. It was noted that the caretaker provider had confirmed that they did not wish to extend the contract further than 30 June 2017. CG confirmed that the CCG had also looked at the quality and capacity of practices in the local area and completed work with the nearest practices to Grange Road to look at utilisation of clinical space.

CG noted that the short amount of time was regretful but that the CCG had held 2 patient engagement events and the caretaker provider was identifying and supporting vulnerable patients to register with other practices.

RL noted that article in Southwark News and asked why only 3 weeks was given for 5000 patients to register with a new practice. CG confirmed that the CCG was unable to complete
their engagement processes and write to patients during the general election period. It was noted that the caretaker provider had decided not to agree to extend the contract length further. CG confirmed that there had been learning for the CCG in terms of the length contracts are let for and in future 6 months extension dates were likely to be added. CG noted Healthwatch are supporting patients to register with new practices.

RL asked about the chronology of the decision making as the Avicenna Health Centre paper refers to the Grange Road Practice despite the decision being made later. CG confirmed that the arrangement at Grange Road Practice had started as an emergency also a temporary caretaking arrangement, that the list did not have scope to increase in building and that the list size was too small to make procurement unviable. She noted that the arrangements put in place for the Avicenna centre were also based on a short-term caretaking arrangement.

RL noted the historical importance of the building and asked what would happen to the building. CG confirmed that the building was owned by Guy's and St Thomas' NHS Foundation Trust and that they still provided services from the building.

AY asked for information about the financial modelling of reimbursement for practices who register more than 0.5% of their register list and outlined an example from south west London which used a different funding structure following discussions with the LMC. JY confirmed that the funding had been allocated to support practices with additional administration time for registering new patients and for clinical time for new patient checks. It was confirmed that the caretaking contract had been funded at an inflated rate to support the caretaker stabilise the care of patients. JW explained that there was not a single model used and that individual CCG’s use a range of factors to model additional funding for practices. It was noted that practices receive 40% on top of the core contract price for new patient registrations in their first year. JY confirmed that the agreement in south west London was not a benchmark or standard for funding in these situations.

AY noted that there were 10 practice sites within 1 mile of Grange Road Practice but asked if the implications for these practices registering new patients had been taken in to account. CG explained that practices will register patients within their practice boundary and the number of new registrations will vary across practices. It was explained that the CCG had completed detailed work looking at space utilisation with the 2 sites closest to Grange Road Practice.

AY asked how the CCG was ensuring that vulnerable patients were going to receive appropriate care. CG explained that the lead clinician of the care taker provider has been
working hard to identify vulnerable patients and ensure they are registered with new practices. CG noted that Healthwatch were also supporting patients to register with new practices and thanked them for this support.

AG confirmed that Healthwatch was supporting patients register with new practices and explained that the main cause of confusion for patients was the notion of practice boundaries. AG confirmed that Healthwatch will be writing to NHS Choices to ask if the website can include information about practice boundaries to make it easier for patients to find out if they live in a practices boundary.

RP thanked the primary care team for the management of a complex situation and confirmed assurance would come back to the Committee following the contract close down.

7.0 Avicenna Health Centre: contract commissioning decision

CG explained that Dr Kadhim had given notice to retire from his contract from 14 July 2017. It was noted that the CCG had agreed to procure a caretaker provider until 31 March 2018, with an option to extend for a further 6 months. The reasons for the decision were noted, including that the practice was in special measure and the caretaker provider will be commissioned to improve processes in the practice; and that there was an opportunity for the CCG to secure suitable premises for health care in the locality.

RL asked if the premises would still be utilised if the Old Kent Road development was completed. CG noted that the CCG needed to look at the strategic options in the area regarding premises.

8.0 Southwark PMS premium contract specification

The committee had no further questions to the paper for information.

9.0 Update on Healthwatch Timely Access to GP practice project

AG explained that one of Healthwatch priorities was timely access to GP practices and that they would be aiming to complete enter and view visits to all practices by the end of August 2017. AG explained that Healthwatch had developed questionnaires for patients, receptionists and practice managers regarding the appointment systems. Fifteen practices have been visited so far and 286 patients have been spoken to. It was noted that practice appointment systems are variable. AG confirmed that at the end of the process a report will
be written and shared with GP federations and the CCG who will be given 20 working days to respond. Healthwatch and the CCG will host a joint event in September regarding access to primary care.

10.0 Requires improvement potential contract remedial notices and breaches – Lordship Lane Surgery

JW noted that the Lordship Lane Surgery had been inspected for the first time on 19 May 2016 and was rated as requires improvement overall following the inspection. It was explained that the Primary Care Joint Committee approved the issuing of a remedial and breach notice to the practice, which was given 28 days to respond. It was explained the first response did not satisfy all areas of concerns and therefore additional information was requested from the practice. The additional information requested from the practice has not been received and therefore it is recommended that commissioners issue a second breach to the practice.

JW explained that in parallel to this process the practice had received a second CQC inspection which despite improvements being noted the practice still has a rating of requires improvement. JW said that following the London standard operating procedure, it is recommended to the Committee for decision that a 2nd remedial and breach notice is issued to the practice.

AN asked how the CQC reports link to the contract mechanisms available to commissioners, i.e. do all CQC visits result in contractual actions. JW explained that the processes of the CQC and CCG as 2 statutory bodies were separate but that the CCG could rely on information within CQC reports to determine if a practice was in breach of their contract. It was explained that the reasons for the proposed breach notice was that the practice had not responded adequately to the first breach notice issued, following the first CQC inspection report. The recommendation was therefore to issue a second breach notice following information outlined in the second CQC inspection report demonstrated that the practice was still in breach of their contract. It was confirmed there would be no delay in the issuing of this breach noticed from the Committee’s approval.

The Committee approved the issuing of the remedial and breach notices.

**Action:** To issue the remedial and breach notices to Lordship Lane Surgery as agreed by the Committee.
11.0 AOB

AY noted that the LMC were not happy with the funding model for additional payments to practices that register patients from Grange Road Surgery.

12.0 Public Open Space

Joan McIvor highlighted concerns regarding the standard of care workers working in care homes and who are providing care in people’s homes. RK noted the importance of ensuring the care people receive is of high quality, he noted that Southwark Council had implemented the ethical care charter which outlines standards regarding the pay and training of carers and said that 50% of contracts were now compliant with the ethical care charter. It was noted all care home contracts will have to meet the ethical care charter. It was discussed that the topic could go for discussion at the CCG’s Quality and Safety Committee to provide more detail around the specific standards.

Elizabeth Rylance-Watson emphasised the importance of workforce and training and suggested that the CCG collects detailed training records from practices, giving an example where the induction of a staff member at her practice could have been more comprehensive. ERW also asked about the process of transferring patient records between practices. It was explained the electronic transfer was now quite quick between practices. It was confirmed that Capita are contracted to transfer patient records.

Martin Dadswell confirmed that Healthwatch had visited his practice and that he had completed a questionnaire.

13.0 Close

RP thanked all members of the public for attending the Committee.
## Present

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<thead>
<tr>
<th>Name</th>
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<tbody>
<tr>
<td>Joy Ellery</td>
<td>JE</td>
<td>Lay Member, Patient Engagement and Membership (Chair)</td>
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<tr>
<td>Rosemary Watts</td>
<td>RW</td>
<td>Head of Membership, Engagement and Equalities, NHS Southwark CCG</td>
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<tr>
<td>Dr Yvonneke Roe</td>
<td>YR</td>
<td>GP Clinical Lead, NHS Southwark CCG</td>
</tr>
<tr>
<td>Martin Dadswell</td>
<td>MD</td>
<td>North (Bermondsey and Rotherhithe) Locality Patient Participation Group</td>
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<tr>
<td>Aarti Gandesha</td>
<td>AG</td>
<td>Healthwatch Southwark</td>
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<tr>
<td>Emmaunel Oyeweleg</td>
<td>EO</td>
<td>South (Dulwich and Peckham) Locality Patient Participation Group</td>
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<tr>
<td>Mark Kewley</td>
<td>MK</td>
<td>Director of Transformation, NHS Southwark CCG</td>
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<tr>
<td>Rachel Doherty</td>
<td>RD</td>
<td>Primary Care Commissioning Manager, NHS Southwark CCG</td>
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<tr>
<td>James Banks</td>
<td>JB</td>
<td>Forum for Equality and Human Rights (FEHRS)</td>
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<td>Christina Ball</td>
<td>CB</td>
<td>FEHRS</td>
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## IN ATTENDANCE

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<th>Name</th>
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<tr>
<td>Corrine White</td>
<td>CW</td>
<td>Administrative Officer – NHS Southwark CCG</td>
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## APOLOGIES

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<tr>
<td>Leslie Boscheratto</td>
<td>LeB</td>
<td>South (Dulwich and Peckham) Locality Patient Participation Group</td>
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<tr>
<td>Rhiannon Hughes</td>
<td>RH</td>
<td>Advising London</td>
</tr>
<tr>
<td>Abi Puddicombe</td>
<td>AP</td>
<td>North (Borough and Walworth) Locality Patient Participation Group</td>
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### Introduction and Apologies

JE welcomed members and attendees to the meeting. All apologies were noted. The process and the ground rules for the meeting were explained.

The declaration of interest register was circulated

JE noted that CB must be added to the COI form.

### Minutes and Matters Arising

**Minutes agreed as an accurate record**

RW confirmed that the CCG were funding Time4Southwark and Community Southwark to work in Acorn & Gaumont, Hurley at the Lister, Walworth Partnership and Elm Lodge GP surgeries respectively.
**Issues from member groups and organisations**

**North Southwark PPG**

MD noted that some members from Nexus wanted to have their own individual PPG meetings as opposed to one large PPG.

It was noted that in terms of the GP contract, it is a requirement to have one PPG per contract. However, there were concerns about communication between practices and patients.

JE wants to discuss this further at PPG Network meeting.

Healthwatch also attended and discussed their project on GP appointment systems.

MD has stated that they are still struggling with numbers, though 11 patients attended.

**South Southwark PPG**

Received the evaluation report of the Extended Primary Care Service and Nigel Smith form Improving health Limited (IHL) talked through the recommendations and noted in particular:

- An increase in number of patients using EPCS.
- Making connections with King’s and IHL
- Better referrals to King’s
- End users have reported positive use of service

Rosemary Watts also discussed the proposed communication campaign and took views on proposed posters:

Proposed changes to NHS prescriptions

Generic feedback:

- Appointments
- Working with different organisations to seek best practice
- 15 patients have been seen

**Southwark PPG Network**

RW reported on PPG Network event that took place in May 2017. Showcase of All Better Together films with Community Southwark and Time4Southwark available so PPGs and practices can talk through their ideas for developing health and wellbeing initiatives

Four practices have been chosen, two in the North and South of the borough. However, other practices are being supported.

**Healthwatch**

AG stated that they have submitted their annual report to Healthwatch England. Please follow link to the annual report 2016/17:


They have been reviewing the GP appointment system and visiting practices. visited 26 practices, to end in August and analysed in September.
Health watch have also been revisiting the findings from the reports they did the previous year about GP telephone messages and information on how to make a complaint.

Going home: speak to older people who were admitted to A&E; follow their journey home (3 days after discharge, then 1 month, identify any issues)

They are also about to start a project looking at mental health crisis care: mapping exercise, MH pathway, staff (reception)

MD highlighted that there is a Wellbeing Hub in Peckham with a 24h telephone number.

AG informed the group that they won a national award for their work with Lambeth Healthwatch on the Going Home Project. The committee recorded their congratulations to EPEC.

**Forum for Equalities and Human Rights in Southwark**

JB encouraging participation in the current consultation on changes to NHS prescriptions.

**Advising London**

No update available.

### GP Patient Survey Results July 2017, Rachel Doherty, Primary Care Commissioning Manager

RD highlighted the key points of the Patient Survey Results:

- Small sample size - 1% of Southwark population
- Friends and Family Test more useful
- Slight improvement on July 2016
- 79% of patients reported good overall experience of GP
- Don’t perform well with comparison to Lambeth and Lewisham CCG’s
- Lower than the national average on all questions

Discussion took place as to gain an understanding as to why Southwark are not performing as well as Lambeth and whether the size of the practice would have an effect on a good or bad result. There are no obvious reasons why due to similar contract funding.

### Role of EPEC in assuring good practice engagement – Rosemary Watts

JE introduced this item and noted that conversations have taken place at a number of previous meetings about the role and membership of EPEC. She in particular noted that the clinical lead for engagement’s terms of office at the CCG has come to an end (Jacques Mizan) and that a number of patient representatives have also moved on.

RW the reminded members that at the previous meeting we had looked at the new NHS
England guidance on engagement highlighted the ten principle of participation:

1. Reach out to people rather than expecting them to come to you and ask them how they want to be involved, avoiding assumptions
2. Promote equality and diversity and encourage and respect different beliefs and opinions
3. Proactively seek participation from people who experience inequality and poor health outcomes.
4. Value people’s lived experience and use all strengths and talents that people bring to the table, working towards shared goals and aiming for constructive and productive conversations.
5. Provide clear and easy to understand information and seek to facilitate involvement by all, recognising that everyone has different needs. This includes working with advocacy services and other partners where necessary
6. Take time to plan and budget for participation and start involving people as early as possible.
7. Be open, honest and transparent in the way you work; tell people about the evidence base for decisions and be clear about resource limitations and other relevant constrains. Where information has been kept confidential, explain why.
8. Invest in partnerships, have on-going dialogue and avoid tokenism; provide information, support, training and the right kind of leadership so everyone can work, learn and improve together.
9. Review experience (positive and negative) and learn from it to continuously improve how people are involved.
10. Recognise, record and celebrate peoples contributions and give feedback on the results of the involvement; show people how they are valued.

Members then discussed what skills, knowledge and experience that members of EPEC need in order to assure the Governing Body that the above principles are met.

The ideas were documented on flipchart and are written up as a power point.

JE and RW to review and to map out what skills exists in EPEC already and whether there are any gaps.

AG asked what are the terms of reference for EPEC. JE reported that they have not been reviewed for a while and will be part of this exercise.

**Date of the Next Meeting:** 21 September, 5 – 8 pm
Summary of the meetings of the Joint Commissioning Strategy Committee for the CCG Governing Body

9 February 2017

The meeting was attended by a range of senior staff from the council and the CCG including; the Strategic Director for Children’s and Adults Services, the Strategic Director of Finance, the Directors for Commissioning, Adult Social Care and Public Health from the council, and the Chair and Vice Chair, Chief Officer, Chief Financial Officer, Director of Integrated Commissioning and Clinical leads from the CCG.

The meeting considered reports from both Finance Directors setting out the financial position of the council and the CCG and the wider health economy. This focused on current budget deficits, cost pressures and savings programmes. There was a particular focus on the background to the council’s deficit position and savings programme, and the historical context of national funding reductions and rising demand. Previous ambitious savings to adult services have not been achieved and this necessitates further reductions in 17/18 to balance the budget. Previously reserves had been used to help fill the gap whilst services were being reconfigured but this option is no longer available as reserves have been depleted. Children’s social services have been protected from cuts in the budget process but are also overspending significantly, especially on placements for children looked after which have grown in number and cost. Other services are being reduced to help cover this deficit. Issues around proposed reductions to Speech and Language Therapy and CAMHS were discussed by the meeting.

The potential impact on the whole system of the council savings programme was considered and it was agreed that earlier identification of issues and joint discussions around budget strategy would be helpful, and the group would take a standing item on the joint financial position. It was also agreed that Council and CCG Officer would review 2017/18 savings in detail to explore ways of jointly mitigating potential negative impacts.

The Directors for Adults, Children and Public Health summarised key issues in their areas for discussion.

The meeting concluded with an update on the Better Care Fund (BCF), noting the delayed national process, and reporting back on the Adults Commissioning Development Group workshop which discussed options for developing the BCF approach to better support the wider integration agenda.

4 May 2017

The meeting was attended by a range of senior staff from the council and the CCG including; the Strategic Director for Children’s and Adults Services, the Director of Finance, the Directors for Commissioning and Public Health from the council, and the Chair and Vice Chair, Chief Officer, Chief Financial Officer, Director of Integrated Commissioning and Clinical leads from the CCG.

The meeting commenced with an update on the financial position of the CCG and the Council. There was a focus on the financial position of the health economy across the South east London area, noting in particular the need for NHS Southwark CCG to make savings of £13m in 17/18 and the extremely challenging savings targets faced by local trusts who collectively need to save £235m. Kings College Hospital faces an unprecedented £71m savings target (10%), whilst South London and Maudsley Mental Health Trust have a 7% cost improvement programme. It was agreed that combined with social care budget pressures this created significant risk in the system that needs to be considered jointly. There was particular interest from the committee in how the hospital trust reductions can be made in a way that protects quality, and it was agreed to examine the potential impact of these reductions in more detail at a future meeting.
There was a budget update from the council confirming the deficit and savings position as described at the February meeting. It was noted that the additional funding announced for adult care in the Spring Budget will help offset the underlying deficit but otherwise the position is unchanged. There was a discussion about the commissioning changes needed to learning disability placements, which are a key area of overspend with high unit costs compared to other areas.

The meeting considered a recent Health and Wellbeing Report on developing a joint approach to financial and transformational challenges (Our Joint Southwark Forward View). This includes the establishment of a new high level leadership group (including a lead council members and CCG non-executive director) to help ensure the potential benefits from taking an integrated approach are realised, helping to overcome any organisational difficulties. This will be supported by a new joint integrated delivery and planning group (IDPG).

A report on the first year of Commissioning Development Groups was presented to the meeting, describing progress made in moving towards a joint population based approach to commissioning as set out in the Southwark Forward View. A lot of useful ground work has been done and now the groups needs to drive forward the agenda by finalising the population segmentation approach and developing commissioning intentions in line with agreed road maps. Progress will be supported by the Partnership Commissioning Team which is now becoming more established with most posts recruited to.

Updates were provided on the development of the mental health strategy, the primary health care model for mental health, the Better Care Fund and review of urgent response and re-ablement towards a more integrated approach.